NH DHHS Operations Assessment

November 2020 Phase IA

ALVAREZ & MARSAL

Executive Summary

TABLE OF CONTENTS

I. Project Overview
II. Approach
III. Recommendations Summary
IV. Recommendation Detail

Executive Summary | Project Overview

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

Founded in 1983, A&M is the world's largest turnaround firm. A&M's Public Sector Services (A&M PSS) was established in 2003. A&M PSS combines the firm's expertise in finance, data analysis, and organization efficiency with the policy knowledge of subject matter experts to provide a balanced approach to program assessment, redesign, and transformation. Our approach acknowledges the essential nature of services administered by state health and human services agencies and the responsibility of state government to ensure that its citizens receive the best possible value from taxpayer funded services. A&M's Team included experienced staff who have led similar engagements in other states and have previously served in leadership roles within other state health and human services agencies.

A&M executed its assessment in two distinct phases:

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

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

In Phase IB, A&M will continue to assess the impact of the pandemic, supporting implementation of opportunities in which efficiencies and improvements may be realized in the short term. A&M will explore 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.

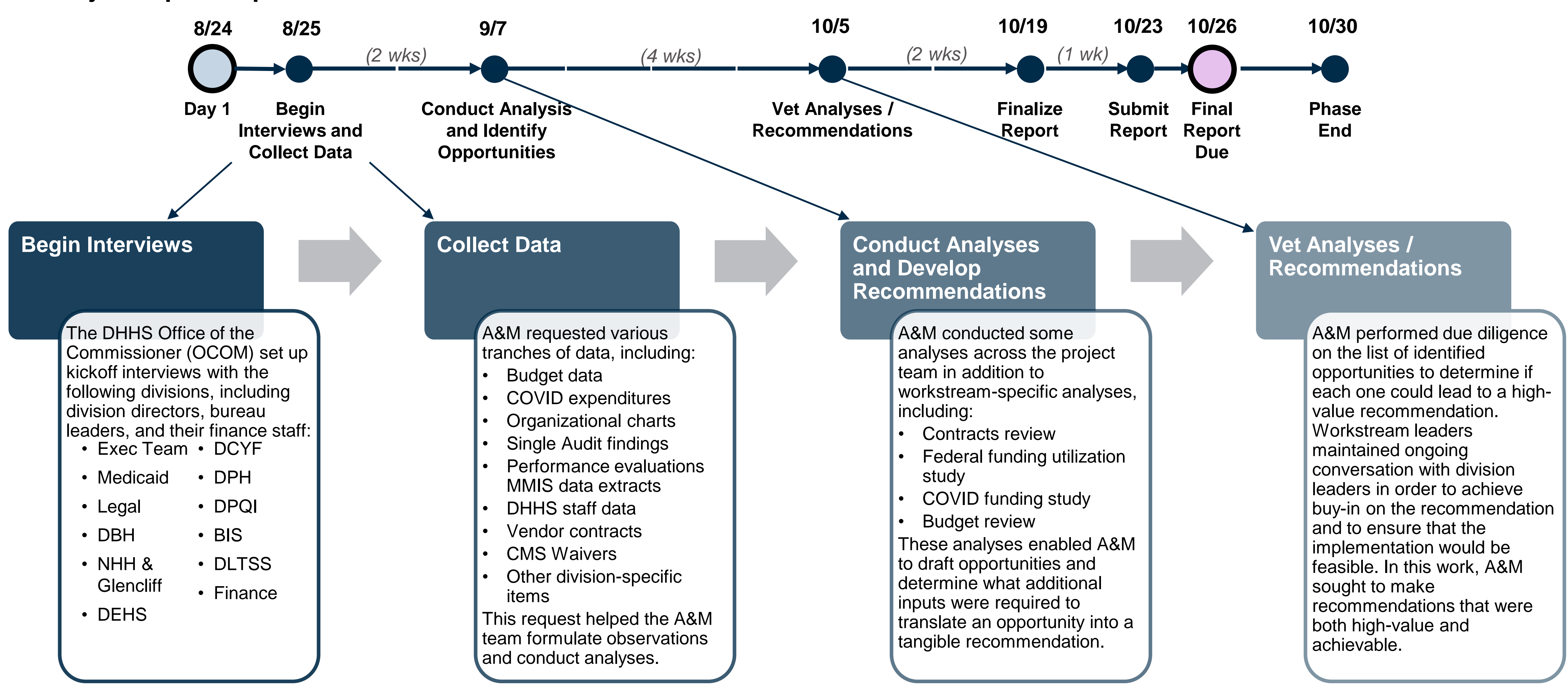
This report presents A&M's Phase IA analysis and recommendations.

Executive Summary | Background

Approach: This assessment was subdivided into three key phases: (1) perform initial interviews and data collection, (2) identify opportunities and conduct analysis, and (3) vet opportunities and recommendations. A&M identified areas of focus, into which we organized our analyses and recommendations presented in this report. The team conducted analyses related to specific divisions such as the Division of Long-Term Services and Supports, as well as certain areas that affect multiple areas of DHHS such as information technology and the Medicaid Management Information System (MMIS).

Recommendations: After performing analysis and vetting the various opportunities alongside DHHS stakeholders, A&M has produced, in this report, 13 recommendations for efficiency. A full list of short-term and long-term recommendations can be found in the following slides. A&M also vetted opportunities but determined not to pursue further action for various reasons (e.g., return on investment was low, analysis was inconclusive, etc.). These opportunities that did not translate into a recommendation have been provided in each workstream portion of this presentation.

New Hampshire engaged A&M to perform a ten-week strategic assessment of DHHS operations. The following timeline describes the major steps and phases of this assessment.



Executive Summary | Approach | Contract Review

The A&M team incorporated a review of Department contracts[1] into our process. A&M reviewed 12 contract groups (listed below) in order to evaluate DHHS's statewide service delivery model in key service areas and identify opportunity areas to increase efficiency, produce cost savings, and improve delivery of services.

1. Review
contracts in groups organized by workstream

2. Create
an inventory of key details across contract groups

3. Identify
key findings both within contracts and across contract groups

4. Hypothesize
improvement opportunities based on initial observations

5. Develop
next steps to more fully investigate opportunities

- Integrated Delivery Networks
- Managed Care Organizations
- Community Mental Health Centers
- "Doorways" Access and Delivery Hubs for Opioid Abuse
- Adult Day Care
- Dev. And Acquired Brain Disorder Services
- Nutrition and Transportation Services
- Disability Resource Center
- Regional Public Health Networks
- Primary Care Services (including for people experiencing homelessness)
- Family Planning Services
- Comprehensive Family Supports

- Services provided
- Population served
- Area(s) served
- Case management requirements
- Funding source
- Eligibility for services

Reduce overlap in services provided across contracts

Maximize value through utilization of federal funding and increased assurance of contract compliance

Streamline potential redundancies in case management and care coordination

[1]This list of contracts was requested to be reviewed in the Scope of Work of this engagement and does not represent an exhaustive list of all contracts reviewed during this engagement.

Executive Summary | Approach | Presentation Key

In this presentation, each recommendation is presented with the following information. This key describes how this information should be interpreted.

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

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

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

Financial Impact:

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

Estimate range provided

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

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

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

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

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

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

Executive Summary | Approach | Focus Areas

The A&M team organized our analyses and recommendations into the following seven focus areas or "workstreams". For all focus areas, we considered the impact of COVID as well as opportunities for short and long-term efficiency improvements.

Focus Area	Description of Analysis Conducted
1. Behavioral Health	Reviewed the current continuum of care across the Behavior Health System, identifying potential gaps and near-term opportunities for increasing capacity for psychiatric treatment.
2. Developmental Services	Performed a comprehensive review of the waiver and service delivery construct, conducted a participant-level analysis to compare costs to level of need, and prescribed various structural changes to this system as detailed in this report.
3. Children, Youth, and Families	Assessed the process by which the Department collects information, applies for and tracks outcomes for IV-E foster care funding.
4. Economic and Housing Stability	Conducted a mapping exercise of the eligibility determination process to identify opportunities for improving performance metrics and investing in infrastructure while offsetting costs.
5. Medicaid Services	Conducted a review of MCO contracts to identify opportunities for short or near-term opportunities to improve provider management practices as well as to assess the need to plan for the Post-PHE period.
6. Medicaid Management Information System (MMIS)	Compared current and historic spending levels on the MMIS to peer states and best practices in MMIS strategy development; and conducted preliminary costs and effort estimates for MMIS replacement.
7. Department-wide Staffing Levels	Analyzed detailed staffing information by division, position, level and function, compared metrics to peer state agencies and staffing needs by function, and assessed the impact of COVID-19 on vacancy rates.

Executive Summary | Recommendations (Short-Term)

The A&M Team identified the following short-term recommendations (potential to implement within 18 months). All figures are general fund; costs reflect one-time and annual; savings are annual.

#	Slide Ref.	Recommendation	Description	Est. Costs ($M) Low	Est. Costs ($M) High	Est. Savings ($M) Low	Est. Savings ($M) High
C.1	56	Maximizing Federal IV-E Funding – Foster Care	In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.	*$0.05M^*	*$0.05M^*	$1.1M	$4.5M
D.1	65	Increase Workforce Capacity	Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.	*$0.10M^*	*$0.16M^*	*Variable*	*Variable*
D.2	65	Implement Technology Projects using COVID Dollars	Implement technology improvements to DEHS systems and other areas to alleviate increased workload due to COVID-19 and improve client experience.	--	--	$2.1M	$2.1M
E.1	78	Eligibility Redetermination	Collect data and complete analyses to inform decision making on eligibility policy, process and system changes, such as the targeted use of automated case closures. Detail tasks and timelines end-to-end. Identify and allocate required resources.	*Variable*			
			TOTAL	**$0.15M**	**$0.21M**	**$3.2M**	**$6.6M**

^ one-time costs

ALVAREZ & MARSAL

Executive Summary | Recommendations (Long-Term)

The A&M Team has identified the following long-term recommendations (implementation time frame 18 months to five years). All figures are general fund; costs reflect both one-time and recurring; savings figures shown are annual only.

