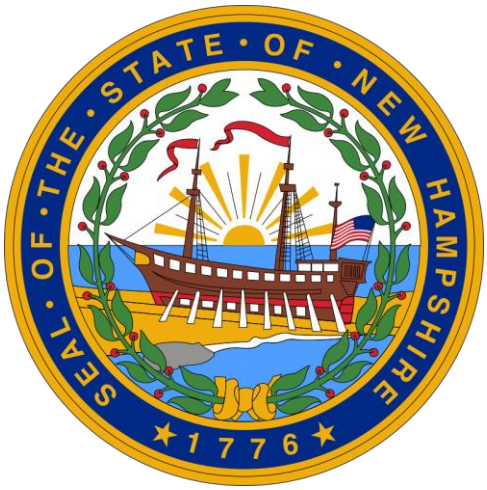

NH DHHS Operations Assessment

January 2021 Phase IB

Prepared by Alvarez and Marsal Public Sector Services, LLC

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PROJECT OVERVIEW

Executive Summary

Background

The New Hampshire Department of Health and Human Services (DHHS) engaged Alvarez & Marsal (A&M) to conduct a strategic assessment of DHHS operations to 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).

A&M's assessment was executed in two distinct phases:

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

Scope

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

In Phase IB, A&M continued to assess the impact of the pandemic and supported the implementation of opportunities in which efficiencies and improvements may be realized in the short term. A&M also explored additional opportunities as requested by DHHS to formulate a long-term vision for the Department to improve services to, and outcomes for, the citizens of New Hampshire.

Approach

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

A&M organized its analyses and recommendations into the following six focus areas or "workstreams," shown below. For focus areas 5 and 6, the team provided advisory and guidance as a continuation of the recommendations issued in Phase IA.

Table/Figure 1. Phase IB Focus Areas

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

Recommendations

Short-Term

A&M identified the following short-term recommendations seen in Table/Figure 2. Short-term is defined as having an implementation time frame of under 18 months. All figures reflect 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 2. Phase IB Short-Term Recommendations

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

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

Long-Term

A&M identified the following long-term recommendations seen in Table/Figure 3. Long-term is defined as requiring an implementation timeframe of 18 months to ten years. 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. Phase IB Long-Term Recommendations

			Est. Costs ($M)		*Est. Savings ($M)*	
#	**Recommendation**	**Description**	**Low**	**High**	**Low**	**High**
D.1.a	Shift 1915(c) waiver services to 1915(k) Community First Choice (CFC)	Shift PAS and related services from the CFI waiver to CFC; services must also be available to developmental waiver participants as an alternative, and not in addition to comparable waiver services.	$0.07M *$0.15M**	$0.11M *$0.25M**	$3.9M	$3.9M
D.1.b	Shift Medicaid State Plan Personal Care Assistant (PCA) services to 1915(k) Community First Choice (CFC)	Shift Medicaid State Plan Personal Care Assistant (PCA) services for waiver participants to 1915(k) CFC.	--	--	$0.37M	$0.37M
D.1.c	Improve coordination of HCBS	With the implementation of CFC, create utilization management protocols to ensure Personal Assistant Services (PAS) benefits for waiver participants are coordinated and are not duplicative.	--	--	$0.0M	$3.1M

**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 (CONTINUED)

Executive Summary | Overview

Scope

A&M performed 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 analyzed 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.

Following the initial identification of issue areas in Phase IA, A&M pursued further analysis in Phase IB. A&M focused on two key areas in this phase, which produced two additional recommendations: implementing a step-down program called Critical Time Intervention (CTI) and revising the funding approach to the State's CMHCs.

Approach

A&M's approach followed a similar process to that of Phase IA, incorporating discussions with stakeholders, document review, and data analysis, with adjustments made for the specific areas. For CTI, A&M reviewed documents and data related to the State's 10-Year Mental Health Plan, Assertive Community Treatment (ACT), admissions at NHH, and the State's Integrated Delivery Networks (IDNs), among other areas. A&M also partnered with third-party authorities, such as the Center for the Advancement of Critical Time Intervention (CACTI) and Arnold Ventures, to review literature and conduct analysis. A&M engaged in multiple conversations with DBH staff, as well as with the staff of CACTI and Arnold Ventures.

To review CMHC funding, A&M reviewed data related to the CMHCs' finances and state-funded CMHC programs. A&M conducted research on bundling rates via Medicaid and on how other states have approached creating bundled rates for select services. This research included interviews with relevant Medicaid staff in other states. A&M also engaged in multiple conversations with DBH staff.

Results

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

Critical Time Intervention

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

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

CMHC Funding

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

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

Executive Summary | Recommendations (Short-term)

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
A.1	Implement Critical Time Intervention (CTI)	Critical Time Intervention, an evidence and community-based practice, may better address the needs of community members; lower hospital readmission rates; and lower hospital readmission costs.	$0.7M	$1.3M	$1.7M	$1.7M
A.2	Rationalize CMHC Funding	Bundling payments of specific state-funded services, such as ACT, and activating currently dormant Medicaid codes may generate savings for the State.	$0.0M	<$0.2M	$0.8M	$1.7M

A.1 | Critical Time Intervention

Recommendation: Implement a statewide Critical Time Intervention program to (1) better address the needs of community members; (2) lower hospital readmission rates; and (3) decrease hospital readmission costs to the State.			
Timeframe	1-2 years	**Complexity**	Moderate

Problem Statement

New Hampshire's 10-Year Mental Health Plan calls for supporting people at risk of hospitalization and reducing avoidable psychiatric hospital readmissions. The State employs a variety of programs to achieve this goal, including Assertive Community Treatment (ACT)**.** Despite substantial efforts by contracted CMHCs, there exists a significant cohort of people stepping down from hospitals without optimal transitional care. Many of these individuals who are not eligible for ACT may instead benefit from a less rigid and restrictive step-down program that still improves their health outcomes.

Findings

A&M's primary findings include the following:

1) Fewer than one percent of individuals screened for ACT receive ACT services. Between January and March of 2020, for example, only 12 new clients received ACT out of a total of 9,022 screened for the service.[1]
2) New Hampshire Hospital, the only state-operated inpatient psychiatric hospital, admits over 1,200 people annually, of which an average of 21 percent are likely to be readmitted. Many of these individuals may not qualify for ACT but would benefit from a less rigid program that helps them transition back into the community.[2]
3) Step-down treatment – a process that helps individuals transition from receiving intensive medical care back into sustainable, independent, and healthy living – is a core part the State's 10-Year Mental Health Plan.
4) CTI, a step-down practice, is a cost-effective and flexible model that can complement a service like ACT. ACT is a community-based *alternative* to hospitalization whereas CTI is a step-down treatment to help individuals transitioning out of hospitals.

COVID Impact

CTI, because of the intimate involvement of the CTI team in each client's daily routine, may enable faster identification of COVID-19 symptoms in clients and thus more timely treatment, if required. It may also make contact tracing easier, as the CTI team is engaged in many aspects of a client's life.

Benefits

CTI provides several benefits, including:

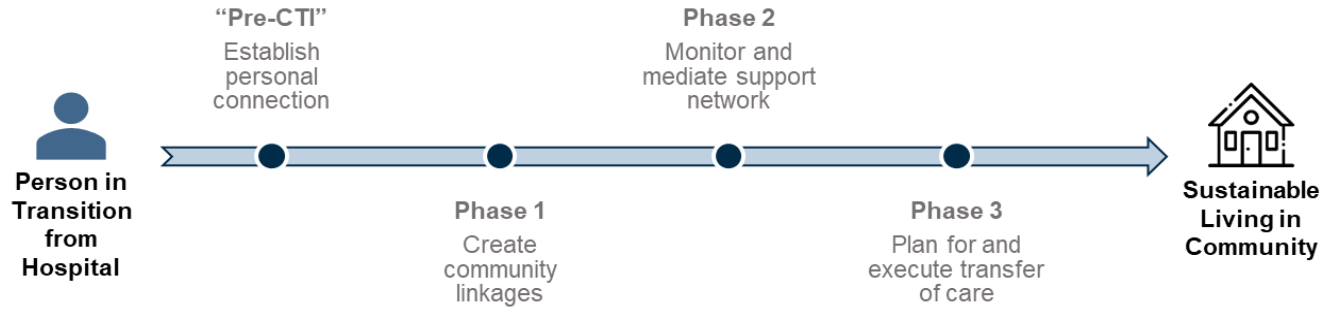
[1] New Hampshire Community Mental Health Agreement Quarterly Data Report: April – June 2020, published October 14, 2020.

[2] Some hospital readmissions are unavoidable; depending on the severity of an individual's SMI/SPMI, inpatient care may be the best setting for treatment. A 2016 survey of state hospitals showed readmission rates by state ranging from 2% to as high as 46%; NHH's rate falls roughly in the center of that range.

1. Numerous studies (including randomized control trials, the "gold standard" in academic literature) demonstrate that CTI drives positive results, including reduced hospital readmission rates, improved clinical outcomes (e.g., reduced substance abuse), and improved continuity of care.
2. Reduced hospital readmissions may translate to avoided costs for the State and the Federal Government, which share the cost of inpatient care. This also means more individuals are living sustainably and healthily in the community.
3. CTI will help many more people in need than ACT alone because of its more open eligibility requirements and because there is a demonstrated need for its application (e.g., 220+ readmissions to NHH annually between FY18-20).
4. CTI complements a variety of care management and coordination efforts already underway (as part of the State's 10-Year Mental Health Plan) by strengthening an individual's connections to family and community.
5. CTI may lead to a more efficient care model at New Hampshire Hospital as fewer readmissions may translate into additional bed space available for those currently on NHH's waitlist.

An in-depth discussion of the CTI model and its potential impact follows below.

Table/Figure 4: CTI Model and Process Overview



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

Phase	Description
Pre-CTI	CTI team meets with a client and establishes personal relationships (prior to discharge).
Phase 1	CTI team connects client to people and agencies ("linkages") that will assume the primary roles of support (e.g., food, housing, healthcare, employment, family, etc.).
Phase 2	CTI team observes operation of client's new support network; mediates any conflict between client and caregivers; and encourages client to take increasing responsibility.
Phase 3	CTI team and client develop plan for long-term goals; plan for and execute final transfer of care to linkages. CTI team ensures client can function independently of CTI.

Eligibility
Individuals eligible for CTI include those with severe mental illness (SMI) and severe and persistent mental illness (SPMI) undergoing a vulnerable moment of transition – e.g., discharge from a psychiatric hospital.

Requirements
CTI has the following key fidelity requirements:

- Focuses on a fixed period of transition;
- Time-limited at nine months;
- Uses a phased approach (beginning, middle, end), employing unique activities in each stage with decreasing intensity over time; and
- Serves as a "Bridge" to long-term provision of supports and services (i.e., the CTI team itself is not the provider).[3]

Origin
CTI was developed originally in New York City by a team of clinicians, researchers, and advocates working with individuals with mental illness and individuals experiencing homelessness. This team observed that transitions from homeless shelters or hospitals back to the community represented one of the greatest challenges for patients. CTI was thus designed as a short-term intervention for people undergoing a "critical time" of transition in their lives.[4]

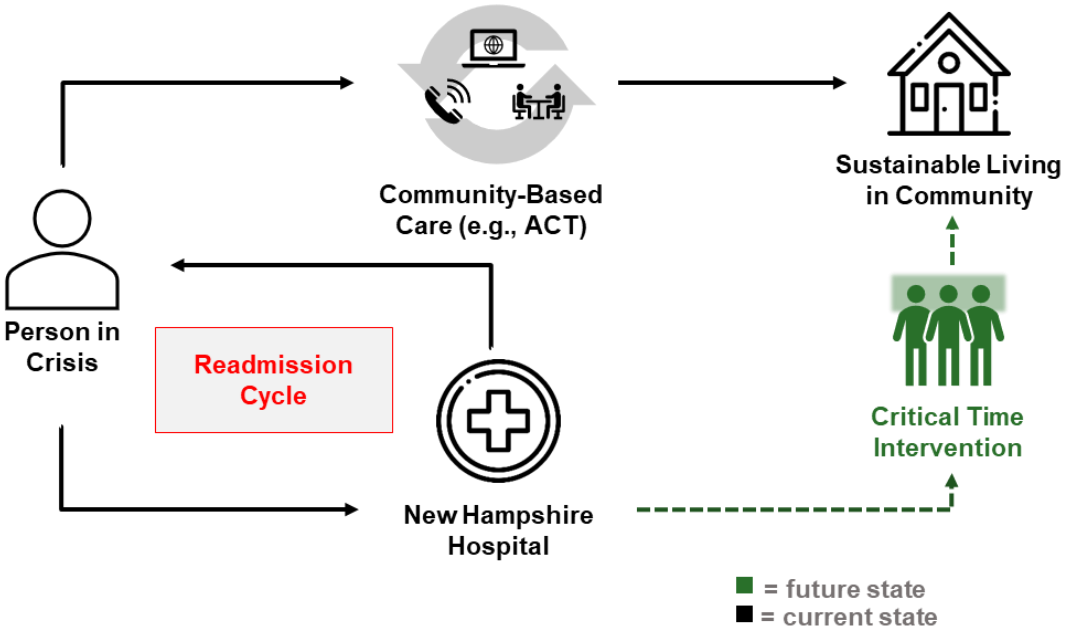
Evidence of Effectiveness
Multiple studies have demonstrated that CTI:

- Decreases hospital readmission;[5]
- Improves housing stability and clinical outcomes (e.g., decreased drug use);[6] and
- Improves continuity of care after inpatient discharge.[7]

As Table/Figure 5 demonstrates, CTI specifically addresses the unique needs of individuals transitioning out of inpatient care. CTI can serve as a targeted complement to more intensive mental health care treatments, such as ACT.

[3] Interview with Daniel Herman, Ph.D, member of CACTI, conducted November 23, 2020.
[4] Center for the Advancement of Critical Time Intervention (CACTI), https://www.criticaltime.org/.
[5] Tomita, Andrew and Herman, Daniel. "Impact of Critical Time Intervention in Reducing Psychiatric Rehospitalization After Hospital Discharge." Psychiatric Services, September 2012.
[6] Kasprow, Wesley and Rosenheck, Robert. "Outcomes of Critical Time Intervention Case Management of Homeless Veterans After Psychiatric Hospitalization." Psychiatric Services, July 2007.
[7] Dixon, Lisa et al. "Use of a Critical Time Intervention to Promote Continuity of Care After Psychiatric Inpatient Hospitalization." Psychiatric Services, April 2009.

Table/Figure 5: CTI Situated in the Continuum of Care



CTI targets individuals in transition and thus at risk of hospital readmission in the future. Hospital patients typically receive little support after discharge other than basic case management, increasing their odds of readmission. CTI aims to break this "readmission cycle" by giving a patient hands-on guidance to return to the community and create linkages that will enable them to live sustainably.

In New Hampshire
26 percent of all NHH discharges (or 342 people) were readmitted within 180 days in FY18; 19 percent (220 people) and 20 percent (240 people) of all discharges were readmitted within 180 days in FY19 and FY20, respectively.[8] CTI, had it been in place, may have supported these individuals and provided them with linkages and tools to remain safely in their communities.

CTI and Other Community-Based Care Models
CTI is not mutually exclusive with or divorced from other community-based care models; CTI is a targeted, time-limited intervention that complements more involved models like ACT. ACT is a community-based *alternative* to hospitalization whereas CTI is a step-down treatment to help individuals transitioning out of hospitals.

Table/Figure 6 and Table/Figure 7 show how CTI and ACT contrast. CTI's lower cost, flexible design, and evidence-backed track record suggest it may be a valuable supplement to ACT. Introducing CTI to NH DHHS' step-down toolkit would demonstrate the State's commitment to supporting people exiting institutional settings.

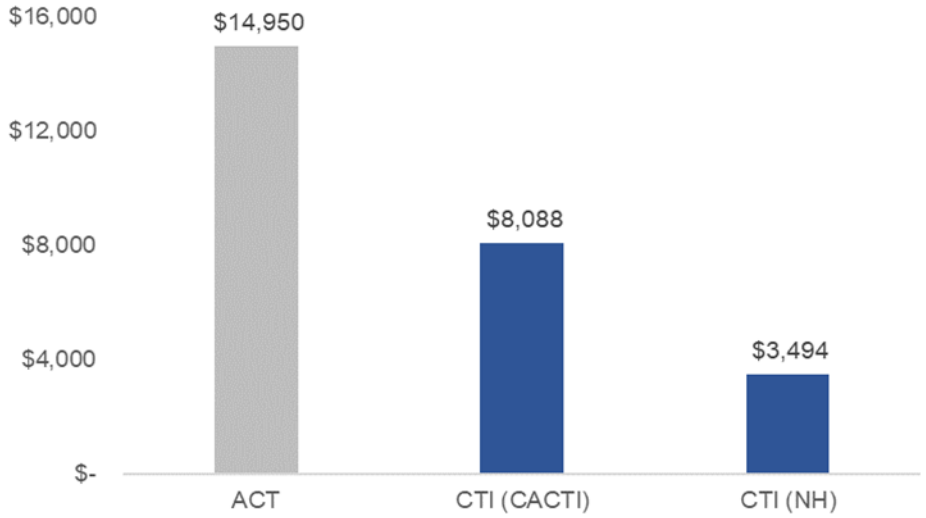
[8] New Hampshire Hospital Admission Data, FY18-20, provided by Andrew Chalsma.

Table/Figure 6: Comparison of Key Criteria for ACT and CTI

Criteria	ACT	CTI
Staffing (per team)	7-10 individuals, including psychiatrist, nurse, peer specialist, Masters-level clinician, functional support worker; staff must be trained in substance abuse, housing assistance, and supported employment[9]	3-5 individuals including one supervisor (Masters preferred but not required) and field workers[10]
Caseload (per team)	10 clients	40-80 clients (~20 per field worker)[11]
Timeframe	Indefinite	9 months
Fidelity Requirements	Extensive*, including: • Large, skilled staffing requirement (as above) • 24/7 team availability • Wide-ranging clinical and social support, from psychiatry to substance abuse support • Rigid engagement requirements with client (e.g., team meetings 4x / week)[12]	Minimal: • Focused on fixed period of transition (9 months) • Phased approach with decreasing intensity • "Bridge" to long-term provision of supports and services
Cost per Client	*See chart below*	*See chart below*

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

Table/Figure 7: ACT and CTI: Average Cost per Client, per Year [13]



[9] New Hampshire Community Mental Health Agreement.
[10] Center for the Advancement of Critical Time Intervention (CACTI), https://www.criticaltime.org/.
[11] Interview with Daniel Herman, Ph.D, member of CACTI, conducted December 7, 2020.
[12] Dartmouth Assertive Community Treatment Scale, Revised 2017.
[13] New Hampshire CMHC 2018 Financial Reports; "Evidence Summary for the Critical Time Intervention." *Social Programs That Work*, The Arnold Foundation, August 2018; June 2020 New Hampshire DSRIP Integrated Delivery Network Semi-Annual Reports.

Cost-Benefit Estimate

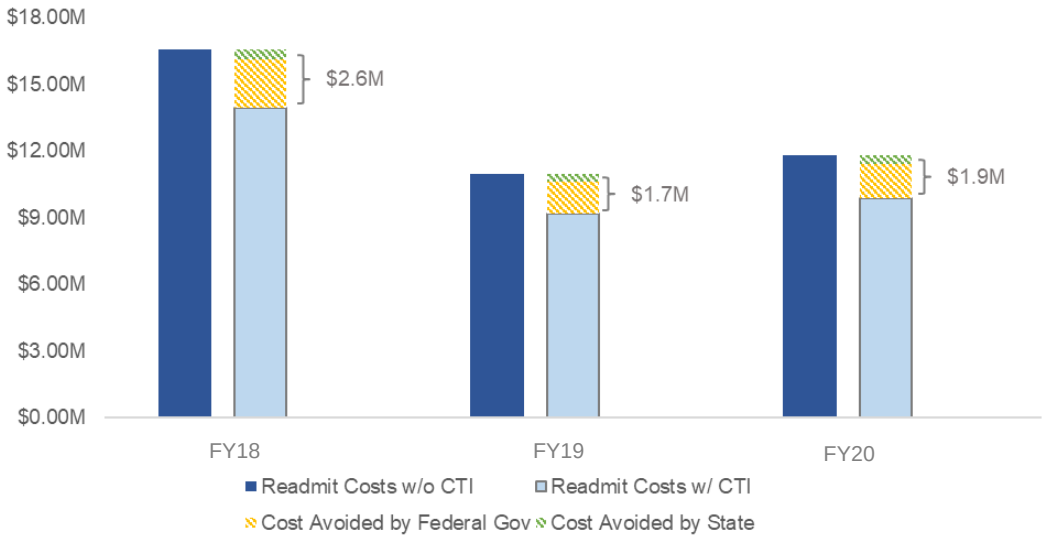
All figures are General Fund; costs and savings reflect average annual figures.

Cost-Benefit	Low	High	Justification
Savings			
Critical Time Intervention	$1.7M	$1.7M	Figures reflect gross savings directly tied to avoiding hospital readmissions.
Investments			
Critical Time Intervention	$0.7M	$1.3M	Costs vary depending on funding method for CTI. Billing through Medicaid will allow for federal match, significantly defraying the cost of CTI to the State.
Net Benefit	$0.4M to $1.0M in average annual savings, as a result of avoided hospital readmissions. Net benefit also includes individuals, who did not return to the hospital, living sustainably in the community.		

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

As discussed above, analysis of NHH readmission data from FY18-20 shows patient readmission rates between 19 percent and 26 percent annually.[14] CTI studies suggest CTI can reduce hospital readmission rates by 26 percent if eligible individuals receive CTI treatment post-discharge.[15] A&M developed a model that projects the pro forma impact of CTI on finances and readmissions between FY18-20. As Table/Figure 8 below shows, this model suggests that CTI's impact for FY18-20 could have led to 209 fewer readmissions to NHH and avoided $6.3 million in hospital readmission costs, of which $1.2 million would have covered by the State.

Table/Figure 8: Pro Forma Impact of CTI on NHH Readmission Costs



[14] New Hampshire Hospital Admission Data, FY18-20, provided by Andrew Chalsma.
[15] "Evidence Summary for the Critical Time Intervention." *Social Programs That Work*, The Arnold Foundation, August 2018.

Table/Figure 8 [continued]

Costs/Savings	FY18	FY19	FY20
Readmit Costs without CTI	$16.6M	$11.0M	$11.8M
Readmit Costs with CTI	$14.0M	$9.3M	$9.9M
Costs Avoided by the Federal Government	$2.1M	$1.4M	$1.5M
Costs Avoided by State	$0.5M	$0.3M	$0.4M

Under the baseline scenario shown above, the savings from avoided readmissions are split evenly between the State and the Federal Government, with the cost of CTI absorbed by the State and the costs of NHH shared evenly between the State and the Federal Government.

It is possible that the Federal Government could shoulder some of CTI's costs if the State billed the program through Medicaid. Table/Figure 9 below outlines the various funding options available to the State, including those that involve billing through Medicaid. A&M recommends billing for CTI through Medicaid, preferably by developing a bundled or "case" rate for the service.

Table/Figure 9: Potential Funding Options for CTI

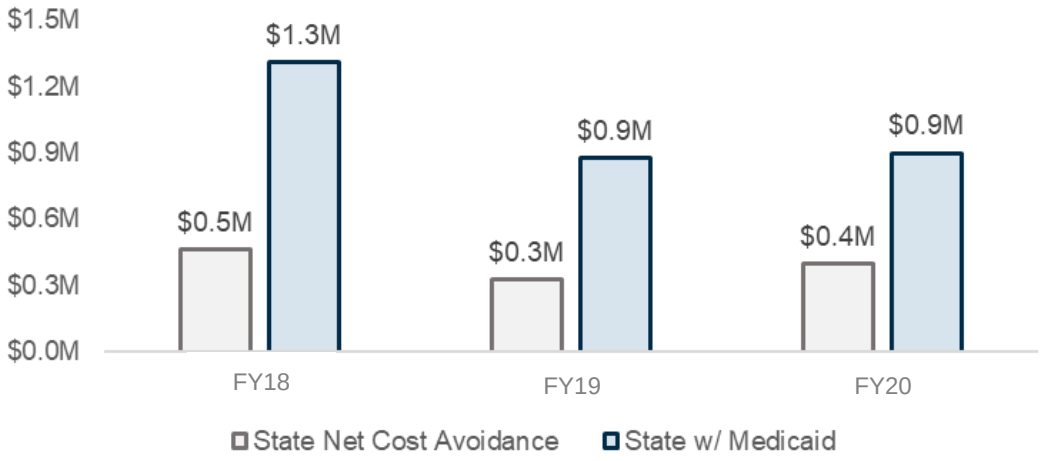
Funding	Advantages	Disadvantages
Government Grants / Contracts	• State contracts or federal grants ensure funds dedicated strictly for CTI capacity creation; SAMSHA has awarded CTI-specific grants in the past (e.g., the Idaho Department of Health and Welfare)[16]	• Grants or contracts require periodic reauthorization and are delivered in discrete amounts that may not always cover costs. • Federal grants are unlikely to prove sustainable over the long term.
Nonprofit / Foundation Grants	• Nonprofit grants can cover some or all program start-up costs, as well as studies of program effectiveness (e.g., RCTs). • Grants can come with organizational expertise in CTI or similar interventions.	• Grants are delivered in discrete amounts that may not always cover costs and may prove time-limited.
Medicaid (FFS)*	• Billing as a fee-for-service via Medicaid allows for FMAP, reducing cost to the State. • Payment is tied to provision of CTI services. • More data created as a result of Medicaid inclusion, making more analysis possible across patients and populations.	• Potential lack of service codes that match all CTI activities.17 • Won't cover those who don't have or won't qualify for Medicaid.
Bundled or "Case" Rate*	• Bundled rate allows for easy, predictable payments to providers. • Payment covers all services a qualifying patient receives, at a set monthly daily rate. • Covers the full scope of CTI activities.	• Bundled rate development necessary as a precursor; will need to win buy-in of providers.
MCOs*	• Payers may be incentivized to promote CTI to reduce hospital readmission costs. • Payment for CTI services can be bundled into existing admin or PMPM rates.	• MCOs are inherently conservative with new programs and typically cost-averse (even for programs with long-run ROI in the form of cost avoidance).

[16] Center for the Advancement of Critical Time Intervention (CACTI), "CMHS funds three new CTI programs through Transformation grant program," https://www.criticaltime.org/2011/02/01/cmhs-to-fund-three-new-cti-programs-through-transformation-grant-program/.
[17] Interview with Daniel Herman, Ph.D, member of CACTI, conducted November 23, 2020.

**** Medicaid options***

If the State had implemented CTI between FY18-20 and billed through Medicaid, it could have avoided $3.1 million in hospital readmission costs, versus $1.2 million if it had shouldered the cost burden of CTI entirely on its own. Table/Figure 10 below demonstrates the annual difference in cost avoidance to the State. These savings are derived from the federal match that the CTI would qualify for if billed under Medicaid.

Table/Figure 10: Potential Medicaid Impact on State Savings



Aside from funding, other key considerations for implementing CTI sustainably include:

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

Implementation

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

Timeline

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

Risks

A&M identified the following key risks to implementation of CTI:

1) Insufficient funding will limit fidelity and thus CTI's effectiveness – funding should be lined up first before implementation and should be sufficient for two years.
2) Hospital partners (i.e., staff) may require ongoing engagement on the benefits of CTI to ensure they see value in the program and cooperate with CTI teams.
3) A lack of – or poorly defined – eligibility criteria will increase the difficulty in identifying the right individuals for CTI, potentially resulting in decreased program effectiveness.
4) The State should endeavor to align a statewide rollout of CTI with other initiatives under its 10-Year Mental Health Plan. Treating CTI as a standalone, disembodied service may lead to confusion about its place in the broader continuum of care.

A.2 | Rationalize CMHC Funding

Recommendation: Rationalize CMHC funding by (1) adopting alternative funding methods, such as bundling payments for specific services (e.g., ACT); and (2) shifting state-funded programs to Medicaid reimbursement.			
Timeframe	1 year	**Complexity**	Low

Problem Statement

New Hampshire provides regular contract funding to the 10 Community Mental Health Centers (CMHCs) that operate across the State. These CMHCs play a vital role in the broader continuum of care, offering a range of mental health services to predominantly lower-income populations.

At the State's request, A&M explored how funding for the CMHCs may be rationalized (i.e., made more efficient in financing or administration) in order to (1) tie funding more closely to the provision of services, and (2) potentially generate savings for the State.

The State spends $6.9 million per year, on average, on contracts with CMHCs. Starting in the next fiscal year, this figure may rise to as much as $9.0 million per year as the State's DSHP payment expires. These State contracts are "block grants" and are not directly tied to the provision of services.

Findings

A&M's primary findings include the following:

1) The State funded 21 CMHC programs with contracts from FY18-21, totaling $28 million.[18] The annual expenditure on these contracts is expected to increase by $2 million annually as a result of the State's DSHP payment expiring.[19]
2) Assertive Community Treatment (ACT) constitutes 41 percent of all State contract funding to CMHCs between FY18-21; the remaining 20 programs constitute 59 percent. Any effort to rationalize CMHC funding should thus start with ACT.
3) Payments for services such as ACT are often bundled in other states and reimbursed through Medicaid on a monthly or daily basis. At least a dozen different states employ a bundled ACT rate.
4) There are at least 21 inactive Medicaid codes that could be activated and may cover the cost of some of the State's contracts.