#	Slide Ref.	Recommendation	Timeframe	Description	Est. Costs ($M) Low	Est. Costs ($M) High	Est. Savings ($M) Low	Est. Savings ($M) High
A.1	16	SMI IMD Waiver	7-10 months for approved Waiver 24-36 months for new system capacity	Pursue an SMI IMD Waiver as an amendment to the Substance Use Disorder (SUD) IMD Waiver as soon as Amendment #1 is approved by the Centers for Medicare and Medicaid Services (CMS). While the dual SMI-SUD IMD Waiver is pending, DHHS should immediately begin re-engaging with private sector IMD providers who have previously expressed an interest in entering the State subject to approval of an SMI IMD Waiver.	$0.07M *$0.3M^*	$0.2M *$0.3M^*	$3.3M	$4.4M
B.1	31	1915(c) Waiver Redesign	3 years	Develop tiered waivers to identify, limit, and address instances where level of need does not align with current service authorization to promote equity.	--	--	$0.1M	$0.6M
B.2	31	1915(c) Waiver Reimbursement Redesign	2 years	Develop tiered reimbursement rates to better align payment with level of need.	$0.7M *$0.4M^*	$0.9M *$0.7M^*	*Variable*	*Variable*
B.3	31	Information Technology Systems Development	4 years	Establish a comprehensive IT system to better manage, report and utilize data in strategic decision-making.	$0.1M *$0.2M^*	$0.2M *$0.3M^*	*Variable*	*Variable*
B.4	31	Modified Wait List Funding	0 years *(savings realized in 2 years, FY22)*	Reduce the available funding for waitlist participants to more closely align allocated funding with trends in spending.	--	--	$4.1M*	$4.1M*
B.5	31	Intensive Treatment Service (ITS) Options Development	4 years	Develop in-state Intensive Treatment Service (ITS) residential options to reduce or eliminate the need for out-of-state placement of individuals with complex care needs currently at an average cost per person of $385,000.	*$4.9M^*	*$6.5M^*	$0.7M	$2.6M
D.3	65	Redesigning Business Processes	1-2 years	Conduct further analysis into current business processes including call center operations, and case-based eligibility model. Consider implementing enhanced Interactive Voice Technology (IVR) and a triage process within the call center and shifting case-based model to a task-based model.	*Variable*			
E.2	78	Health Plan Performance Incentives	2 years	Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.	*Variable*			

** Revisions to these numbers are underway by division staff and subject to change*

^ one-time costs

Executive Summary | Recommendations (Long-Term) cont.

The A&M Team has identified the following long-term recommendations (implementation time frame ten years). All figures are general fund; costs and savings reflect cumulative savings over the duration of the timeframe.

#	Slide Ref.	Recommendation	Timeframe	Description	Est. Costs ($M)		Est. Savings ($M)	
					Low	High	Low	High
F.1	91	New MMIS Strategy Adoption	10 years	Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time.	*variable**	*variable**	$5.5M	$21.6M

** See Slides 96-99 for long-term implementation plans*

ALVAREZ & MARSAL

Behavioral Health

Stakeholder Engagement

Key Personnel Interviewed

Division of Behavioral Health

- Katja Fox, Director
- Jayne Jackson, Finance Director
- Philip Bradley – Office of Legal and Client Services
- Kelley Capuchino, Senior Policy Analyst
- Erica Ungarelli, Director, Bureau of Children's Behavioral Health
- Julianne Carbin, Director, Bureau of Mental Health Services

New Hampshire Hospital

- Heather Moquin, CEO
- Joe Caristi, CFO
- Dan Rinden, Revenue Integrity Manager
- Donna Ferland, Finance Manager

Other DHHS Stakeholders

- Ann Landry, Associate Commissioner for Population Health
- Henry Lipman, Medicaid Director

Data Request

Key Data Reviewed

- 10-year Mental Health Plan
- New Hampshire's Olmstead Agreement
- Contracts with Community Mental Health Centers
- Contracts with providers for the Doorways Access and Delivery Hub Services
- Federal Grant Reports
- Program Inventory Reports
- SUD IMD Waiver
- CMHC Quality Service Reviews
- CMHC Financial Information
- Supported Employment Quality Reports
- Waitlist data for various entities
- New Hampshire Hospital information: financial statements, cost reports
- New Hampshire Hospital Report on Medicaid Charges and Payments
- Upcoming RFP drafts for services delineated in the 10-year Mental Health Plan
- More sources for the IMD Waiver can be found in the appendix

A&M reviewed the full continuum of care of New Hampshire's behavioral health system in order to identify the most valuable and achievable opportunities for improvement.

1. **Scope:** A&M was tasked with performing a strategic assessment of the behavioral health system 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 into (e.g., mobile crisis units, emergency departments, etc.) the most intensive levels of care (i.e., psychiatric hospitalization). A&M was also tasked with analyzing the financial information and other operational indicators of the Division of Behavioral Health (DBH) and various entities such as New Hampshire Hospital (NHH), New Hampshire's Community Mental Health Centers (CMHCs), and other providers.

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

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

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

Behavioral Health | Recommendations | (Long-Term)

The A&M Team has identified the following long-term recommendation in behavioral health (implementation time frame two to three years). All figures are general funds; costs reflect both one-time and recurring; savings figures shown are annual only.

#	Recommendation	Timeframe	Description	Est. Costs ($M) Low	Est. Costs ($M) High	Est. Savings ($M) Low	Est. Savings ($M) High
A.1	SMI IMD Waiver	7-10 months for approved Waiver 24-36 months for new system capacity	Pursue an SMI IMD Waiver as an amendment to its Substance Use Disorder (SUD) IMD Waiver as soon as Amendment #1 is approved by the Centers for Medicare and Medicaid Services (CMS). While the dual SMI-SUD IMD Waiver is pending, DHHS should immediately begin re-engaging with private sector IMD providers who have previously expressed an interest in entering the State subject to approval of an SMI IMD Waiver.	$0.07M *$0.3M^*	$0.2M *$0.3M^*	$3.3M	$4.4M

^ one-time costs

ALVAREZ & MARSAL

Behavioral Health | SMI IMD Waiver | Summary (1 of 2)

Recommendation

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

Findings

States have limited options to cover inpatient BH care within the Medicaid system due to the IMD exclusion. This typically encourages states to invest in the full continuum of community-based care, but NH has found workarounds through the DSH program, allowing a fragmented continuum to persist as evidenced by two measures: Emergency Department (ED) wait lists and long inpatient length of stay (LOS)—especially non-certified days—at NHH. An SMI-IMD Waiver can serve as the catalyst to entice new market entrants to develop facilities and programs to alleviate these two bottlenecks.

Observations:

- In the recent past, NH has faced a capacity gap of ~14,000[1] patient days / year driven by a waitlist[2] ranging from 20-70 adults / day
- Dual SUD-SMI IMD Waivers have become a viable option since CMS' approval of DC's (December 2019) and Vermont's (January 2020) waivers
- While NH has previously considered an SMI IMD waiver, A&M revisited these analyses to confirm financial viability and operational benefits

COVID Impact: We expect the volume of patients seeking inpatient BH care to increase as a result of mental illness and substance abuse being exacerbated by COVID-19 pandemic. NH must be prepared for the potential influx of individuals into the BH system.

Benefits

An SMI IMD Waiver could create the following benefits:

- The waiver could attract new operators to NH, resulting in (1) expansion of capacity across DRF, inpatient psychiatric, and transitional housing beds, and (2) decrease in ED Boarding days. An IMD Waiver would require a modest increase in State GF to draw much larger influx of federal match. This would also free up DSH funds to be redistributed to other hospitals.
- If the new capacity created can decrease the total amount of ED Boarding days from patients who ultimately are admitted to hospital by 50 percent, we estimate an indirect positive annual impact of $3-4 million to State GF.

	Low	High
Savings	$3.3M	$4.4M
Costs	$0.07M *$0.3M^*	$0.2M *$0.3M^*
Net Benefit*	**$3M**	**$4.1M**
Timeframe	7-10 months for approved Waiver; 24-36 months for new system capacity	
Complexity	High	

^ one-time implementation fees; * Net Benefit excludes one-time costs

[1] (38 average patients / day x 365 days / year)
[2] 10-year Mental Health Plan

Recommendation

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

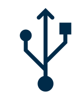
Implementation Requirements

People

A team of individuals is required to develop Amendment #2 to the waiver. Additionally, providers of these services must be engaged.

Process

Once approved, the appropriate processes for movement of patients throughout the behavioral health system of care must be adjusted to accommodate new providers (e.g. statewide waitlist, triage, and referral mechanism).



Technology

N/A

Prep. Work

The waiver amendment application must be prepared by a knowledgeable team with adequate experience in preparing CMS waivers and actuarial support from Milliman.

Statute

This amendment is dependent on Amendment #1 being approved by CMS.

Timeline Outline

Target Start Time: To Be Determined

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

Risks

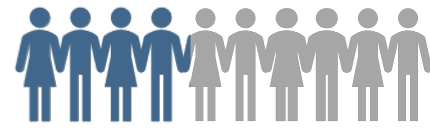
- CMS approval of Amendment #1 to re-baseline SUD IMD waiver
- Support of community mental health advocates
- Continued interest in NH on the part of private sector operators
- Workforce availability to staff new facility

New Hampshire must address capacity issues to meet system needs and prepare for an expected increase patients seeking inpatient BH care due to behavioral health issues exacerbated by COVID.