[18] New Hampshire CMHC Mental Health Contracts and Amendments.
[19] Interview with Julianne Carbin, Tanja Godtfredsen, Jayne Jackson, and Kyra Leonard, November 23, 2020.

Table/Figure 11: CMHC FY18-21 Budgeted State Contracts by Program

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

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

These contracts average $6.9 million annually between FY18-21 and are poised to increase by $2.0 million annually with the expiration of the State's DSHP payment. Most of the increased cost is projected to stem from ACT and Emergency Services.[20]

A&M was unable to obtain documentation of the Medicaid codes billed for each program, and it is unclear if such an inventory exists. A&M did obtain a partial list of inactive Medicaid codes that could potentially be used to bill for some or all contract-funded services.[21] It is unclear from conversations with State stakeholders and from document review why these codes are inactive. Further research and analysis is required in this area. Determining what codes are billed by each program and what inactive codes might be used in the future could yield meaningful savings for the State.

COVID Impact

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

[20] Interview with Julianne Carbin, Tanja Godtfredsen, Jayne Jackson, and Kyra Leonard, November 23, 2020.
[21] Email correspondence with Kelley Capuchino, November 12, 2020.

Benefits

The primary benefits of develop a bundled rate for ACT and shifting state-funded programs to Medicaid include:

1) Creating a bundled rate allows for effective reimbursement of providers, based on actual service delivery, while allowing the State to control costs (since it sets the rate).
2) Depending on the rate set, bundling ACT can be cost-neutral to the State while eliminating the overhead of contract management, or can generate incremental savings.
3) Bundled rates are ideal for multidisciplinary services, like ACT, that involve many diverse activities that may not all be individually billable under Medicaid. At a minimum, a bundled rate streamlines the billing process for those diverse activities to one stream.
4) Shifting state-funded CMHC programs to Medicaid reimbursement, if possible, would allow for the State to take advantage of FMAP for those services billed to Medicaid.

Cost-Benefit Estimate

All figures are General Fund; savings reflect average annual figures while costs reflect one-time costs.

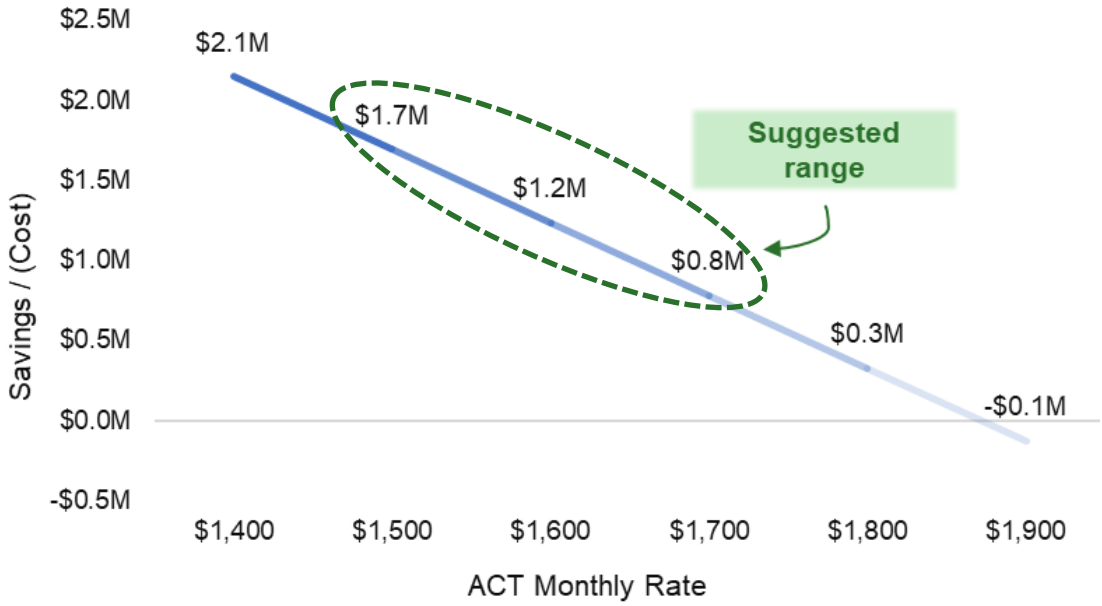
Cost-Benefit	Low	High	Justification
Savings			
Rationalize CMHC funding	$0.8M	$1.7M	Developing a bundled rate for ACT will allow for federal match for all ACT funding to CMHCs. (State contracts are not eligible for federal match.)
Investments			
Rationalize CMHC funding	$0.0M	<$0.2M	Minimal investment likely required, other than potential spend on accounting firm to validate a proposed ACT rate.
Net Benefit	$0.6M to $1.7M in average annual savings, as a result of developing a bundled rate for ACT. Net benefit also includes improved management of ACT service delivery and costs.		

A&M modeled the impact of a bundled ACT rate by developing a range of rates (benchmarked against other states), applying those rates to 2018 CMHC financials (the most recent data made available to A&M), and backing out that year's contract payments.[22] See Table/Figure 12 below for an illustration of potential rates and the savings or costs they could generate. Bundled ACT rates are common among states, including New York, Massachusetts, Iowa,

[22] New Hampshire CMHC 2018 financial reports.

Rhode Island, North Carolina, Delaware, Oregon, Ohio, Washington, and Nebraska. New York sets a monthly rate[23]; Massachusetts[24], Iowa[25], and Rhode Island[26] operate under daily rates.

Table/Figure 12: Potential ACT Rates and 2018 Pro Forma Savings / Costs



A&M's model compares the net savings or cost to the State if a particular rate had been in effect during 2018. Bundling ACT in this manner allows the State to obtain a federal match for all ACT spending. The effect of implementing a bundled ACT rate on CMHC revenue is minimal: a rate of $1,500 causes an average revenue decline of 0.7 percent; a rate of $1,700 causes an average revenue increase of 0.2 percent.

DHHS stakeholders also identified over Medicaid codes that are currently "inactive" – that is, not being billed by the CMHCs. It is possible that these codes may be applicable to some or all the existing contract-funded CMHC programs.

The State should consider creating a complete inventory of the codes used by each program. As of the date of this report, it is not clear that such an inventory exists. This inventory will allow for deeper analysis of program costs and potential savings from activating currently-inactive Medicaid codes.

[23] New York State Office of Mental Health, Regional ACT Rates, Effective 4/1/2020.
[24] Commonwealth of Massachusetts Regulations, Section 430.03, https://www.mass.gov/regulations/101-CMR-43000-rates-for-program-of-assertive-community-treatment-services.
[25] Iowa Department of Human Services, "Assertive Community Treatment Reimbursement Rates Report." December 215, 2018.
[26] "Behavioral Health Comparison Rate Report". Prepared for State of Rhode Island Executive Office of Health and Human Services, Milliman Client Report, February 13, 2020.

Implementation

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

Timeline

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

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

Risks

A&M identified the following key risks to creating a bundled ACT rate:

1) Shifting programs to Medicaid may not cover those ineligible for Medicaid – the State may consider continuing contracts, in some form, to cover that portion of the population.
2) Utilization management is critical – the State will need to define what level of service qualifies for the monthly rate, and what level of service may require a reduced (e.g., half-monthly) rate, to promote cost containment.
3) The CMS approval process is rigorous – the State will need to demonstrate strong evidence of the positive outcomes of ACT and the benefits of shifting to a bundled rate.
4) The State should focus on describing and showing the value of the specific activities delivered under ACT when submitting its SPA and engaging with CMS.

B. SUNUNU YOUTH SERVICES CENTER

Executive Summary | Overview

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

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

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

Results
As a result of the review completed of SYSC. A&M has identified two high-level recommendations that should occur; a) continue to build out the System of Care for DCYF and SYSC to inform a feasible timeline and long-term plan for right-sizing the SYSC facility and b) identify current uses for the SYSC facility.

Executive Summary | Recommendations

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
B.1.a	SYSC System of Care and Long-Term Plan	Continue to build out the System of Care for DCYF to inform a feasible timeline and long-term plan for right-sizing the SYSC facility.				
B.1.b	Establish Concurrent Uses for SYSC	Identify concurrent uses for the SYSC facility to offset costs.				

B.1 | SYSC System of Care and Long-Term Plan

Recommendation: DHHS should (a) continue to build out the System of Care for DCYF and SYSC to inform a feasible timeline and long-term plan for right-sizing the SYSC facility, while simultaneously (b) identifying concurrent uses for the SYSC facility to offset costs.			
Timeframe	1 to 5 Years	**Complexity**	High

Problem Statement

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

Findings

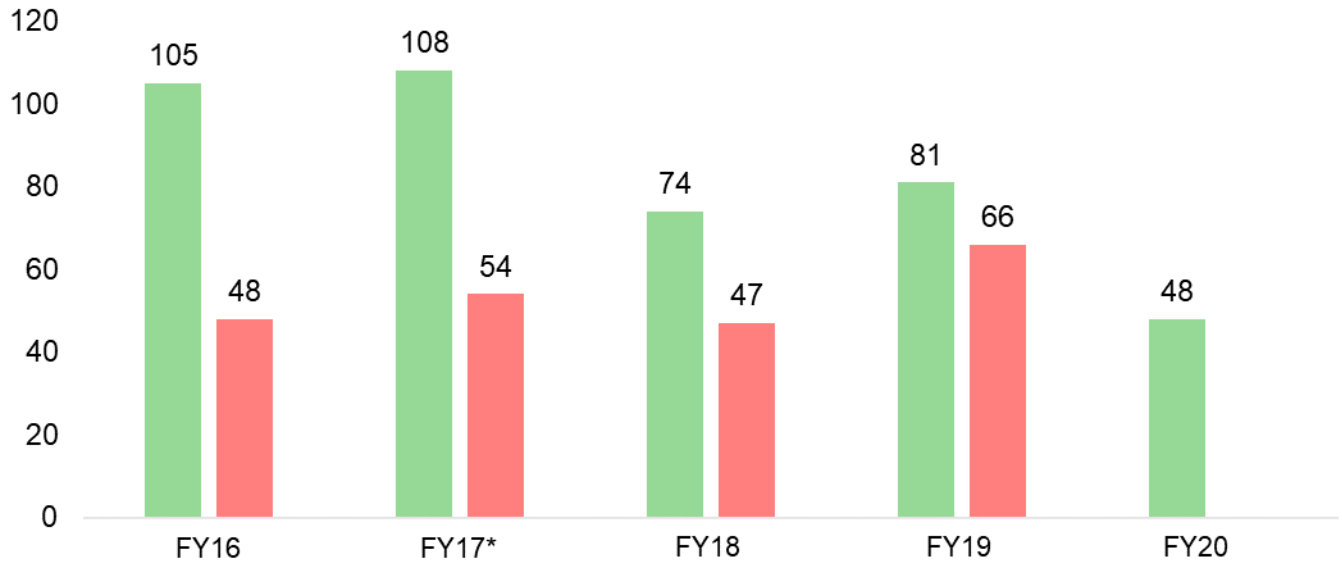
Recent trends in juvenile justice have focused on diverting youth from the juvenile justice system, shifting resources from incarceration to community-based alternatives. In recent years, New Hampshire has enacted the following juvenile justice reform efforts:

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

Among the most prominent reasons for the decreased census at SYSC is the decline in using secure facilities to incarcerate juvenile offenders, stemming in part from changes to sentencing and the implementation of sentence review enacted by the New Hampshire in HB 517.

While admissions of committed juveniles at SYSC have decreased by 56 percent between FY 17 and FY 19, recidivism rates increased by 31.5 percent during the same period. In FY 19, the recidivism rate for SYSC was 81.5 percent, indicating gaps in the current System of Care. Moreover, the average utilization of SYSC in FY 20 was 12 percent, with an average daily population of 16.9 individuals. Lastly, recidivism rates have increased since the implementation of HB 517.

Table/Figure 13: SYSC Admissions and Returns



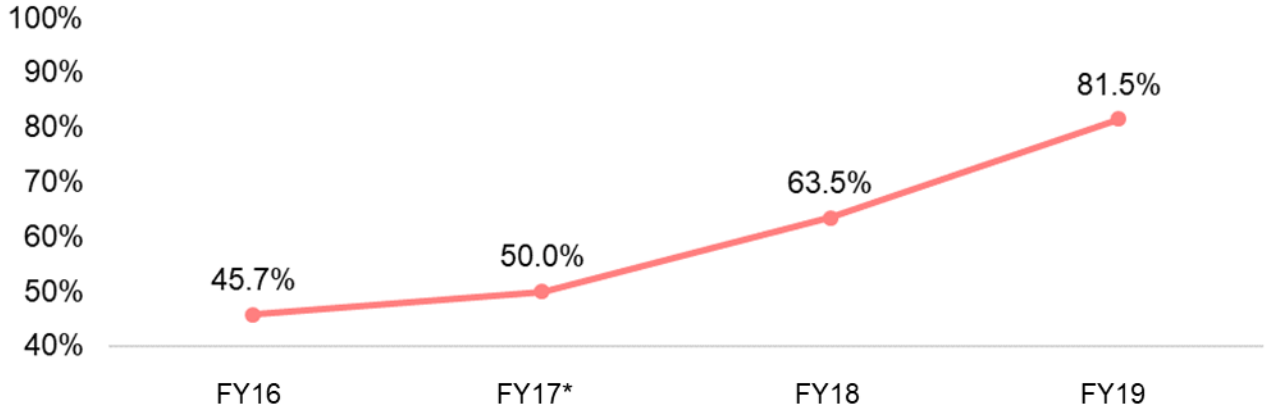
** HB 517 Implemented*

SYSC Admissions: *Includes all committed admissions at SYSC during the FY*

SYSC Returns: *The number of admissions that were entering as committed, and had previously been committed at SYSC*

Table/Figure 13 shows that SYSC admissions have decreased by 56 percent since FY 17. This decrease in the census is consistent with national trends in juvenile justice, which have focused on using incarceration as a last resort placement. While admissions have decreased (a positive indicator), the amount of returns or number of admitted children that had previously been committed has remained constant, leading to an increase in recidivism rates, as shown in Table/Figure 14**.**

Table/Figure 14: SYSC Recidivism Rates



** HB 517 Implemented*

Increasing recidivism rates suggest a gap in the JJS/DCYF System of Care, 1) youth who leave SYSC are not receiving the level of care necessary to support them outside of the

correctional setting; 2) youth who stay at SYSC for a short time (3mo) often do not have enough time to receive the treatment they need.

To understand the current gaps in the JJS System of Care, A&M reviewed the entire DCYF System of Care outlined in Table/Figure 15 below.

Table/Figure 15: DCYF System of Care

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

Gaps in the System of Care

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

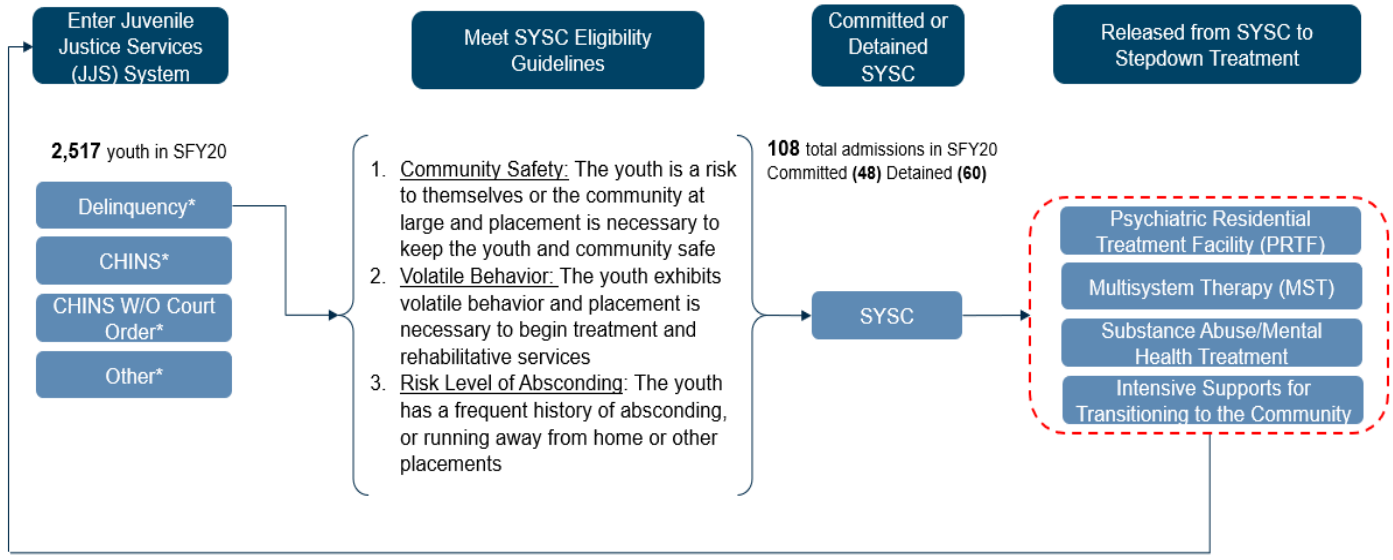
11 Due to the requirements outlined in HB17, youth released from SYSC are often returned to parent/guardian with minimal or no requirements to “step-down” into a more appropriate placement. Without adequate post-discharge treatment, youth are more likely to re-offend. From FY 16 to FY 19, recidivism rates increased by 31.5 percent.

Gaps in the System of Care Currently Being Addressed

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

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

Table/Figure 16: SYSC System of Care Gaps



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

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

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

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

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

Additionally, A&M reviewed recent juvenile justice facility closures and compared them to the current SYSC facility. A total of six states and seven facilities were reviewed for facility size, state cost per youth per facility, facility utilization and youth placement after the facility closed. A&M made the following observations:

- Six of the facilities in Table/Figure 17 had more than one in-state correctional placement option to youth after closure
- Woodside Juvenile Rehab Center (VT) intended to privatize its correctional operations by 10/1/2020. Until the new facility is operational, they are utilizing community based residential treatment programs in VT and placing youth in NH SYSC when needed
- New Hampshire does not have any other in-state correctional facility placement options

Table/Figure 17: Juvenile Justice Facility Closures

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

**average cost across state*

As it currently stands, SYSC is not in a position to be able to close short-term. However, NH DHHS should begin to review repurposing opportunities for the SYSC facility. Research had documented successful prison repurposing efforts with adult prisons and states and localities are beginning to recognize opportunities to transition former youth juvenile justice facilities into sustainable outlets for community development. Publicly available information on such efforts is limited, and little is known about successes or lessons learned from these efforts. A&M utilized the only known report regarding repurposing juvenile justice facilities, *Transforming Closed Youth Prisons, Repurposing Facilities to Meet Community Needs* published by the Urban Institute[27].

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

Table/Figure 18: Youth Correctional Facility Repurposing Efforts in Six Communities

	**Whittier CA,** is launching a large-scale development project
	**Beaumont, TX**, will open a hub for social services
	**Apache County, AZ**, built a LOFT teen community center
	Fulton County, NY, is developing a sustainable mixed income housing community
	Hunts Point, NY, is creating a campus for affordable housing, open space, and development
	Washtenaw County, MI, is developing a sustainable, mixed-income housing community

A deeper review of the effort to repurpose facilities in TX and AZ is provided below.

Beaumont, Texas: Al Price Juvenile Correctional Facility, after remaining vacant for six years will be repurposed into a “one-stop shop for social services”. The Dream Center, a local organization, will use the buildings to provide social services, housing, and recovery support for residents in need, including people with substance abuse issues, at-risk youth, and displaced veterans. The land was transferred to the county with the requirement that the land be used for a public purpose. The Dream Center, in partnership with the Harbor House Foundation, signed a lease for the property, providing an opportunity to fulfill a public purpose and relieve taxpayers of maintenance costs. The 20-year lease places the monthly rent at $1 and contains an option for two five-year renewals. Additionally, after an initial grace period for utilities costs, The Dream Center will absorb all the maintenance and renovation costs, which will be funded by grants and donations.

Apache County, Arizona: The Apache County Juvenile Detention Center was converted into the LOFT Legacy Teen center, which offers communal space, free internet, a music room, and other entertainment for young people. Apache County had closed the facility in 2015 due to cost. Apache County is a small, rural county that lacked adequate social services for youth in need. Costs for repurposing were minimal, as much of the remodeling work was done by probation staff.

Previous Studies in New Hampshire

Given the high fixed costs required to maintain the SYSC facility, NH DHHS has pursued multiple alternative uses and/or cost saving measures that could be implemented while concurrently keeping the SYSC facility operational in its current capacity. Table/Figure 19includes previously suggested concurrent uses for the SYSC facility made by legislators and external parties through previous reports. During the COVID-19 pandemic, the unused spaced mentioned in recommendations 6, 7, and 8 are currently being used as additional correctional space to apply with social distancing. Of the identified eight recommendations, DHHS was only able to implement one due to reasons listed below.

Table/Figure 19: Alternative Uses/Cost Saving Measures for SYSC Facilities[28]

	Recommendation	Implemented?	Rationale
1	Explore the Possibility for SYSC to house an extension of New Hampshire Hospital services for psychiatric and substance abuse care	✘	• Cost • Extensive Requirements • Concern of DOJ Payback
2	Establish a Psychiatric Residential Treatment Facility (PRTF)	✘	• Cost • Extensive Requirements
3	Privatize Education and Food Services	✘	• No Cost Savings Associated
4	Private Provider operates a correctional facility on SYSC property	✘	• No Cost Savings Associated • Concern of DOJ payback
5	Convert unused space into outpatient SUD juvenile treatment and housing for youth up to 21 years of age as they transition back into the community	✓	A private provider was hired to run a SUD treatment facility in 2018. The program subsequently closed due to provider challenges.
6	Convert unused space into a pregnant and parenting teens program	✘	• Cost • Extensive requirements for renovations • Concern of DOJ Payback
7	Use unused space as a place to relocate the Secure Psychiatric Unit patients, currently at New Hampshire Hospital	✘	• Cost • Extensive Requirements • Concern of DOJ Payback
8	Appropriate money for renovation and restoration of the Spaulding and Pinecrest buildings on the DHHS/SYSC site and utilize these buildings to provide community services such as outpatient drug treatment/residence for youth, outpatient mental health or consider utilization as state office space for state local needs	✘	• Cost (requires significant upfront cost to renovate and restore Spaulding and Pinecrest buildings)

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

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

Report to Fiscal Committee of the General Court as to Most Appropriate, Cost Effective, Long and Short-Term Uses of SYSC
Date: 1/2014
Internal/External: Internal
Authors/Reason for Commission: Directed by HB 260, Chapter 249, Laws of 2013
Areas Reviewed: Advantages and disadvantages of the current facility use; potential alternative uses; viability of using another facility; ways the current cost could be reduced.

Cost Reduction Plan for Sununu Youth Services Center
Date: 11/2015
Internal/External: Internal
Authors/Reason for Commission: Directed by Chapter 276:206, Laws of 2015
Areas Reviewed: Opportunities for privatization of services; offering additional compatible services at SYSC; considers the most appropriate cost effective, other uses of the center.

NH DCYF Adequacy and Enhancement Assessment
Date: 7/2018
Internal/External: External
Authors/Reason for Commission: Directed by DHSS after the recent organizational realignment of NH DHHS
Areas Reviewed: Reviews the adequacy and alignment of the current ecosystem of independent partners and stakeholders to ensure a comprehensive, child and family centered system that is more preventative, responsive, and effective for all children, youth, and families involved with the child welfare and/or juvenile justice system.

Committee to Study Alternatives to the Continued Use of the SYSC Facility
Date: 11/2018
Internal/External: Internal
Reason for Commission: Directed by HB 1743, Chapter 355:7, Laws of 2018
Areas Reviewed: Disposal of the existing facility; transition to a smaller correctional facility; transition to small residential treatment facilities with the capacity for secure placement; ability to use excess capacity at SYSC for an outpatient drug treatment facility for youth; if the department has updated all policies procedures and practice consistent with the legislative intent of HB 517. While each report contains specific recommendations, all reports have identified the following themes regarding what should be done at SYSC:

1. Continue to build out the System of Care for DCYF and SYSC
2. Establish a feasible timeline and long-term plan for right-sizing the SYSC facility
3. Identify concurrent uses for the SYSC facility

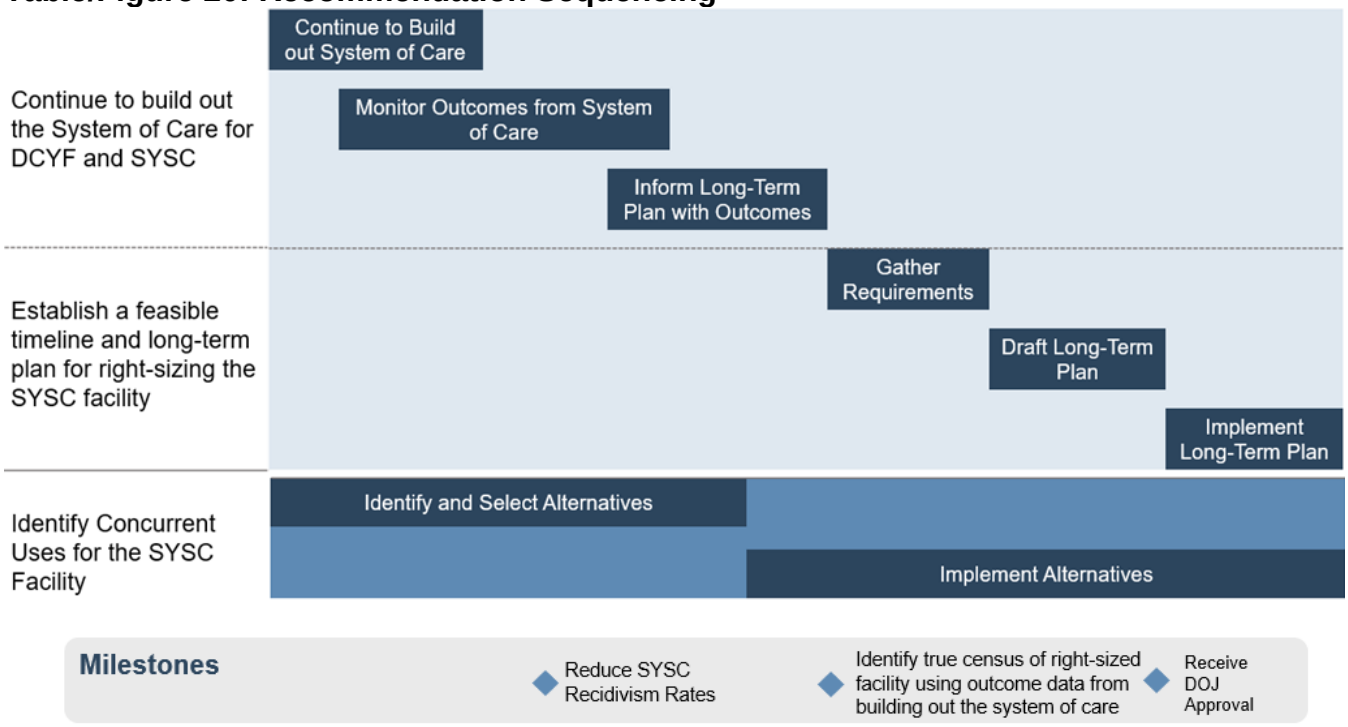
These themes align with the current A&M recommendations. The two recommendations A&M is putting forward for SYSC are intended to build upon one another with the purpose of putting DHHS in a position to effectively execute any decisions on future uses of the SYSC facility.

Benefits

Focusing on the gaps in the current System of Care will allow NH DHHS to effectively shift from using the SYSC facility to another facility while minimizing youth disruption. Building out the System of Care will create more alternative placements for youth consistent with national trends. It will also allow for step-down and transitional options for eligible youth committed at SYSC with the opportunity to reduce recidivism rates.

Identifying a concurrent use of the SYSC facility, while not necessary, will help NH DHHS offset the high fixed costs associated with day-to-day operations.

Table/Figure 20: Recommendation Sequencing



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

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

Implementation

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

Timeline

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

Risks

The following risks regarding addressing current process gaps were identified:

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

C. GRANTS MANAGEMENT

Executive Summary | Overview

Scope
As a part of the review of the efficiency of DHHS, A&M reviewed DHHS' indirect cost allocation practices. This review was initiated following kickoff interviews with stakeholders whereby representatives from multiple divisions identified grants management and contracting as an operational issue area, with large workloads per staff member. Reports of insufficient staffing support for grants management indicated that indirect cost allocation should be examined.

Approach
A&M began by developing an understanding of the grant selection and cost allocation processes and learning the historical context and issues that have arisen in DHHS' grant selection processes. A&M also reviewed federal grant applications and reports in order to understand the indirect cost allocation levels of recently executed discretionary federal grants. This review also incorporated cost allocation results in order to understand the current state of cost allocation in active grants.

Results
A&M aggregated the indirect costs of several large discretionary grants and determined that while for some grants the indirect cost allocation was at or near the ten percent level, not all grants conformed to this best practice-level of administrative allocation. The subsequent section will present the following findings from A&M's review:

- An overall assessment of DHHS' cost allocation budgeting and reporting against the organizational maturity framework
- A brief overview of recent changes in grant selection and cost allocation made by DHHS
- Prior state process findings and key pain points and current state process analysis
- Key assumptions in the current state that DHHS should reexamine

A&M will also present select projections and sensitivity tables to highlight the financial impact of these cost allocation decisions. A&M has hypothesized select process control changes to help tackle the indirect cost allocation issues that have led to potential underutilization of federal funding for administrative activities.