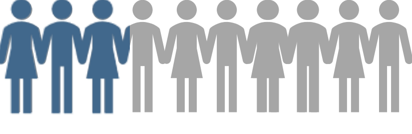
COVID & Adverse Mental Health Conditions

A recent CDC publication[1] on mental health in the pandemic found:

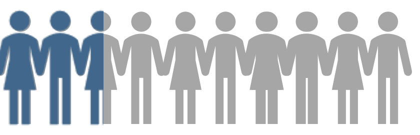
40.9% reported at least one adverse mental or behavioral health condition



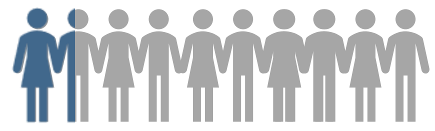
30.9% experienced symptoms of anxiety disorder or depressive disorder



26.3% experienced symptoms of a trauma- and stressor-related disorder (TSRD)



13.3% started or increased substance use to cope with stress or emotions related to COVID-19



Wellness & COVID

A Kaiser Family Foundation (KFF) tracking poll[2] conducted in July found:

53% of respondents reported that their mental health has been negatively impacted due to worry and stress over the coronavirus.

36% of respondents have experienced difficulty with sleeping and **32%** have experienced difficulty with eating.

12% of respondents have increased their alcohol consumption or substance abuse.

12% of respondents are reporting worsening chronic conditions.

[1]Centers for Disease Control and Prevention. (2020, August 14). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. Morbidity and Mortality Weekly Reports. Available at CDC.gov

[2]Panchal, Nirmita *et al*, The Implications of COVID-19 for Mental Health and Substance Use, (KFF, Aug 21, 2020). Available at kff.org

The IMD exclusion rule leaves a significant gap in what Medicaid will cover for inpatient psychiatric care, leaving New Hampshire (and all states) to foot the bill.

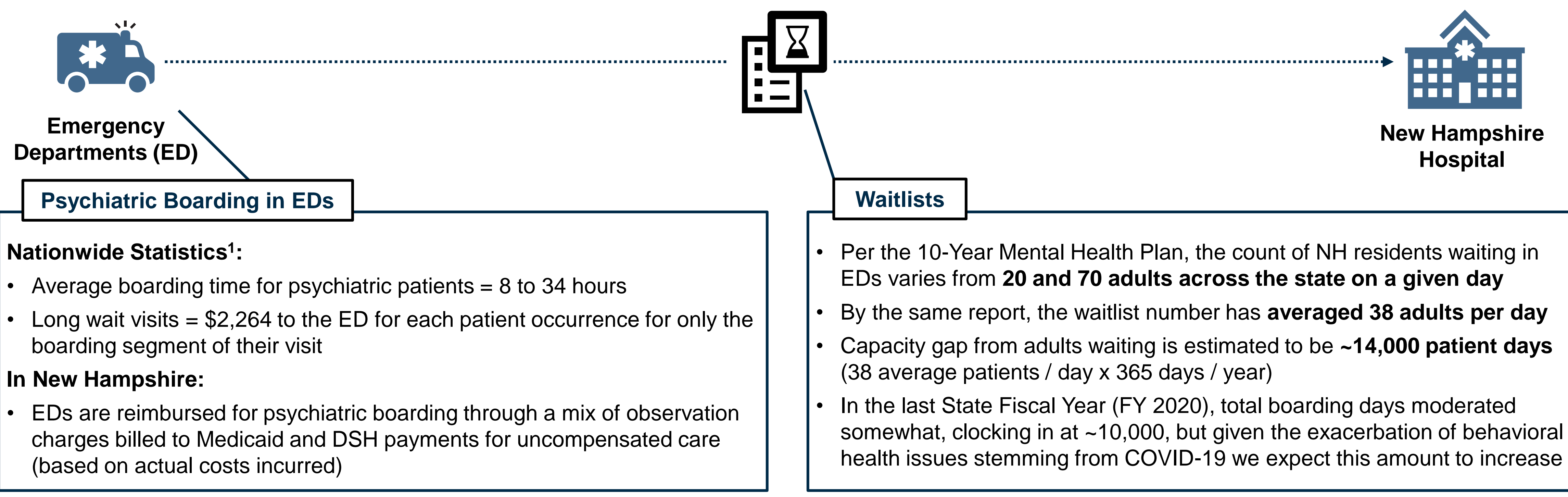
Age	Psychiatric Hospitalization Coverage	Institution
0 to <21	Beneficiaries <21 years of age can obtain coverage under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.	Hampstead for <18; 18-21 at NHH
21 to 64	**Beneficiaries are not covered by Medicaid under the IMD Exclusion rule, which applies to any "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."** State general funds are used to finance inpatient psychiatric hospitalization care for this population.	New Hampshire Hospital
65+	Beneficiaries can be covered under State Plan option (as is the case in NH).	Glencliff

IMD Exclusion in NHH

In FY20, NHH recorded the following:

IMD Exclusion Cases	**268**
IMD Exclusion Total Patient Days	**12,821**
IMD Exclusion Certified Patient Days	*7,160*
MCO Members	*97.4%*
FFS	*2.6%*

New Hampshire Hospital, the fulcrum of the BH system, faces ongoing capacity constraints which causes delays in critical care delivery and incurs high costs to the state.



Psychiatric Boarding in EDs

Nationwide Statistics[1]:

- Average boarding time for psychiatric patients = 8 to 34 hours
- Long wait visits = $2,264 to the ED for each patient occurrence for only the boarding segment of their visit

In New Hampshire:

- EDs are reimbursed for psychiatric boarding through a mix of observation charges billed to Medicaid and DSH payments for uncompensated care (based on actual costs incurred)

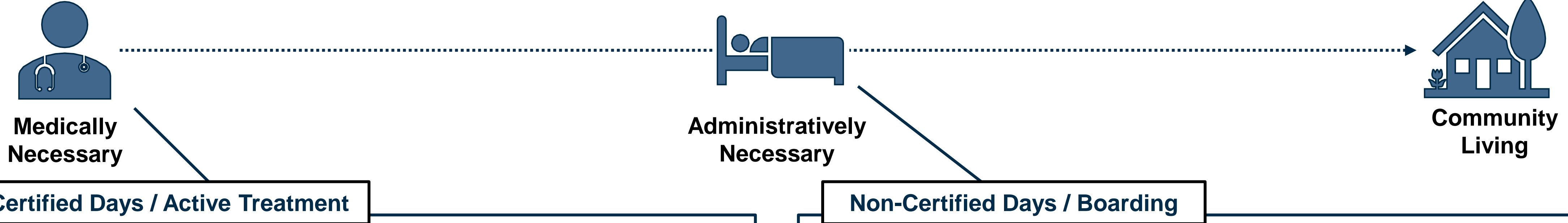
Waitlists

- Per the 10-Year Mental Health Plan, the count of NH residents waiting in EDs varies from **20 and 70 adults across the state on a given day**
- By the same report, the waitlist number has **averaged 38 adults per day**
- Capacity gap from adults waiting is estimated to be **~14,000 patient days** (38 average patients / day x 365 days / year)
- In the last State Fiscal Year (FY 2020), total boarding days moderated somewhat, clocking in at ~10,000, but given the exacerbation of behavioral health issues stemming from COVID-19 we expect this amount to increase

Bottom Line: Psychiatric boarding doesn't just delay critical care for vulnerable patients, it does so at an enormously high cost—a large portion of which is financed by State GF through the Medicaid & DSH programs.

[1] *American College of Emergency Physicians*

Not only do psychiatric patients face delays prior to being admitted, but on average their stays are 79% longer than is medically necessary due to administrative and other barriers to discharge.



Certified Days / Active Treatment

CMS Expectation[1]:

- Based on CMS guidance, states are expected to achieve average LOS (ALOS) of 30 days in IMD for SMI-SED demonstrations
- Stays in IMDs that exceed 60 days are not eligible for Federal Financial Participation (FFP)

In New Hampshire:

- ALOS for Certified Days = 26.7 across all IMD Exclusion cases
- ALOS for All Days = 47.8 across all IMD Exclusion cases

Non-Certified Days / Boarding

CMS Expectation[1]:

- States should provide coverage of services during longer IMD stays for beneficiaries who need them, but with other sources of funding than FFP

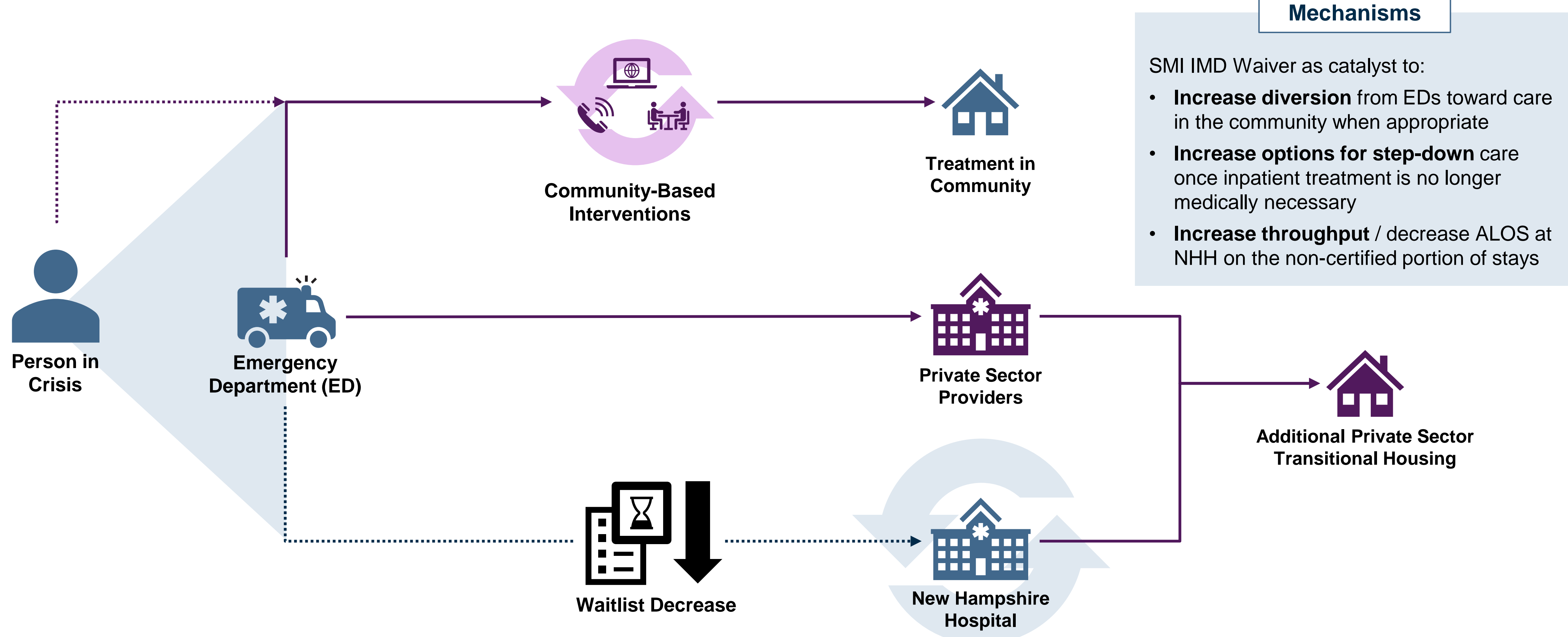
In New Hampshire:

- ALOS for Non-Certified Days = 21.1 across all IMD Exclusion cases
- Would continue to be covered under DSH program after Waiver

Bottom Line: Administrative delays don't just negatively impact the patients who are unable to continue their recovery at home as quickly as they'd like, but also tie up capacity that could serve others whose needs are more acute (e.g., those boarded in EDs).