Executive Summary | Recommendations

#	Recommendation	Description	Costs/Investments	Savings (low)	Savings (high)
C.1	Grants Management Process Restructuring	Restructure the discretionary grant application and selection process to increase the potential to draw more administrative dollars from federal grants by building more indirect cost allocation into grant applications. DHHS should also mandate and enforce Finance final approval on both new discretionary grants and discretionary grant renewals.	*Retroactive views of past grant spending have been provided, but forward-looking savings are dependent on grants pursued.*		

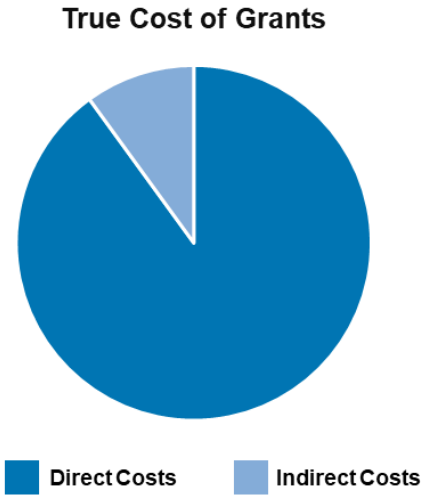
C.1 | Grants Management Process Restructuring

Recommendation: Restructure the discretionary grant application and selection process to increase the potential to draw more administrative dollars from federal grants by building more indirect cost allocation into grant applications. DHHS should also mandate and enforce Finance final approval on both new discretionary grants and discretionary grant renewals.			
Timeframe	3 to 6 months	**Complexity**	Low

Background

Many federal government initiatives operate through the service delivery provided by state government agencies. State agencies apply for federal grants and, upon being selected as a grantee, are responsible for providing the staff to execute the tasks outlined in the grant award. Speaking generally, when state agencies apply for federal grants, the staff must outline and project the budget by which the grant award will spent.

Grant budgets directly tie funding to goods, services, travel, supplies, and the accompanying staff that work directly on the execution of the grant. However, a portion of each grant may be allocated to the indirect costs necessary to administer the grant. This indirect administrative allocation covers a portion of the various functions within a state agency that support the actions of grant activities. Indirect administrative costs include information technology hardware, software, and staff support, finance functions, human resources support, and other property, plant, and equipment that all divisions, bureaus, offices use.



In the process of developing a grant application, a state agency must determine what costs may be included. First, costs should be separated into indirect and direct costs. Next, each indirect cost that could feasibly apply to the grant should be determined to be allowable or not allowable. The determination of which indirect costs are allocated to administration is made according to both the state's cost allocation plan and the specific stipulations of a grant. Allowable costs must be outlined in the NH DHHS's agreed-upon, current cost allocation plan, set in effect on July 1, 2007 (with a Public Assistance Cost Allocation Plan amendment dated September 30, 2019). The grant application must be reviewed to see if any indirect costs are expressly disallowed. After removing from the cost allocation any indirect costs that are disallowed, all allowable costs included in the cost allocation plan should be built into the indirect budget.

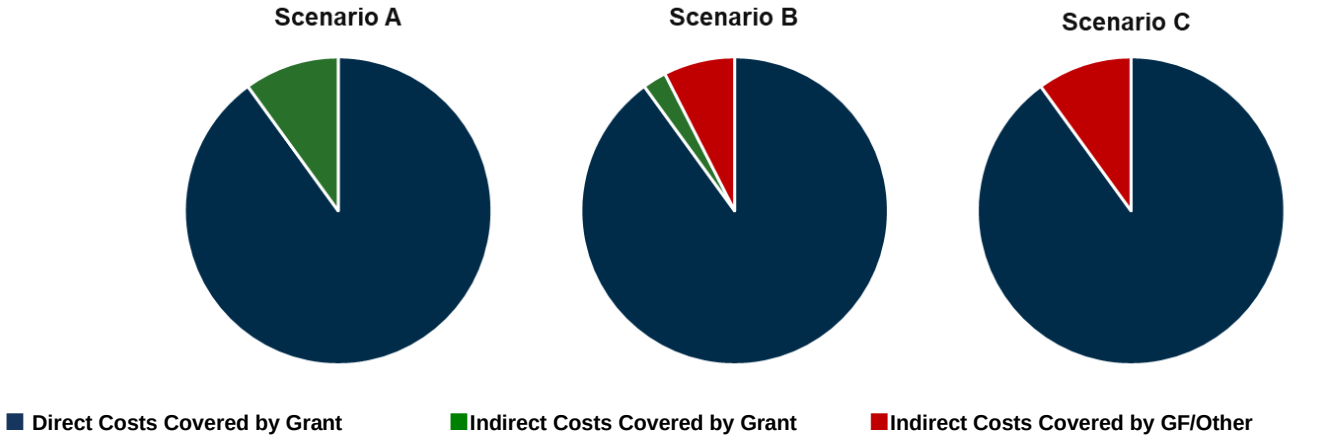
Separate from *which* costs are included in indirect cost, the *amount* allocated to indirect cost must be determined. For example, "Grant A" may stipulate that the applicant can draw down a maximum of five percent on administration, whereas "Grant B" may have no stipulation at all. In these cases, department staff have discretion to include a reasonable amount of indirect

cost allocation into the grant. 2 CFR §200.414 [29](Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards) outlines the legal requirements for indirect cost allocation for federal awards. For state governments, the code states that the indirect costs must follow the negotiated plan (in this case, New Hampshire's 2007 plan and 2019 PACAP updated plan), but no cap is set on the amount of indirect costs per grant that can be allocated. §200.414(f) offers guidance for federal award recipients without cost allocation plans, stating that recipients can allocate a flat ten percent rate to the award for indirect costs. Given that New Hampshire DHHS is a state government agency with an agreed plan, DHHS does not meet section f requirements, but this ten percent benchmark is a helpful heuristic when developing a baseline of acceptable indirect cost allocation on each grant.

The Importance of Indirect Cost Allocation

The true cost of a grant includes direct and indirect activities. State agencies must include these indirect costs into grant budgets in order to avoid them being covered by the General Fund. While under-allocating indirect costs does translate to more funds for direct services, the state General Fund must foot the bill for the remainder of the true cost of the grant. Indirect cost allocation helps state agencies to recoup the full cost of executing the grant. The following scenarios in Table/Figure 21 represent the three levels at which organizations could draw down indirect allocations.

Table/Figure 21: Cost Allocation Scenarios



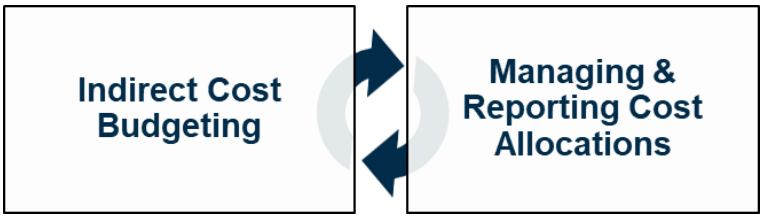
	A: Indirect Fully Included	B: Indirect Partially Included	C: Indirect Not Included
Direct Costs	Fully funded by the federal award	Fully Funded by the federal award	Fully funded by the federal award
Indirect Costs	Funded by the federal award. This scenario provides funding coverage for indirect activities,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

The monitoring and reporting of grant spending is important if the indirect cost allocation dollars are to be realized. However, grant spending cannot be monitored if it has not been built

[29] 2 CFR 200

in the original budget. Further, as the volume of grants managed by a single staff member increases, the ability to manage each grant with the appropriate care to fully realize the value of each grant decreases. If a grant cannot be managed, it should not be pursued. Thus, under-allocating indirect costs decreases the ability of the department to fully staff, and it also hampers the ability to monitor indirect allocation in new grants. In this manner, the cycle becomes self-reinforcing.

Assessing Indirect Cost Allocation



Realizing indirect cost allocation from federal grant awards is predicated on proper grant budgeting inclusion of indirect costs for new grants and managing cost allocation for previously awarded grants. These two factors are dependent on each other to be done properly.

1. The latter factor is reliant on the former to be effective. That is, a state agency cannot managing indirect cost allocation on grants if the indirect cost allocation was not built into the grant budget. The grant budget must have a fully included indirect cost allocation in order for the management to happen.
2. The effective management of grant awards can only be done if the state agency has adequate staffing support to manage the grant in the first place. This staffing support is indirectly tied to the General Fund available for the state budget, which in turn is bolstered by the effective draw-down of administrative indirect cost allocations.

An organization's ability to budget and manage the indirect cost allocation can be examined within the following framework in Table/Figure 22, which A&M used in order to assess DHHS' indirect cost allocation practices.

Table/Figure 22: Organizational Maturity in Indirect Cost Allocation

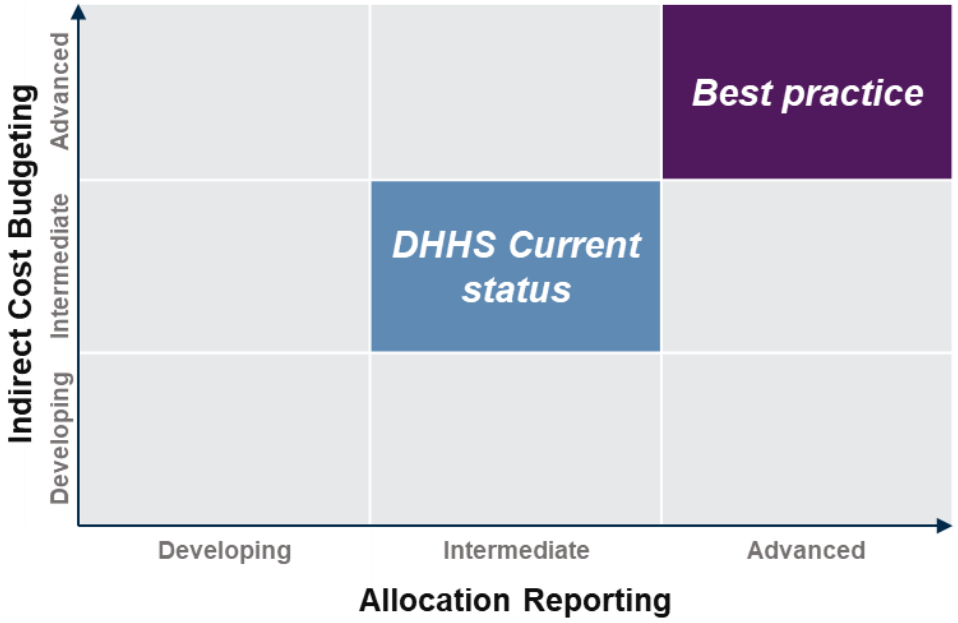
Status		Indirect Cost Budgeting	Management & Reporting
Developing		Little grant budgeting control exists; indirect cost allocation may or may not be included	Reports are not created and cost allocation is not reviewed
Intermediate		Some controls implemented; indirect cost allocation included inconsistently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

This best practice framework is A&M's application of the matching principle, as outlined in United States Generally-Accepted Accounting Principles, to state financial management. This bedrock accounting principle states that expenses must be tied to the revenues that they generate. While the matching principle specifically relates to financial statements, the idea should be applied throughout an organization's practices for proper financial management. This maturity framework measures the level to which an organization applies the matching principle in its grants management activities.

Problem Statement

A&M evaluated DHHS against the aforementioned organizational maturity framework in order to identify the state of DHHS' cost allocation practices. A&M's assessment against this high-level maturity framework is seen below in Table/Figure 23.

Table/Figure 23: NH DHHS Organizational Maturity in Indirect Cost Allocation



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

A&M determined that the grants management processes should further be studied in order to identify if DHHS could improve upon the existing discretionary grant development system.

Findings

Indirect Cost Budgeting

A&M began by identifying the indirect cost allocation percentage of selected high dollar-value discretionary grants, as seen in Table/Figure 24.

Table/Figure 24: Indirect Cost Allocation for Selected[30] Grants[31]

Grant	Year	Indirect %	Grant	Year	Indirect %
Immunization	2020	14.8%	Mental Health Block Grant	2019	5.0%
Overdose Data to Action (OD2A)	2019	10.0%	Medication-Assisted Treatment (MAT)	2016	3.8%
Preventative Health and Health Services	2019	9.4%	State Opioid Response II (SOR)	2020	1.2%
Maternal Infant and Early Childhood Home Visiting Formula (MIECHV)	2020	9.1%	Prohealth	2020	0.3%
Breast and Cervical Cancer Early Detection Program	2020	9.1%	State Opioid Response I (SOR)	2018	0.1%
Public Health Crisis Response (Opioid)	2018	9.1%	Public Health Emergency Preparedness (PHEP)	2020	0.0%
Cancer Registry Program	2020	9.1%	Strategic Prevention Framework-Partnership for Success (PFS)	2019	0.0%
Comprehensive Cancer Control Program	2020	9.1%	MAT Grant (Supplement)	2017	0.0%
Maternal and Child Health Services (MCH)	2019	8.9%			

This table demonstrates that DHHS is incorporating a wide range of cost allocation percentages into discretionary grant budgets (ranging from less than one percent, as in the case of the first SOR Grant, to at or near ten percent, as in the case of the OD2A grant). In short, DHHS grant budgets do not consistently build in indirect cost allocation to the original budget, leaving those expenditures to be covered by General Fund sources.

Management & Reporting

Further, according to analysis performed in conjunction with the Office of Finance, fully 8.5 percent of all DHHS grants did not draw down any cost allocation to indirect costs at all in 2020, as shown in Table/Figure 25.

Table/Figure 25: Grants without Cost Allocation Reported in FY20

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

[30] The initial sample of grants examined included a smaller selection of grants, but the full list of those examined have been included for completeness.

[31] This sample includes grants from the Divisions of Public Health and Behavioral Health due to these divisions being more heavily grant-driven relative to other divisions, but this analysis is intended to apply to all divisions. The inclusion of grants from two divisions is intended to be illustrative only and is not an indicator that this study applies exclusively to grants from these two divisions.

Based on the cost allocation results from Fiscal Year 2020, some grants did not record any cost allocation to salary and benefits at all. As programs do not continue operating without staff supervision, then the grant program must not have recorded the appropriate allocations. If cost allocations were built into budgets, the precise reason for this result must be identified on a case-by-case basis by finance and program teams. If these grants did not have cost allocation built into the budget, then indirect cost allocation for future grant renewal should be reevaluated. In either case, the result is the same: no cost allocations realized means that the indirect activities of these grants were covered in full by the state General Fund.

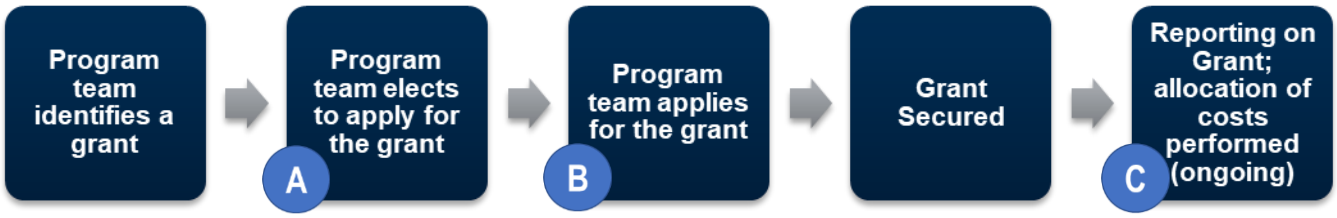
A&M examined both of these interdependent areas, but the recommendation is focused on the indirect cost budgeting portion because of the downstream effects of drawing down administrative dollars. Improved management and reporting of existing grants would provide effective changes, but DHHS is limited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

The following section will walk through the process changes in the grant selection process that DHHS[32] has recently made before making recommendations for further improvements.

Previous Process (prior to Autumn 2020)

DHHS has recently made process changes in an effort to increase the draw-down of federal funding to cover indirect administrative costs. The previous process has been outlined in Table/Figure 26 below, with the key issues arising from select process steps highlighted.

Table/Figure 26: Previous Grant Development Process



The following key issues arose from the structure of this process, shown with the letters corresponding to the pictured process steps:

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

[32] DHHS' grant applications are governed by NH DHHS Grants Office (GO) Policy & Procedures – Applying for Federal Awards and were most recently updated August 2020.

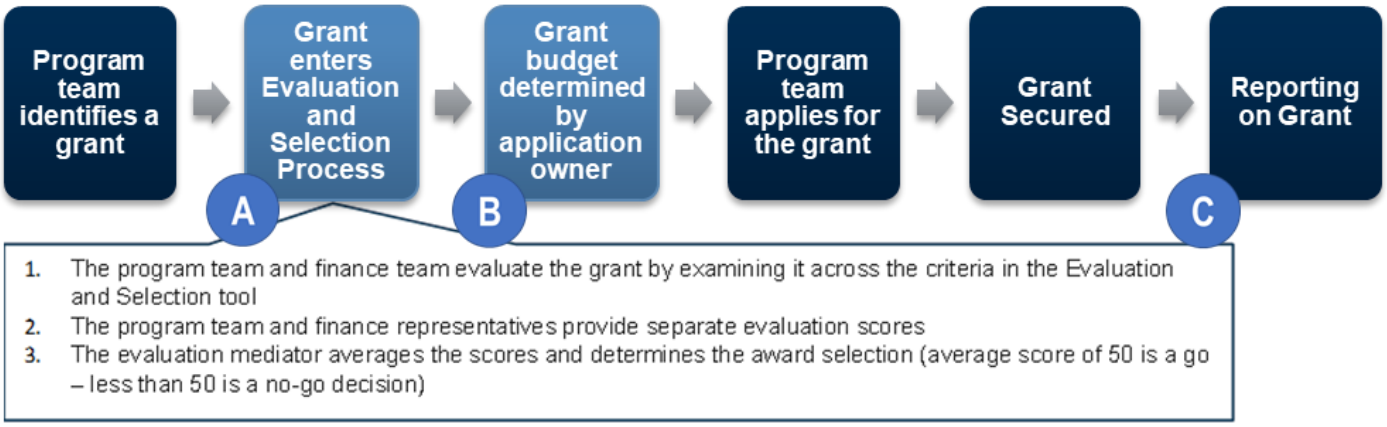
B Under this previous process, an instance could occur where a grant application was submitted without review. For example, a grant could be secured before input from support staff (such as finance or program quality and integrity) have reviewed the budget. If repeated and taken to its logical endpoint, the department could theoretically continue to win grant awards but not have the contract management, finance, IT, program quality, and HR support required to fully manage and support the grant. In essence, the department would have plenty of federal dollars to spend on services but not enough General Fund dollars to support the oversight and management of the programs.

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

New Process (implemented Autumn 2020)

Previous to the start of A&M's engagement, DHHS leadership identified shortcomings in the grant application process following examples where grants were submitted that did not have an appropriate amount of indirect allocation compared to the size of the grant. In response, DHHS leadership instituted a new "Evaluation and Selection Tool" (EVST) in order to ensure that new grant pursuits meet the mandate and capacity of the department. These process changes (shown in Table/Figure 27) were initiated in the Autumn of 2020, with the first deployment of the tool in November of 2020.

Table/Figure 27: New Grant Selection Process



Progress Made and Remaining Issues:

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

where participants in the process hedge their scores as counterbalance to the other party in the process. Assuming the program team member prefers to pursue the grant, the program representative scorer in the evaluation process would be incentivized to score each criteria at the maximum level In order to maximize chances of securing a grant award. Likewise, assuming a finance and operations team member is skeptical that adequate support exists to support a new grant, the representative scorer in the evaluation process would be incentivized to score each criteria at the minimum level. Assuming both premises and both parties acting rationally, the average score of the EVST process would trend toward the median score possible. The first party to relent on their position (i.e., under the maximum for program and above the minimum for finance) would be the one whose score tips the balance. If both parties are acting rationally within the previous assumptions, the averaging structure of the scoring mechanism does not incentivize cooperation.

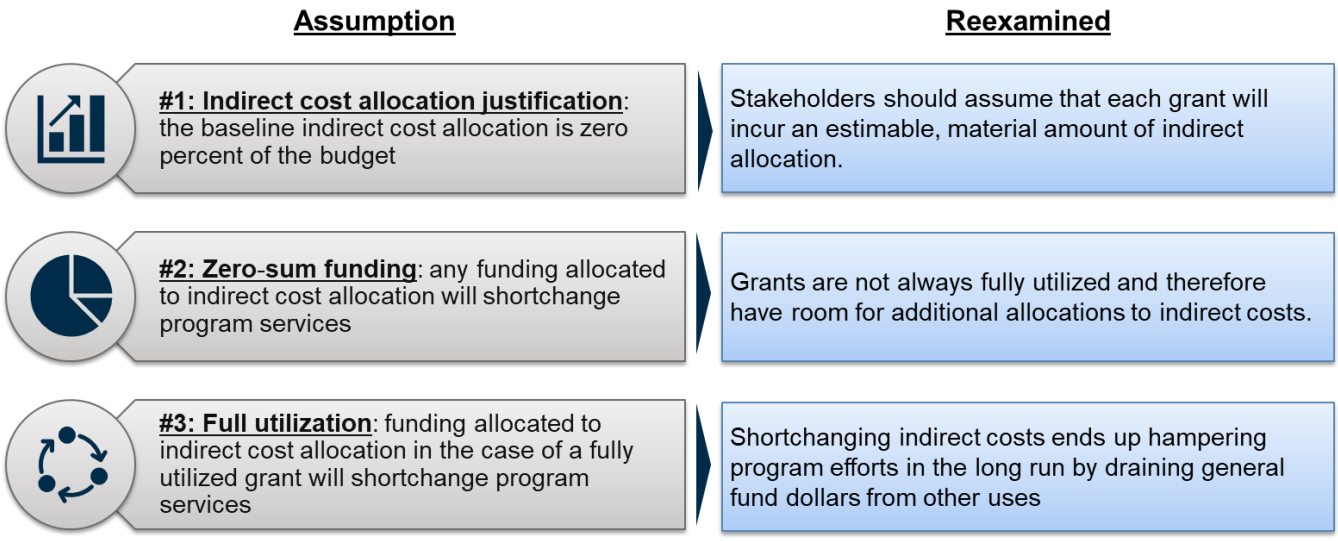
B This newly revamped process solves the key issue from the legacy process of finance being included into the grant selection process, but the process does not mandate finance sign-off on the selections. The team that put together the grant budget is supposed to follow the application policy, but no preventative or corrective controls exist to ensure the budgeting policy is followed. Though the Federal Grant policy states in section 4.3 that "Finance must be involved in the development of any application for Federal Awards," the program staff is ultimately responsible for submitting the grant application.

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

Rethinking Key Assumptions

The zero-sum approach to indirect cost allocation is premised on the following assumptions (outlined in Table/Figure 28) that impede DHHS from changing the culture of grant budgeting.

Table/Figure 28: Underlying Assumptions in Grants Management



This section will reexamine each assumption. Assumption #3 (Full utilization) is related to #2 (Zero-sum funding), as it is an assumption of a hypothetical scenario not presented in Assumption #2. For clarity, this assumption has been presented separately.

Assumption 1: Indirect Cost Allocation Justification

The program-driven approach that has led to instances of zero indirect allocation in select grant budgets is built on an underlying assumption that indirect activities and costs are not part of the grant execution unless they are specifically foreseeable. This forces finance teams, in their effort to secure indirect funding, to manufacture a build-up of indirect similar to a zero-based-budgeting approach. In these cases, finance team members must fully justify and advocate for each indirect cost being built into the budget. This approach assumes zero indirect costs unless otherwise proven. Based on this assumption, certain unforeseeable but allocable costs can be ignored and thereby not reimbursed; indirect costs are likely to be understated as a portion of the total administrative amount.

This approach must be turned around. While the specific amount of an indirect activity may not be easily projected in the grant development process, grant budget developers must assume that indirect costs *will* be incurred. The exact nature and amount of the indirect costs may be unknown, but a relative range should be established where the program and finance team operate on the assumption that a grant of sufficient size will require indirect-type activities to be executed. Rather than finance determining from a bottoms-up perspective what the administrative load should be, DHHS should implement a top-down approach of setting a target for the indirect cost allocation based on historical grant practices. DHHS cannot simply assume a fixed percentage on each grant, as indirect costs must be both allowable by the DHHS cost allocation plan and the specific grant; however, it is a reasonable that a certain range of indirect cost allocation can be assumed. Therefore, the amount at which the administrative load is set should be the greater of the allowable amount set by the grant-maker or a percentage range determined by the DHHS finance office. After the amount of indirect administrative allocation is determined that is appropriate for the grant, the program and finance team should jointly develop justification for the cost allocations based on the aforementioned tree. The program team and finance team can then work in collaboration to determine how the program team should manage the cost allocation to indirect costs.

Division directors and program team members must be at the table to understand that the administrative load must be drawn down and managed, but the ultimate say and discretion to set the administrative allocation in a grant application should not rest solely under the program team’s purview. Under the current, newly created process, the amount of indirect administrative costs incorporated into a grant application can be used as a negotiation tool by division directors to offer finance appropriate incentive to endorse the grant. This status does not lead to DHHS being able to draw down the appropriate full amount of administrative dollars to which it is entitled and still could lead to under-drawing or understating the actual amount. By retooling the process such that all parties assume indirect costs must be incorporated at a certain level and mandating that indirect costs are necessary for a grant to proceed, DHHS can have greater assurance it will draw down the appropriate amount to which it is entitled.

Assumption 2: Zero-Sum Funding
Part of the reason that DHHS is likely under-drawing its administrative grant amount is that the perception exists that allocating more grant dollars to administration will directly take away dollars serving the general public. In other words, the amount of money to be drawn down is a strictly zero-sum pool. *While it is true* that, in many cases, the maximum grant award is a set amount by the Federal Government and more dollars for one line item means less for another line item. However, this assumption implicitly assumes that the entirety of the grant funding award will actually be used.

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

Assumption 3: Full Utilization
In situations where grants are fully utilized, shifting allocation from program services to administrative services should not be treated as a zero-sum exercise, though in a more indirect fashion, for the following reasons:

- Federally granted administrative dollars can fund DHHS activities like DPQI, OCOM, Finance, IT, clerical support, and building funding
- Unutilized federal dollars for these indirect costs means the State is on the hook for a higher proportion of these costs
- The more General Fund dollars that are used for these indirect costs means less General Fund dollars available for other expenditures

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

The following sensitivity table, demonstrates how small, incremental changes in funding mix percentage can lead to significant General Fund expenditure avoidance. Simply changing the funding mix arbitrarily cannot be done, as the funding shift must have an allocable federal grant behind it. However, including more indirect cost allocation in grants provides DHHS an opportunity to drive this shift in funding mix.

Table/Figure 29: Savings Sensitivity in Funding Mix

	Administrative Spend Starting Point (Illustrative, in M)			General Fund Expenditure Avoided (M)		
Funding Shift[33] (GF→Federal)	**$5.0**	**$10.0**	**$20.0**	**$5.0**	**$10.0**	**$20.0**
1.0%	$5.0	$9.9	$19.8	$0.05	$0.10	$0.20
2.0%	$4.9	$9.8	$19.6	$0.10	$0.20	$0.40

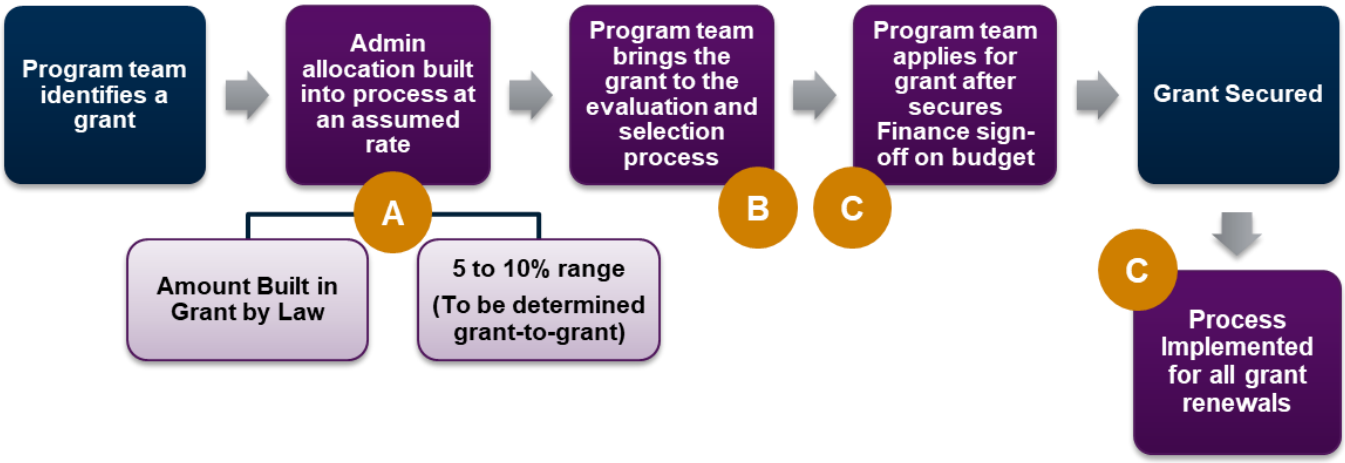
[33] *1.0% = 1.0% increase in federal fund/General Fund ratio toward the General Fund

3.0%	$4.9	$9.7	$19.4	$0.15	$0.30	$0.60
4.0%	$4.8	$9.6	$19.2	$0.20	$0.40	$0.80
5.0%	$4.8	$9.5	$19.0	$0.25	$0.50	$1.00

Future State Creation

A&M recommends the following process in Table/Figure 30 be implemented in order to address some of these issues.