[1] *CMS State Medicaid Director Letter SMD # 18--011 and CMS Expenditure Authority #11-W-00331/3 for Behavioral Health Transformation for District of Columbia*

An SMI IMD Waiver could act as a catalyst for private sector providers to enter the market, expand the overall capacity of the system, and reduce the strain on New Hampshire Hospital.



Mechanisms

SMI IMD Waiver as catalyst to:

- **Increase diversion** from EDs toward care in the community when appropriate
- **Increase options for step-down** care once inpatient treatment is no longer medically necessary
- **Increase throughput** / decrease ALOS at NHH on the non-certified portion of stays

Alvarez & Marsal

New Hampshire should begin work on the waiver application, with eventual completion slated for 7 to 10 months following the start of work to securing approval. Developing additional capacity is likely to take 1-3 years of additional time.

Start Amendment Process

NH should pursue another amendment to its SUD IMD Waiver—as soon as Amendment #1 is approved by CMS—to add an SMI IMD Waiver along the lines of what was approved in DC & VT.

Costs:

- Modest cost for the application in terms of actuarial support and documentation
- Modest ongoing cost of reporting through CMS-64 submissions
- Modest ongoing cost of other customary waiver oversight

Engage Providers

While the Dual SMI-SUD IMD Waiver is pending, DHHS should immediately begin re-engaging with private sector IMD providers who have previously expressed an interest in entering the State subject to approval of an SMI IMD Waiver.

Systemwide capacity gains increase ED diversion, increase step-down options from acute care, and increase throughput at NHH.

	Before Waiver	FMAP	State Share	LOS Reduction	After Waiver + Additional Step Down Capacity	FMAP	State Share
Medicaid Beneficiary - Medicaid Care Management (Standard Medicaid)							
ED LOS (days)	4.0	--	--	75%	1.0	--	--
ED Per Diem	$2,250	--	--	--	$2,250	--	--
Observation	*$1,125*	*50%*	*50%*	--	*$1,125*	*50%*	*50%*
Uncompensated	*$1,125*	*50%*	*50%*		*$1,125*	*50%*	*50%*
IMD LOS (days)	45.0	--	--	33%	30.0	--	--
IMD Per Diem	$1,071	50%	50%	--	$1,506	50%	50%
State Share	$28,598	--	--	--	$23,715	--	--
Difference in State Share	**--**	**--**	**--**	**--**	**($4,882)**	**--**	**--**
Medicaid Beneficiary - Granite Advantage (Expansion Medicaid)							
ED LOS (days)	4.0	--	--	--	--	--	--
ED Per Diem	$2,250	--	--	75%	1.0	--	--
Observation	*$1,125*	*90%*	*10%*	--	*$1,125*	*90%*	*10%*
Uncompensated	*$1,125*	*50%*	*50%*	--	*$1,125*	*50%*	*50%*
IMD LOS (days)	45.0	--	--	33%	30.0	--	--
IMD Per Diem	$1,071	50%	50%	--	$1,506	90%	10%
State Share	$26,798	--	--	--	$5,193	--	--
Difference in State Share	--	**--**	**--**	**--**	**($21,605)**	--	--

Scenario Description

- High-level illustration depicts the patient journey of a Medicaid beneficiary in mental health crisis both before and after a waiver is put in place
- The model is intended to illustrate the future vision and potential but is not intended as a calculation of savings in the aggregate
- Two different profiles of patient are analyzed: Standard Medicaid (Medicaid Care Management) and Expansion Medicaid (Granite Advantage), due to the differential in Federal Medical Assistance Percentage (FMAP)
- This example is focused on the patient’s stay in the ED (i.e., stabilization, assessment, and potentially boarding) and IMD (i.e., inpatient care, both medically- and administratively necessary days) of an episode of care

Systemwide capacity gains increase ED diversion, increase step-down options from acute care, and increase throughput at NHH.

Difference in State Share after Waiver – MCM (Standard)

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

Difference in State Share After Waiver – GA (Expansion)

		Reduction in ED LOS				
		20%	40%	60%	80%	100%
Reduction in IMD LOS	10%	($18,538)	($19,078)	($19,618)	($20,158)	($20,698)
	20%	($19,216)	($19,756)	($20,296)	($20,836)	($21,376)
	30%	($19,894)	($20,434)	($20,974)	($21,514)	($22,054)
	40%	($20,571)	($21,111)	($21,651)	($22,191)	($22,731)
	50%	($21,249)	($21,789)	($22,329)	($22,869)	($23,409)

Discussion

- Scenario outcomes are particularly sensitive to changes in assumption regarding reduction in LOS, both in ED and IMD
- For MCM (Standard Medicaid) beneficiaries, any reduction in IMD stay above 30% results in savings to the State General Fund
- For Granite Advantage (Expansion Medicaid), any level of reduction in IMD stay results in savings to the State General Fund due to the increased FMAP (90% vs. 50%) available to fund Medicaid Expansion

Behavioral Health | SMI IMD Waiver | Cost of Recommendation

New Hampshire Hospital would receive higher reimbursement for some IMD Days under a Waiver, part of which would be financed through State General Funds.

% in GA Program (Expansion Medicaid)

MCO Collections Rate	25%	30%	35%
60%	$(192,101)	$(130,367)	**$(68,633)** (Low Estimate)
63%	$(199,727)	$(134,563)	$(69,400)
67%	$(207,353)	$(138,760)	$(70,167)
70%	**$(214,980)** (High Estimate)	$(142,957)	$(70,934)

Sensitivity Variables

- **MCO Collections Rate** – while current MCO collection rates (60%) weigh down the potential impact from the SMI IMD Waiver, DBH is planning to pursue (by December) an RFP to procure an improved claims submission and billing system. The current claims system requires manual intervention, does not support batch claims submission, and drives higher-than-normal non-collectible revenue.

- **% in GA Program** – expansion Medicaid draws a higher FMAP (90% vs. 50% regular FMAP), which means that the impact of higher IMD rates is attenuated for those beneficiaries who gained eligibility under NH's Medicaid Expansion program.

Behavioral Health | SMI IMD Waiver | Savings of Recommendation

New Hampshire would realize indirect benefits through attracting new market entrants to the behavioral health system in New Hampshire.

ED Psych Boarding Per Diem (Totals in M)

Share of Boarding Costs Reimbursed as Observation

	$1,250	$1,750	$2,250	$2,750	$3,250
35%	$2.0	$2.8	$3.6	$4.4	$5.2
40%	$1.9	$2.7	$3.5	$4.3	$5.1
45%	$1.9	$2.7	**$3.4**	$4.2	$4.9
50%	$1.9	$2.6	$3.3	$4.1	$4.8
55%	$1.8	$2.5	$3.3	$4.0	$4.7
60%	$1.8	$2.5	$3.2	$3.9	$4.6
65%	$1.7	$2.4	$3.1	$3.8	**$4.4**

Low Estimate ($3.4)

High Estimate ($4.4)

Indirect Capacity Increase

In FY 2020, **NH recorded almost 10,000 ED boarding days[1] across all hospitals**. While this number has come down vs. prior years, the **COVID-19 PHE is exacerbating the root cause**, which is the prevalence of mental illness and substance abuse.

DHHS leadership believes that putting in place an SMI IMD Waiver **will attract new market entrants to NH**, resulting in expansion of capacity across DRF, inpatient psychiatric, and transitional housing beds (e.g. 150-bed private psychiatric hospital). The calculations above reflect the share of ED Boarding days that eventually become hospital admissions (NHH and others). Development of additional inpatient psychiatric beds would result in **decreased ED Boarding days** with a positive, direct impact to State GF. Assuming that the SMI IMD Waiver can reduce by half the total amount of ED Boarding days attributable to patients who end up being admitted to acute psychiatric hospitals, we estimate an indirect positive annual impact of $3.4-4.4 million to State GF.

[1]According to ED Waitlist data provided by NHH

Developmental Disabilities (DD)

DD | Executive Summary | Overview

Scope: Medicaid-financed services for individuals with intellectual and/or developmental disabilities (I/DD) are comprised of life-long supports to assist people with complex needs (including behavioral or medical needs). Services provided to this population are often high cost and long-term. The A&M team conducted an in-depth review of BDS operations and programs across waiver and non-waiver services to assess operational efficiency.

Approach: A&M bases its assessment of operations around four cornerstones of I/DD service operations optimization:

- **Systems Economy and Efficiency** – Operations promote the best alignment between assessed need and service authorization
- **System Infrastructure** – Adequate systems are in place to collect, measure, monitor and report service utilization for decision-making
- **Access to Services** – Appropriate mechanisms are in place to provide participants access to appropriate services with adequate funding
- **Community System Infrastructure** – Sufficient community services are available to meet the needs of those deemed eligible to receive services

Using these guideposts to service delivery, the A&M team, in partnership with DLTSS and BDS staff gathered and reviewed a significant number of documents, policies, and budgetary information to conduct an analysis of the BDS operations. In addition to its document review, A&M also conducted numerous phone calls with members of the DLTSS and BDS Executive Leadership team to conduct targeted follow up interviews.