Table/Figure 30: Proposed Future State of Grant selection



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

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

C Finance sign-off is mandated and enforced on both new discretionary grants and discretionary grant renewals. This increased financial control over grant budgets is a shift in decision-making responsibilities, but this will help DHHS grow to be more sustainable in the long term. This shift in responsibility aligns with financial management principles of segregation of duties. Given that the Office of Finance bears the responsibility for the financial health of the agency, this office should have ultimate authority on the expenditure of grant money, even if the grant is federally funded. Stronger control over the decision-making process must be granted to the finance department in order to ensure the opportunity for proper indirect cost allocation is given.This analysis focuses primarily on the process for new discretionary grant applications. Grant renewals that are being processed are encouraged to follow this process, but it is not required. It is A&M's auxiliary recommendation that grant

renewals be subject to another selection review to prevent grandfathering of grants where indirect costs were not sufficiently allocated.

COVID Impact

The importance of appropriate indirect cost coverage is amplified by the COVID-19 pandemic due to the heightened use and involvement of federal grant award dollars from the CARES Act and other funding sources. As a custodian of federal money, state agencies have a responsibility to ensure funding is being used both according to statutory requirements and to best practice. Further, COVID has shifted the activities of many NH DHHS staffers, as the agency is responsible for a significant portion of the response responsibility. While these relief funding sources must be used for the appropriate services, DHHS must ensure that the appropriate indirect cost allocation is being drawn down on these federal awards. If these irregular, COVID-related activities are not being appropriately coded by support staff and management, DHHS will be unable to draw down its normal sources of indirect cost allocation (which, in some cases, were below best practice levels).

Benefits

Adjusting the grants selection and cost allocation process to incorporate more indirect costs into grant budgets could create short-term changes where programs do not receive the level of service dollars expected. However, in the long-term, DHHS could expect to see a boon in funding stability for support staffing. That is, as DHHS phases out over time from lower indirect cost allocation grants and into higher indirect cost allocation grants, the department indirect functions could realize more federal coverage of their indirect costs. Furthermore, DHHS could avoid pursuing grants for which the administrative burden of running the grant exceeds the actual benefit of the federal funding.

A&M's recommendation of process change to realize future savings is contingent on the determination of value by DHHS leadership. Fundamentally, three questions must be considered in order to realize these indirect cost allocation dollars:

1. **Are grant budgets properly built and allocations properly administered?**

Under-allocating indirect costs into budgets is not against the law. It is fundamentally a choice of value by DHHS leadership.

2. **Is the department intending to be lean in administering the grant?**

DHHS cannot build in indirect cost allocation when no indirect activities exist to support the allocation. If DHHS leadership intends for grants to be managed in a lean manner, or if very little support is needed to manage a grant, the indirect allocation may well be at an appropriate level in some of these selected grants.

3. **Was the funding mix having the effects it was intended to?**

The under-allocating of indirect costs means that a higher percentage of the grant dollars are directed toward services. While this narrative outlines the larger DHHS-wide effect of under-allocating, this determination of value could vary grant-to-grant. It very well could be the intention of DHHS leadership to build in a higher percentage for services at the expense of indirect cost allocation.

Ultimately, the decision to change the grant selection process provides DHHS more internal financial control over the programs it pursues and the method of budgeting for those federal programs, but this choice requires some internal culture change. If DHHS elects to continue in the current process, the risk of unrealized indirect cost allocation may persist. It is at the discretion of DHHS leaders if the internal shift will be worth the potential benefits in the future.

Cost-Benefit Estimate

The exact savings projections of instituting increased controls over indirect cost incorporation cannot be projected with strong confidence because such a projection depends on the amount of grant funding DHHS will receive, which is unknown. A&M performed a backward-looking analysis at executed grants that DHHS has secured. The grants examined in this analysis are a selection of larger grants by dollar value. These grant selections are presented in order to provide a sample on the scope of the issue in DHHS.

The following analysis in Figure QQ is presented as a sensitivity table, projecting scenarios where DHHS was able to draw down a minimum of 5.0 percent, 7.5 percent, and 10.0 percent of grant award as administrative cost. In cases where the actual indirect allocation exceeded the sensitivity levels, the General Fund impact has been left blank.

Table/Figure 31: Unrealized Indirect Cost Allocation Sensitivity Table (amounts in k)

Grant	Grant $ per Year	Indirect $ per Year	Actual Indirect %	*Assuming indirect % of:*		
				5.0%	7.5%	10.0%
State Opioid Response II	$28,100.0	$175.0	0.6%	$1,231.6	$1,934.9	$2,638.2
State Opioid Response I	$22,900.0	$7.5	0.03%	$1,137.4	$1,709.8	$2,282.2
Public Health Emergency Preparedness	$5,300.0	$0.0	0.0%	$263.7	$395.6	$527.4
Mental Health Block Grant	$4,800.0	$242.2	5.0%	*5% is the maximum allowable*		
Public Health Crisis Response (Opioid)	$3,900.0	$356.0	9.1%			$35.6
Overdose Data to Action	$1,200.0	$122.4	10.0%			
Preventative Health and Health Services	$2,400.0	$227.6	9.4%			$15.3
Immunization	$2,300.0	$345.6	14.8%			
ProHealth	$2,000.0	$5.8	0.3%	$94.2	$144.2	$194.2
MCH Grant	$2,000.0	$176.4	8.9%			$22.5
Partnership for Success	$1,900.0	$0.0	0.0%	$92.5	$138.8	$185.0
MIECHV Grant	$1,500.0	$137.2	9.1%			$13.7
Breast and Cervical Cancer Early Detection Program	$1,200.0	$108.8	9.1%			$10.9
MAT Grant	$1,000.0	$38.5	3.8%	$12.8	$38.4	$64.0
Cancer Registry Program	$600.0	$50.9	9.1%			$5.1

MAT Grant (Supplement)	$300.0	$0.0	0.0%	$12.5	$18.8	$25.0
Comprehensive Cancer Control Program	$200.0	$21.4	9.1%			$2.1

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

The sum total of the missed grant indirect allocation should not be taken as a projection of how much New Hampshire would be able to realize with these process changes. Likewise, budget priorities should not assume these savings. For one, the various grant opportunities vary based on outside factors and federal decisions. It would be inappropriate to project that because DHHS received a certain amount of award dollars for a particular program that they would receive similar amount in the following biennium. However, this retroactive “what if” view provides illustrative scenarios of federal funds foregone that could have been realized for administrative functions.

Federal awards are intended to deliver services to NH residents. It is the shared mission of the program staff members and support staff to accomplish this goal. However, strong financial and operational controls must exist in order to avoid unintended effects. In the current case of DHHS, which is experiencing relatively higher vacancy rates in numerous divisions, it is not beneficial to DHHS to pursue programs for which it cannot adequately support or monitor.

Implementation

Area	Requirements
People	The effort to change this process would require a “change champion” from the grants office to run point on communication and compliance. The finance team would need to receive training on the new approval process; a change management effort would need to be completed to communicate the process change within program teams.
Process	A fully reformed process map would need to be rolled out as an additive procedure for the August 2020 policy and procedure document. DHHS should consider appropriate corrective measures to address potential noncompliance.
Technology	N/A. DHHS recently engaged in a procurement process to secure more cost allocation capabilities within their software platform, ultimately re-hiring the previous vendor after considering other options.

Preparation Work	A grant approval form would need to be created for documentation of approval by finance for each grant to go forward. A system to review and maintain these records would be required to ensure ongoing compliance.
Statute	DHHS should codify the changes to the grant process within the policy and procedures.

Timeline

Task	Month 1	Month 2	Month 3	Month 4+
Policy Development: Finance Approval forms, noncompliance penalties, grants policies				
Change Management Plan Creation & Vetting				
Policy Rollout: Training Finance Staff and Program Staff				
Ongoing management of new process and communication with stakeholders				

Risks

The biggest risk in the implementation of this process change is that of noncompliance to the new policy. In enforcing the policy whereby finance must give final approval on new grants *and* grant renewals, DHHS should mandate documentation of finance approval of the final budget narrative submitted. Additionally, appropriate measures to avoid noncompliance should be considered.

D. LONG TERM SUPPORTS AND SERVICES

Executive Summary | Overview

Scope

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

Approach

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

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

Results

Services within the Choices for Independence (CFI) waiver for people with physical disabilities and seniors are closely aligned with the required components of a CFC programs. Within the developmental waivers, the service alignment is less straightforward and will require a non-trivial effort to carve out the participants and the services most appropriate for CFC. Within the existing array of waiver services, A&M has identified services that can be shifted to comprise the required and optional components of a CFC program. Waiver participants also receive PAS under the Medicaid State Plan PCA service called Personal Care Attendant Services (PCAS). Of the $6.2 million of PCAS spending for waiver participants, $6.0 million was for CFI participants. Shifting Medicaid State Plan PCA and 1915(c) waiver services to CFC authority will increase federal participation in service expenditures, improve coordination, and reduce the duplication of home and community-based service benefits. A&M recommends that DHHS engage stakeholders in planning and implementation of a CFC program that prioritizes the independence and community integration of people with disabilities to live in their own homes and require supports with ADLs and IADLs.

Executive Summary | Recommendations

#	Recommendation	Description	Costs (low)	Costs (high)	Savings (low)	Savings (high)
D.1.a	Shift 1915(c) waiver services to 1915(k) CFC	Shift PAS and related services from the CFI waiver to CFC; Services must also be available to developmental waiver participants as an alternative, and not in addition to comparable waiver services.	*$.07M** *$.15M^*	*$.11M** *$.25M^*	$3.9M	$3.9M
D.1.b	Shift Medicaid State Plan PCA services to 1915(k) CFC	Shift Medicaid State Plan PCA services for waiver participants to 1915(k) CFC.	--	--	$0.37M	$0.37M
D.1.c	Improve coordination of HCBS	With the implementation of CFC, create utilization management protocols to ensure PAS benefits for waiver participants are coordinated and are not duplicative	--	--	*$0*	*$3.1M*

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

D.1 | 1915(k) Community First Choice

Recommendation: DLTSS should a) shift PAS and related services from the CFI waiver to CFC; b) shift Medicaid State Plan PCA services for waiver participants to 1915(k) CFC; and c) create utilization management protocols to ensure PAS benefits for waiver participants are coordinated and are not duplicative.			
Timeframe	2 Years	**Complexity**	Moderate

Problem Statement

Virtually all demographic changes in the United States point to large future increases in demand for long-term supports and services (LTSS) which encompass a variety of services that assist people who have functional limitations. Within the array of LTSS, personal attendant services (PAS) provide assistance with activities of daily living (ADLs)[34] and instrumental activities of daily living (IADLs) so that people can remain in their homes.[35] Medicaid is a critical part of financing for LTSS and PAS. In New Hampshire in 2014, LTSS accounted for 55.7 percent of total Medicaid spending.[36] New Hampshire has four 1915(c) waivers that provide home and community-based services as an alternative to institutional care. In 2019, these waivers purchased $349 million in services. Spending for New Hampshire's four home and community-based waivers 1915(c) waivers is growing at an annual rate of 4.8 percent.[37] As the State responds to the growing demand for LTSS, DHHS must minimize the administrative burden of delivering these services, ensure eligible citizens can easily access coordinated services, and leverage federal funds to maximize the economic benefits of the predilection for services provided in home and community-based settings.

Background

To improve the community integration of people with disabilities, the Affordable Care Act (ACA) amended section 1915 of the Social Security Act, adding section 1915(k) the benefit known as Community First Choice (CFC), allowing states to amend their Medicaid State Plan to provide attendant services and related supports in home and community-based settings. This option became available on October 1, 2011 and provides a six percent increase in federal matching payments to states for service expenditures related to this option.[38] For the first full calendar year the state offers CFC, the State's share of Medicaid for home and community-based attendant services and supports, i.e., maintenance of effort (MOE), must be the same or exceed the level of state expenditures attributable to the preceding twelve-month period.[39]

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[34] Activities of Daily Living include eating, bathing, getting dressed, mobility, continence and toileting.
[35] Instrumental Activities of Daily Living include cleaning and maintaining the home, managing money, moving within the community, preparing meals, shopping for groceries and necessities, and taking prescribed medications.
[36] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, (May 2018), Aging and Long-Term Care Policy, An Overview of Long-Term Services and Supports and Medicaid: Final Report.
[37] From FY14-FY19 repriced Medicaid encounter claims data provided by Milliman.
[38] Medicaid.gov, Community First Choice (CFC) 1915(k).
[39] Centers for Medicare & Medicaid Services, Community First Choice State Plan Option Technical Guide, pp. 40-43.

To reduce the administrative complexity of similar basic services provided to all waiver populations, the 1915(k) Community First Choice option provides states the opportunity to consolidate personal attendant services (PAS) within an optional Medicaid State Plan service. While different benefit authorities such as 1915(c) waivers provide states the flexibility to target services across populations, CFC seeks to reduce the administrative complexity that results when multiple authorities provide similar types of services across different populations. The CFC option requires services to be available across populations for people who meet institutional level of care making it possible to standardize eligibility and needs assessments while better coordinating services. CFC offers states the opportunity to provide personal assistance and related services in a coordinated manner that highlights self-direction, person-centered planning, and flexible service delivery.[40] CFC, as an optional Medicaid state plan service does not require periodic renewal as required for waiver programs. As of February of 2020, eight states (CA, CT, MD, MT, NY, OR, TX, WA) offer attendant services and supports under CFC.[41]

There are required services that must be included in all CFC programs, as well as additional services that may be included at the state's option. Case management and supported employment cannot be provided under CFC. States are required to complete an assessment of each person, and to identify and provide those CFC services and supports that are determined to be necessary and appropriate. All services and items must be linked to an assessed need and identified in a person-centered plan. CFC services are often provided to waiver participants as a component of a single coordinated individual plan.

Required	Optional
1. ADLs, IADLs, and health related tasks 2. Acquisition, maintenance, and enhancement of skills necessary for the person to accomplish ADLs and IADLs and health related tasks 3. Back-up systems or mechanisms to ensure continuity of services and supports 4. Voluntary training on how to select, manage, and dismiss attendants	1. Transition costs from an institution to a home- or community-based setting 2. Expenditures relating to a need that increases independence or substitutes for human assistance

Some aspects of CFC program administration are similar to 1915(c) waivers. States, for example, are afforded discretion in determining the delivery model for available CFC services. Services may be provided through a traditional agency-provider model, a participant-directed model, or a hybrid that combines these models. CFC services are authorized using a person-centered planning process that identifies the person's strengths, goals, preferences, service needs, and desired outcomes that must be driven by the person receiving services. All CFC

[40] U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services, (12/30/16), SMD#16011 RE: Community First Choice State Plan Option.
[41] Kaiser Family Foundation (February 4, 2020), Key State Policy Choices About Medicaid Home and Community-Based Services.

services must be provided in locations that comply with the Home and Community-Based Settings Rule and states must have a quality improvement strategy that addresses both individual and systemic issues.

New Hampshire does not have a CFC program. Under the current delivery system, New Hampshire provides PAS under the Medicaid State Plan and four 1915(c) waivers. Personal Assistance Services provided under the State Plan are "carved in" and thus included as a managed care plan benefit. Waiver participants are typically "carved in" to managed care for acute and primary care. All waiver services are "carved out" of managed care, and thus not included as a managed care benefit.

Under the Medicaid State Plan, a consumer-direct service called Personal Care Attendant Services (PCAS) provides support for ADLs and IADLs specific to the assessed needs of a person who uses a wheelchair for mobility and resides in a non-institutional setting. The service is intended to provide short term support for someone who, for example, is recovering in their home following a serious injury. PCAS include assistance with medications and nutrition, housekeeping, assistance with bowel and bladder care, and personal grooming.

The State contracts with a single provider for the provision of PCAS services. Attendants are paraprofessionals who must be employed by New Hampshire's Independent Living Center and cannot be a member of the person's family.[42] Each person receiving services is clinically assessed by a registered nurse using the Self-Care Functional Evaluation to develop a person-centered Care Plan.[43] In comparison to PAS provided under the waivers, the rate paid for PCAS is higher. Thirty-four states offer personal care services as an optional state plan benefit. New Hampshire is one of two states (the other is Utah) that does not base the functional needs assessment on a standardized tool. Over half of the states that use standardized tools have utilization control measures in place. New Hampshire does not cap PCAS utilization.[44]

New Hampshire has four 1915(c) waivers that support people who meet institutional LOC. The Choices for Independence Waiver (CFI) serves adults with physical disabilities and seniors ages 65 and older. The CFI waiver includes CFC required services (Personal Care, Backup Systems, Voluntary Training) and optional services that align straightforwardly with CFC. The service alignment in the other three waivers – Developmental Disabilities (DD), In Home Supports (IHS) for Children with Developmental Disabilities, and Acquired Brain Disorder Waiver (ABD) is less straight forward. For example, the DD waiver has residential habilitation/personal care services in which personal care is a portion of a broader service offered at eight levels based upon intensity of need. While appropriate for CFC in levels one and two, the participant driven focus of CFC presents challenges in ensuring the health and safety of people in levels three through eight.

[42] New Hampshire Department of Health and Human Services, (December 1, 2017), Personal Care Attendant PCA Provider Manual Volume II.
[43] Granite State Independent Living Tools for Living Life Independently, Personal Care Attendant Services
[44] Kaiser Family Foundation (February 4, 2020), Key State Policy Choices About Medicaid Home and Community-Based Services.

While state General Fund dollars are appropriated as match for the DD, ABD and IHS waivers, the CFI waiver match relies primarily on county funds. This is due to the unique agreement negotiated between the county and the state regarding funding for nursing homes. The state General Fund contributes only 5 percent of the approximately 50 percent match for the CFI waiver.

Findings

By shifting Medicaid State Plan PCAS for waiver participants and PAS services provided under the waiver to 1915(k) CFC, the State could derive efficiency through improved coordination of care and leverage the enhanced 6 percent FMAP. In FY19, a total of $6.2 million in PCAS were provided to waiver participants. CFI waiver participants accounted for $6.0 million of PCAS expenditures.[45] While in some situations it would be appropriate for a person to receive both State Plan PCAS and personal care services under the CFI waiver, this spending may also indicate duplication of services to address the same needs.

To understand which 1915(c) waiver services could be administered under 1915(k) CFC authority, A&M conducted a review of New Hampshire's four waivers to identify services that align with the required and optional components of CFC. Our approach identified opportunities to claim an enhanced CFC FMAP. To identify potential CFC services, the A&M team applied the following guiding principles:

- The focus of CFC is supporting individuals who want to or live in their own homes rather than group homes or other provider-controlled settings.
- Do not include residential services in CFC. The flexibility extended to states in administering residential services under 1915(c) authority makes it the preferred authority for residential services.
- To the extent possible, leverage existing services and providers to address the required components of CFC programs.
- Minimize the disruption of a CFC implementation on people receiving services and service providers.

This analysis yielded an understanding that CFI services and philosophy readily align with CFC principles. The DD, ABD, and IHS waivers include participants who could benefit from the CFC program's focus on community integration. As participants' needs increase, the comprehensive nature of 1915(c) waiver services is more appropriate to meet those needs. Due to the way these waiver services are "bundled," extracting the PAS component of, for example, Residential Habilitation, is a non-trivial task.

Table/Figure 32: Waiver Review

Service	CFI	DD	ABD	IHS
Personal Care (required)	Personal Care	Residential Hab Personal Care L1-2	Residential Hab Personal Care L1-2	Enhanced Personal Care
	Home Health Aide			
	Homemaker			

[45] From FY14-FY19 repriced Medicaid encounter claims data provided by Milliman.

Service	CFI	DD	ABD	IHS
Backup Systems (required)	Personal Emergency Response Systems			
Voluntary Training (required)	Participant Directed and Managed Services	Participant Directed and Managed Services	Participant Directed and Managed Services	
Transitional (optional)	Community Transition Services	Community Support Services PDMS	Community Support Services PDMS	
	Enviro Mods	Enviro and Vehicles Mods	Enviro and Vehicles Mods	Enviro and Vehicles Mods
Independence (optional)	Home delivered meals			
Other (considered but not recommended)	Respite[46]	Respite	Respite	Respite
	Adult Medical Day[47]	Community Participation Services (Day Hab)	Community Participation Services (Day Hab)	
	Non-medical transportation	*transportation not a standalone service*	*transportation not a standalone service*	*transportation not a standalone service*

A&M identified $4.2 million in potential savings which would come from the enhanced 6 percent FMAP reimbursement for applicable CFC services. As seen below in Table/Figure 33, the $4.2 million includes estimates for both CFC required and optional services drawn from 58 procedure codes, as well as from the State Plan. For each code A&M conferred with DLTSS to determine a conservative estimate of expenditures that would be redirected or consolidated within a K plan.

Table/Figure 33: 1915(k) Implementation: Estimate of Cost Savings (six percent FMAP)

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

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

Table/Figure 34. Sensitivity Table of Potential Efficiency Savings for Personal Care

State Plan Expenditures – Personal Care[48]	All Waivers	CFI Waiver	DD/ABD/IHS Waivers
Total FY19 Encounter Claims	$6,165,996	$5,982,338	$183,658
Savings Range (0-50%)	All Waivers	CFI Waiver	DD/ABD/IHS Waivers
0%	$ -	$-	$-
5%	$308,300	$299,117	$9,183
10%	$616,600	$598,234	$18,366
15%	$924,899	$897,351	$27,549
20%	$1,233,199	$1,196,468	$36,732
25%	$1,541,499	$1,495,585	$45,915
30%	$1,849,799	$1,794,701	$55,097
35%	$2,158,099	$2,093,818	$64,280
40%	$2,466,399	$2,392,935	$73,463
45%	$2,774,698	$2,692,052	$82,646
50%	$3,082,998	$2,991,169	$91,829

COVID Impact

The public health emergency created by the COVID-19 pandemic has underscored the risks of providing services in congregate settings. Expanding service options enables people to maximize their independence, affording them greater control to minimize risk of exposure based upon an individual assessment of their needs and circumstances.

Recommendation

To increase community integration and promote independence for people with disabilities, create and implement a CFC program that supports people who meet institutional level of care by focusing on services that assist them with ADLs and IADLs. CFC should target waiver participants who live in their own homes for whom independence and community integration are priorities. CFC must be agnostic regarding disability type, and deliver services based upon a standardized functional needs assessment. Submit a Medicaid State Plan Amendment (SPA) authorizing implementation of a CFC program. Prior to SPA submission, DHHS must complete planning and preparation to ensure the smooth transition of existing services and the roll out of new services under CFC 1915(k) authority. Critical steps in this process include:

- Recruit/hire a CFC director who will be part of NH's LTSS team and coordinate PAS Medicaid State Plan CFC services for waiver participants.
- Recruit/hire a CFC program specialist to support the CFC director.
- Review existing application processes for State Plan HCBS and Waiver Services to create a CFC application process.

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

- Review existing processes to assess functional needs and select a standardized tool for use by CFC to assess needs and inform LOC determination and service authorization.
- Identify existing waiver protocols that can be used or refined and used to support CFC operations i.e., quality assurance and improvement.
- Review existing information systems to identify systems that can support application/eligibility determination, needs assessment, planning, service authorization and billing.
- Create a CFC implementation plan to include a communication plan to engage stakeholders in the planning and implementation process and a training plan to minimize disruption to people receiving services, case managers and service providers.

Cost-Benefit Estimate

Cost-Benefit	Low	High	Justification
Savings			
Shift 1915(c) (waiver services) services to 1915(k) CFC	$3.9M	$3.9M	A&M estimates $3.9M per year can be derived from shifting PAS and related services from the 1915(c) waivers to CFC;
Shift Medicaid State Plan PCA services to 1915(k) CFC	$0.37M	$0.37M	A&M estimates $0.4M per year can be derived from shifting Medicaid State Plan PCA services to CFC.
Improve coordination of HCBS	$0	$3.1M	A&M estimates up to $3.1M per year may result from better coordination of PAS benefits.
Investments[49]			
CFC Program Director	$40,000	$60,000	CFC Program Director
CFC/Waiver Program Specialist	$30,000	$50,000	CFC/Waiver Program Specialist
Functional Needs Assessment	$150,000 (one time)	$250,000 (one time)	Estimated costs include a review of the Medical Eligibility Assessment (MEA), alignment of LOC criteria across waiver targeted populations, and development of an algorithm to align needs with service authorization levels.
Information System modifications	*variable*	*variable*	Acknowledging the current limitations of DHHS' information systems (IS), needed improvements should be considered within a broader scale plan to address the agency's IS needs.

[49] Costs are estimated using the state General Fund portion only of program administration; note that as a Medicaid service and the administration of CFC may be claimed by a state as approved within cost allocation plan at 50% General Fund / 50% federal funds.

Net Benefit	$4.1M	$7.2M	Net benefit is annual and does not include one-time costs.

Implementation

Area	Requirements
People	BDS should hire a) 1 CFC Program Director who should be part of the LTSS team and also work collaboratively with the Medicaid Director and/or designee to plan and implement a CFC Program, and b) 1 CFC/waiver program specialist.
Process	A 1915(k) CFC implementation would require an estimated one year of planning, stakeholder engagement and internal preparation followed by a one-year implementation process.
Technology	The major implication on the existing IT infrastructure is the added complexity in managing/creating procedure codes for the CFC SPA. As such, A&M does not anticipate additional technology is required for this recommendation.
Preparation Work	DHHS will need to create a CFC application process; significant work will be needed to implement a standard needs assessment and service authorization process. Medicaid must prepare and submit a SPA; Stakeholder engagement should begin concurrently with internal cost-benefit and gap assessments.
Statute	N/A

Timeline

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

Risks

There are significant stakeholder, administrative, and budgetary risks from a 1915(k) implementation. To identify these risks, A&M reviewed summaries of CFC State Plan Amendments in five states (CA, MD, MT, OR, and TX). A&M also interviewed state agency staff in Oregon and Connecticut knowledgeable of their respective states' K plan implementation. Risks associated with CFC program implementation include:

1. In states that elect the CFC option, authorized services are available to any Medicaid eligible individual who meets the level of care (LOC) for institutional services. States cannot target any specific group within this broader eligibility group, so 1915(k) serves children and

adults including seniors, people with physical disabilities as well as individuals with I/DD.[50] Anyone meeting the LOC requirement is eligible and cannot be placed on a waiting list. This is in contrast to 1915(c) waiver services which allows waiting lists. States with extensive waiting lists for waiver services that have implemented CFC have reported a consequent increase in state spending.

2. In addition to the services available through the CFC benefit, natural supports provided by unpaid caregivers play a critical role in assisting people to remain in community-based settings. The identification of natural supports in the assessment is an important aspect of determining a person's needs. Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of the attendant. States that have implemented CFC report increased state spending when unpaid supports shift to paid supports.

3. Several states have been approved to include CFC as part of a service package available in a managed care arrangement. When a state is including a CFC payment in a health plan, the capitation rate must include a separate CFC section in their Actuarial Certification. The state must use only CFC services in calculating that portion of the entire capitation payment attributable to CFC in the separate section in order to be able to claim expenditures at the enhanced Federal Medical Assistance Percentage (FMAP).[51]

4. Our analysis indicated limited to no correlation between ADL scores on the MEA and waiver service authorization for PAS (R^2 = .29).[52] Aligning assessed needs with service authorization, while a sound approach from an administrative perspective, may create operational challenges with unclear benefits. This may be a point of contention for people who have come to rely on PAS and for providers who rely on the revenue generated by these services.

5. Because CFC aspires to serve people across targeted disability populations, states must refine systems using a cross-disability perspective. The state will need to assess and address disparities between PAS services, such as the rate differential in which PCAS is reimbursed at a higher rate than paid for PAS under the CFI waiver. Finding this common ground across disability populations can have both fiscal and policy impacts. Facilitating consensus regarding CFC protocols will require extensive and substantive stakeholder engagement that requires a significant investment in time and a commitment to iterative dialogue and compromise.

6. States that have implemented CFC programs report instances of unanticipated expenditures. In OR, the number of people on waiting lists who were determined eligible for CFC and their demand for the array of services covered by CFC (including high-cost residential services) resulted in substantial unanticipated spending. In CT, the CFC

[50] Cooper, Robin, (November 2017), National Association of State Directors of Developmental Disability Services, Waiting Lists and Medicaid Home and Community-Based Services, p.4.
[51] U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services, (12/30/16), SMD#16011 RE: Community First Choice State Plan Option.
[52] From FY19 MMIS expenditure data provided by DLTSS staff.

programs did not plan for the coordination of CFC benefits with waiver services. People on waivers were initially able to access CFC in addition to PAS-like waiver services. Their CFC program subsequently implemented utilization controls to assess total needs and coordinate benefits between CFC and waiver services.

7. There are several operational challenges in the provision of existing PAS. Case management provided by the CFI waiver lack robustness. Systems for service authorization, planning, and utilization management are lacking for waiver services. Information systems and technology that support the provision of PAS are inadequate. DHHS is experiencing high vacancy rates that impact the agency's ability to perform day-to-day transactional activities, not to mention administrative time needed for operational and transformational changes. These existing vulnerabilities present a risk in implementing new programs or service. Planning must seek to minimize disruption of services that people rely on or risk destabilization of service providers.

8. Due to MOE requirements, savings in the first year of CFC implementation must be used to fund other PAS spending, which may include, for example, funding for new waiver participants. Neither OR and CT expressed significant concerns regarding the CFC MOE requirements. New Hampshire, however, due to the unique approach the state uses to fund nursing facility and thus the CFI waiver match, must carefully consider how General Fund sources should be shifted from the enhanced CFC match to other HCBS services. Because the majority of this shift will be derived from shifting CFI services, the state must work with its counties to formulate an approach that meet MOE requirements.