Results: As a result of the A&M review and analysis of relevant documentation and data, several key recommendations for transforming the BDS service delivery system emerged. Notably, findings through this analysis identified an overarching lack of access to data for the day-to-day and systems planning needed to efficiently and effectively manage a program of its size. However, within these limitations A&M was able to identify significant areas of program reform, that, if taken, would result in a stronger systemic management of BDS operations, likely resulting in significantly improved long-term operations through more effective management of current resources.

A&M recommends that NH DHHS:

1. **Conduct** a 1915(c) waiver redesign by implementing tiered waivers
2. **Develop** tiered reimbursement rates to better align payment with level of need
3. **Establish** a comprehensive IT system to better manage, report, and utilize data in strategic decision-making
4. **Modify** Wait List Funding
5. **Develop** an in-state network of private service providers with increased capacity for supporting individuals with intensive residential support needs

DD | Executive Summary | Recommendations (Long Term)

The A&M Team has identified the following long-term recommendations in Developmental Disabilities (implementation time frame two to four years). All figures are general funds; costs reflect both one-time and recurring; savings figures shown are annual only.

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

** Revisions to these numbers are underway by division staff and subject to change*
^ one-time costs

Stakeholder Engagement

Key Personnel Interviewed

Division of Long-Term Services and Supports

- General/Division-level: Deb Scheetz, Jennifer Doig
- Bureau of Developmental Services: Sandy Hunt
- Bureau of Adult and Elderly Services: Wendi Aultman
- Bureau of Family Centered Supports: Deirdre Dunn

Data Request

Key Data Reviewed

- 18 months of MMIS claims data
- DD, IHS, ABD, CFI waivers
- Staffing and Organizational Charts
- Rate Schedules by Waiver
- Area Agency Boundary Maps
- Area Agency Contracts / Other DLTSS Contracts
- Audit Findings
- Department Ongoing Projects
- 36 months of budget files
- Conflict of Interest Correction Action Plan
- History of DLTSS IT Modernization Efforts
- Wait List Data
- DRF Data
- Provider Billing Manual

DD | 1915(c) Waiver Redesign: Tiered Waivers | Summary (1 of 2)

Recommendation

Conduct a 1915(c) Waiver Redesign by Implementing Tiered Waivers.

Findings

Problem Statement: There are inadequate controls on services individuals have access to once deemed waiver eligible. There is an enhanced likelihood of over-serving individuals or exacerbating the mismatch between the amount or type of service most appropriate for the individual with services available under the current waiver construct.

Observations: To increase the correlation between support need and service authorization and utilization and to reduce the potential for over-serving, it is recommended that BDS introduce a tiered waiver structure in which service and funding caps are placed at specific levels to constrain service authorizations based on level of need.

COVID-19 Impact: COVID-19 has shifted the way in which individuals receive and service providers provide services. Due to the movement away from congregate-based settings to a more de-centralized service approach (i.e. more individuals living independently, day services being provided remotely, etc.) there is a greater need to have access to reliable data to track how individuals are utilizing services during the pandemic.

Benefits

A tiered waiver structure aligns initial waiver access to a service structure more directly correlated with assessed need. Implementing a tiered waiver is not meant to close the door to service for anyone who meets BDS eligibility. A tiered waiver structure ensures that as someone enters or utilizes services, they enter through the door most closely aligned with their assessed need. Under this new construct, BDS would be able to incentivize access to lower tier waivers through services promoting independence, individual choice, and control of services. Such options may continue to shift the role of high-cost congregate services as demand for lower-cost, high-value services increases. In both models, Waiver 1 focuses on less congregated care, greater independence, and a lower reliance on state-funding. This is accomplished by promoting a service array which targets intermittent supports that are more individualized to the person than the setting.

	Low	High
Savings	$0.1M	$0.6M
Costs	--	--
Net Benefit	$0.1M	$0.6M
Timeframe	3 years	
Complexity	Moderate	

Recommendation

Conduct a 1915(c) Waiver Redesign by Implementing Tiered Waivers.

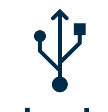
Implementation Requirements

People

BDS will need a dedicated Waiver Manager to plan, coordinate, implement and monitor this structural change. This position is currently funded but unfilled.

Process

BDS should conduct in-depth stakeholder engagement as well as establish a waiver re-write and public comment period prior to CMS submission.



Technology

Significantly increased IT infrastructure will be needed to collect and manage waiver data under the new structure. This is more fully addressed in Recommendation B.3.

Prep. Work

BDS should conduct additional analysis on service array (including type, frequency and duration) when finalizing waiver "lines" for funding and authorization.

Statute

n/a

Timeline Outline

Target Start Time:

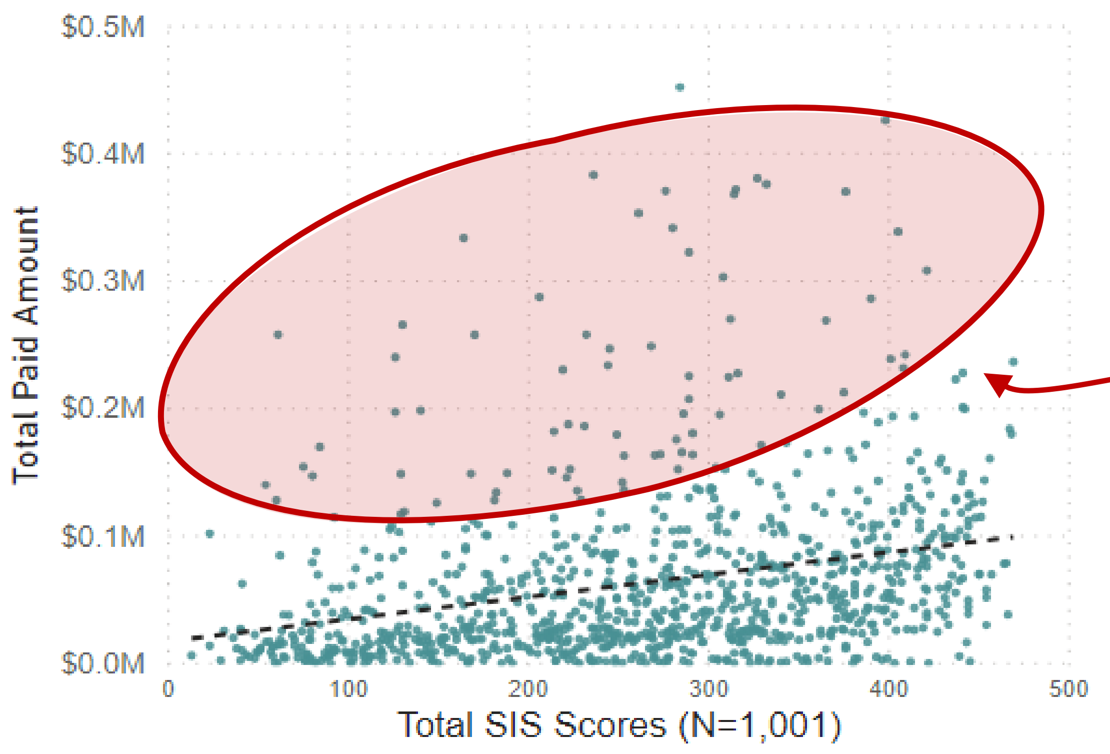
	Year 1	Year 2	Year 3	Year 4
Stakeholder Engagement				
Waiver Drafting				
Public Comment				
Implementation				

Risks

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

The Support Intensity Scale (SIS) is one of two standardized and widely used tools to determine funding / level of need in the field of I/DD. A&M found that SIS scores have not been and could not be used to explain or direct the annualized costs of NH's DD population.

Spread of SIS Scores by Total Paid Amount



At a glance, there are many individuals who have annualized costs in excess of expected spend when compared to their peer group (clusters around the best fit line).

An optimal waiver system in which individuals are provided intensifying (and more costly) services along on a sliding scale of assessed needs would produce strong (approaching 1) coefficients of correlation and determination (R Squared approaching 1).

In New Hampshire, the correlation output suggests that an individual's annualized cost to the State is not tied to his/her assessed need.

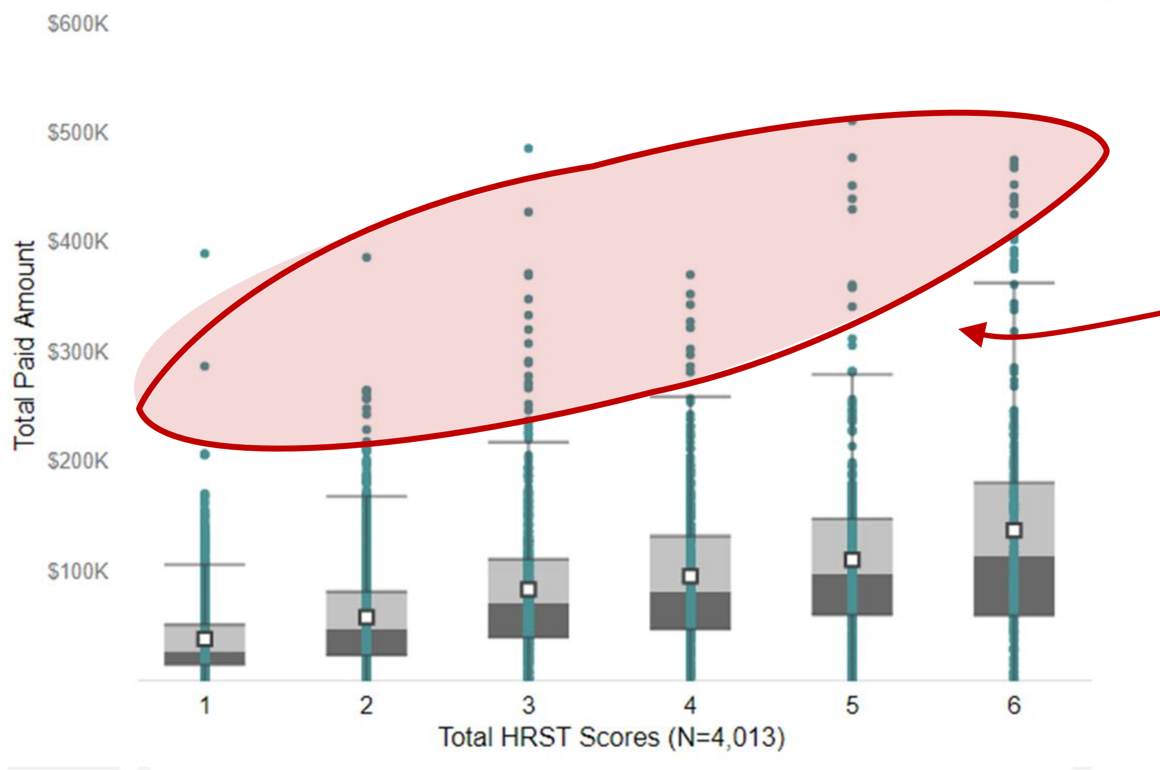
Correlation Output (SIS Scores by Total Paid Amount)

Correlation Coefficient	**0.29**
R Squared	**0.09**

ALVAREZ & MARSAL

The Health Risk Screening Tool (HRST) is the second of two standardized and widely used tools to determine funding and level of need in the field of I/DD. As with the SIS, there are inconsistencies between expenditures for individuals' services and their assessed need.

Spread of HRST Scores by Total Paid Amount



Assessing the distribution of individuals by HRST categories (1-6, in ascending order of supports intensity) reveals outliers (>1.5 IQR* highlighted in red) who are receiving far more in services than their peers. These individuals represents 4% of the total sample population.

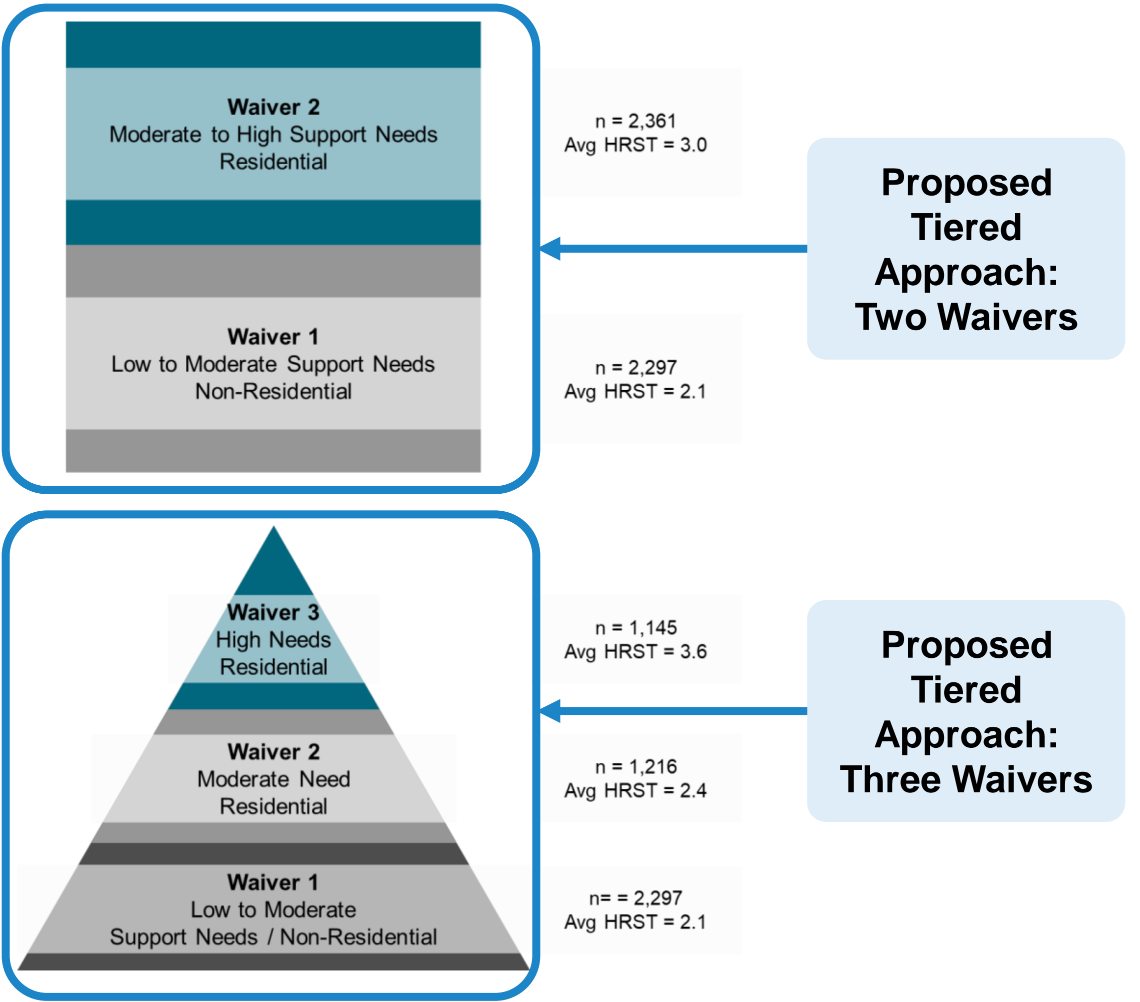
It is also noted that a portion of individuals group in level one of the HRST scoring spend up to the median spend of individuals in level six. This range in spend, while directionally appropriate in the aggregate, indicates there are opportunities to better align assessed need to service spend.

Outlier Analysis (HRST Scores by Total Paid Amount)

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

* IQR = Interquartile range; a commonly accepted statistical measure/threshold used to identify outliers, resistant to the influence of outliers.

A tiered service delivery model would allow BDS to better project and control spend when comparing assessed need to annual cost of service. A&M has outlined two approaches to a tiered waiver program.



Description of Two and Three Waiver Approaches

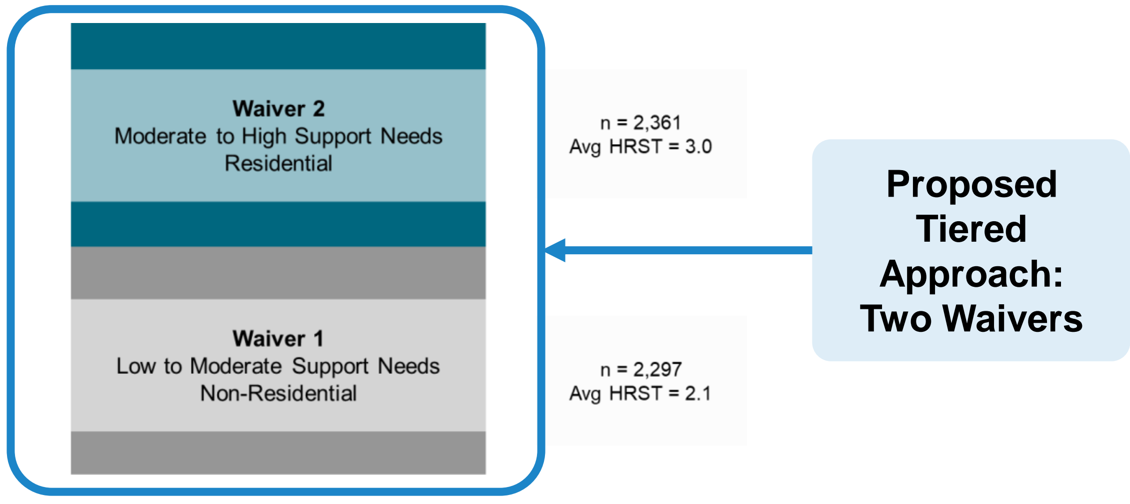
Option 1: Two Tiers

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

Option 2: Three Tiers

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

In the two-waiver model, BDS would be better able to serve high support needs individuals and control costs. Between the status quo and the three-waiver model (on next slide), this is the risk-averse option affecting only 3% of the current waiver population.



Proposed Tiered Approach: Two Waivers

Establishing a two-waiver model in which individuals are grouped by their support needs benefits both individuals with I/DD and BDS operations.

- **Individuals with I/DD** benefit from a more targeted waiver supported by staff working with a more consistent range of individuals' needs.
- **Families** benefit from a more egalitarian system in which dollars are allocated based on need rather than external, non-assessment factors.
- **BDS** and **Area Agency** staff will be better able to explain policy decisions using a data-driven approach.
- In addition, **BDS staff** will have greater control over policy administration, as changes can be made to target waiver imbalances in one waiver without affecting the operations of a second waiver.
- **The State** is estimated to save between $0.07-$0.18M annually. This value is derived from low-impact cost containment measures affecting a small subset of the population (125 individuals, or 3% of the total FY20 DD population) with low support needs yet high average expenditures. For these individuals, impact is evenly distributed at an average 11% reduction in individualized yearly costs. These savings are a byproduct of best practices in DD operations and are not a result of cost-cutting measures.

Methodology for Waiver 1 population (at 15% limit for cost containment)*

2,781 initial population determined by makeup of 100% non-residential services

2,172 pop with costs reflective of appropriate supports

Cost containment measures would affect 3%, or 125, individuals with costs slightly exceeding (<15%*) the W1 cap. — 125

10%, or 484, individuals have annualized costs in excess of their current service supports system and would be moved to Waiver 2, where they will have more targeted and better access to more intensive supports. — (484)

Ending W1 Count: 2,297

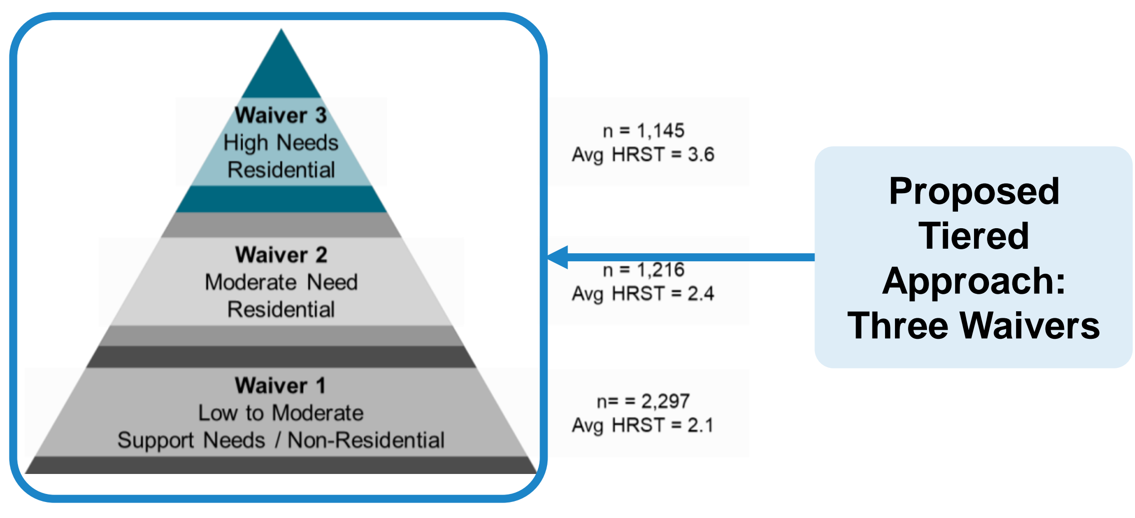
** Savings at 15% limit is $.18M; Savings at 10% limit is $.07M*

Note: A tiered approach using this model would grant the state flexibility in determining the population subject to cost containment measures. A&M has taken a conservative approach in its modeling with the goal of maximizing operational efficiency rather than short-term cost savings. Only 3% of ISPs would be affected by cost containment.

W2 Methodology not pictured but follows same approach. W2 in the two-waiver model is uncapped and derives no savings.

DD | 1915(c) Waiver Redesign: Tiered Waivers | Analysis (5 of 6)

A three-waiver model further delineates high needs from moderate needs in the upper, residential waiver (Waiver 2 in the two-waiver model). BDS would be better able to serve high support needs individuals, especially those requiring 24/7 residential care.



Establishing a three-waiver model in which individuals are grouped by their support needs benefits all stakeholders. The benefits are largely the same – just to a greater degree – than the two-waiver model.

- The State is attentive to the needs of individuals at the high end of the spectrum with high costs in excess of $.25M / year. A three-waiver model would allow such individuals to "step down" to a lower second tier that would not exist in a two-waiver model
- The State is estimated to save $0.28-$0.58M annually, with savings coming from cost containment measures at both the Waiver 1 and Waiver 2 levels. These savings are a byproduct of best practices in DD operations and are not a result of cost-cutting measures.

Methodology for Waiver 1 population (at 15% limit for cost containment)*

2,781 initial population determined by makeup of 100% non-residential services

2,172 pop with costs reflective of appropriate supports

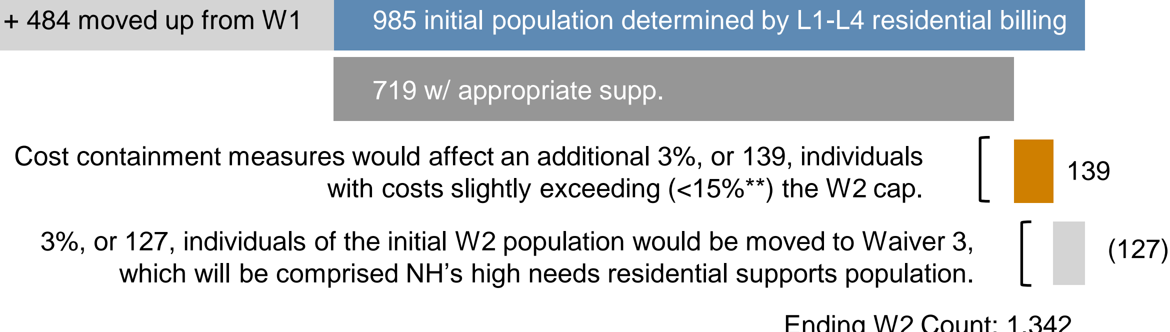
Cost containment measures would affect 3%, or 125, individuals with costs slightly exceeding (<15%*) the W1 cap. — 125

10%, or 484, individuals have annualized costs in excess of their current service supports system and would be moved to Waiver 2, where they will have more targeted and better access to more intensive supports. — (484)

Ending W1 Count: 2,297

** Savings at 15% limit is $.18M; Savings at 10% limit is $.07M*

Methodology for Waiver 2 population (at 15% limit for cost containment)**



+ 484 moved up from W1

985 initial population determined by L1-L4 residential billing

719 w/ appropriate supp.

Cost containment measures would affect an additional 3%, or 139, individuals with costs slightly exceeding (<15%**) the W2 cap. — 139

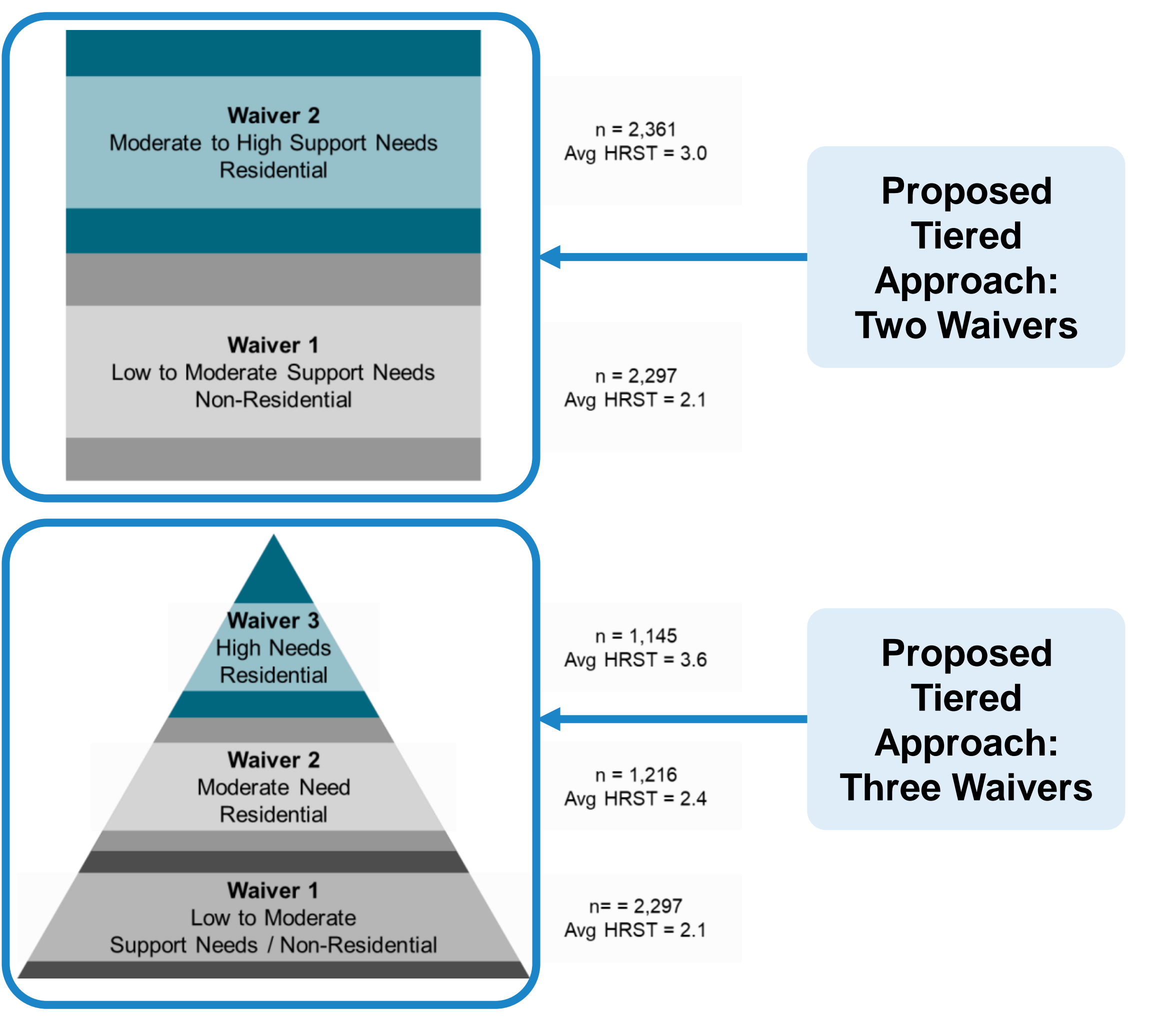
3%, or 127, individuals of the initial W2 population would be moved to Waiver 3, which will be comprised NH's high needs residential supports population. — (127)

Ending W2 Count: 1,342

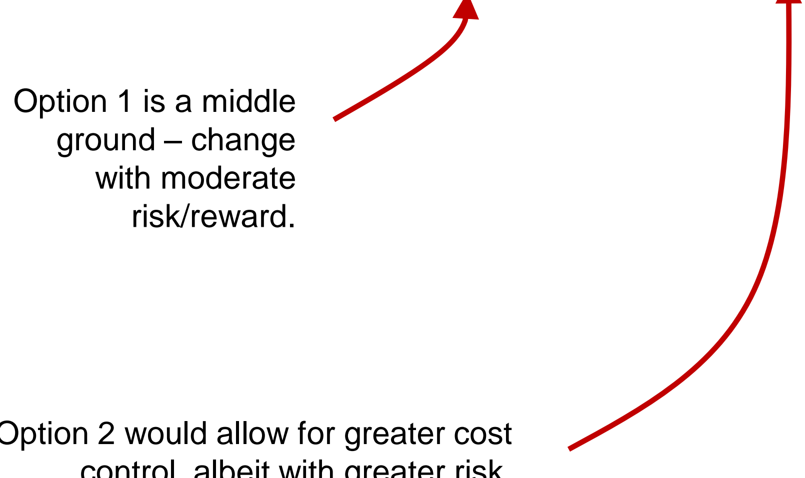
** *Savings at 15% limit is $.41M; Savings at 10% limit is $.21M*

W3 Methodology not pictured but follows same approach. W3 in the three-waiver model is uncapped and derives no savings.

Both the two-tier and three-tier service delivery models would generate savings and equip BDS with additional tools to control costs and better direct services.



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



DD | 1915(c) Waiver Redesign: Rate Methodology | Summary (1 of 2)

Recommendation

Implement a new waiver reimbursement rate methodology to promote alignment between support needs and support budgets while increasing the opportunity to establish appropriate controls on overall waiver funding.

Findings

Problem Statement: Under the current DD Waiver, an antiquated rate schedule and methodology is used to reimburse service providers for services rendered. The last revision to the rate methodology was completed in 2007 and, through discussions with DLTSS and BDS staff, it was identified that there is little or no historical understanding of how the current methodology was developed.

Observations: In conducting this analysis, it was identified that by individual, by service funding allocations are not strongly correlated with service need assessment. While the state does utilize a common rate table (as published in the 1915(c) approved waiver application), the rates are occasionally retrofitted to fit the budget of an individual's ISP. As a result, there is significant spread in both (a) the amount of authorized and therefore billable service units and (b) the process in which individuals are attributed to levels of support in the current structure.

COVID Impact: During COVID many providers in New Hampshire, were forced to shut down operations to protect the health and safety of this population with heightened risk. During this time, providers, through flexibilities provided under the Appendix K, were able to create and implement new service delivery systems under existing structures. However, such action is not sustainable. While BDS has identified several new service delivery models – such as virtual supports for Day Habilitation, Personal Care, Behavioral Supports, etc. – such models are only allowable while the Appendix K is still active. Following the expiration of the Appendix K, states will have to ensure systems and structures are in place to support new service delivery types, should the state wish to maintain them post-pandemic.

Benefits

A sound rate methodology is critical to maintain long-term services and supports. The rates paid and units authorized form the basis for system sustainability and effective policy decision-making. Introducing a formulaic methodology as recommended by A&M grants transparency and objectivity to service provision which would otherwise be influenced by external factors. Rates can be adjusted at an incremental level based on the individual rate components, whether it be DSP wages, transportation, overhead, etc. to create an equitable service environment.

	Low	High
Savings	***variable***	***variable***
Costs	**$0.7M** ***$0.4M^***	**$0.9M** ***$0.7M^***
Net Benefit	***variable***	***variable***

Timeframe	2 years
Complexity	High

^one-time costs

Recommendation

Implement a new waiver reimbursement rate methodology to promote alignment between support needs and support budgets while increasing the opportunity to establish appropriate controls on overall waiver funding.

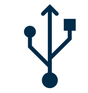
Implementation Requirements

People

BDS will need a dedicated Waiver Manager as well as a standalone assessment unit (5 FTE) unless assessment processes are contracted through Community Support Network, Inc (CSNI).

Process

Stakeholder engagement is critical, BDS will need to develop a cost reporting template for service providers. An RFP for a rate setting entity and an assessment licensing agreement will also be needed to operationalize this recommendation. To promote efficiency and CMS compliance under the Direct Billing Corrective Action Plan, rate development should be completed by July 2023.



Technology

The State must invest in IT infrastructure to manage the increased complexity of the proposed rate process. This is more fully addressed in Recommendation B.3.

Prep. Work

Stakeholder engagement should begin immediately upon project commencement to introduce the idea of new rates. Initial work to vet and select an assessment should also start prior to rate setting.

Statute

n/a

Timeline Outline

Target Start Time:

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

Risks

- Modifications to rate methodology may be concerning to stakeholders. There may be significant resistance to changing the rates all the way through rate implementation
- Based on rate development and programmatic restricting, the State may see a net increase in service costs. In such a case, the State may not have adequate funding to fully fund the new rate schedule delaying implementation
- The Corrective Action Plan related to direct billing may impact data availability
- BDS lacks the staffing capacity and resources to commit to a rate setting project. If a waiver manager, at minimum, is not hired at BDS, it is unlikely that the project will be successful
- Assessment data currently collected by BDS may be found to be outdated or unreliable for rate setting needs which may increase the cost and amount of time for project completion

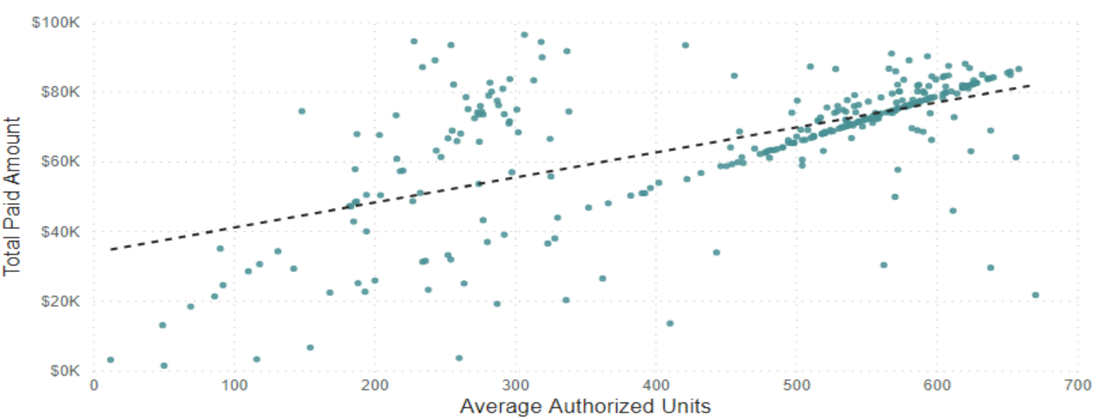
DD | 1915(c) Waiver Redesign: Rate Methodology | Analysis (1 of 2)

The current rate methodology used to reimburse providers has not been updated since 2007. BDS staff have maintained operations by relying on manually intensive Individual Budget Allocations and retroactive adjustments to budgets to meet needs.

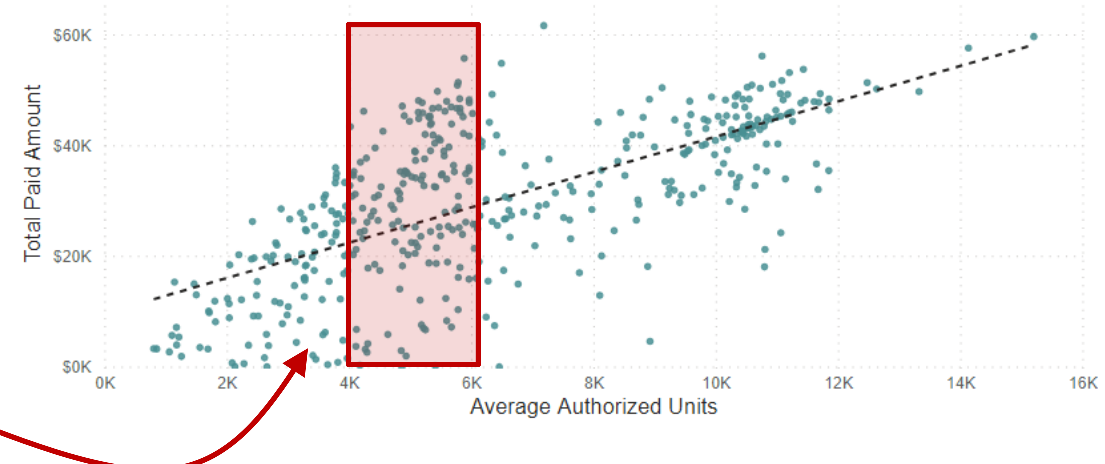
In discussions with DLTSS staff, A&M determined two primary contributing factors contributing to the spread of payments:

1. **Individual Budget Allocations** – BDS develops an Individual Budget Allocation (IBA) specific to the service participant where authorizations are requested and approved. While IBAs provide greater flexibility in individualized service planning, they can introduce extraneous factors which are difficult to explain retroactively.
2. **Budget Modifications to Meet Provider Revenue Needs** – Under the current reimbursement structure, BDS has identified that, at times, authorization modifications are made to cover service provider costs. This approach has been taken due to a lack of sound and adequate reimbursement rates to support services to meet the current support needs.

Spread in Authorization and Paid Amount for Residential Habilitation L5



Spread in Authorization and Paid Amount for Day Habilitation Level 5

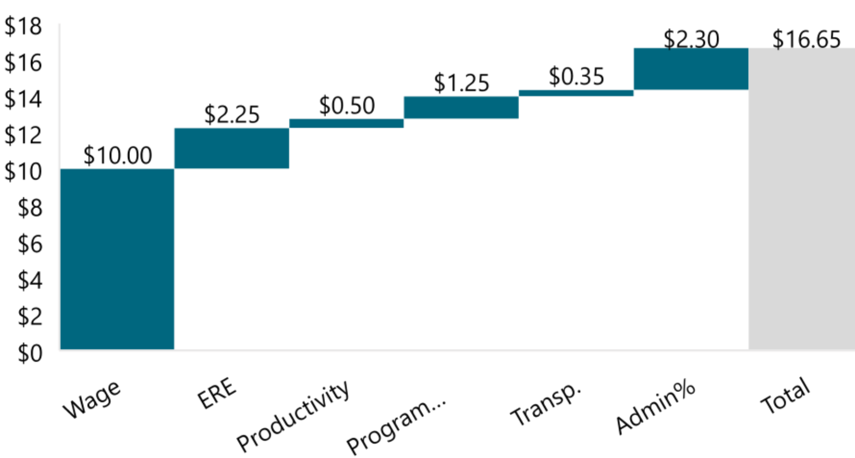


Within each service there is unexplained variance. An individual's assessed need alone does not explain their level (and cost) of service provision. In this example, individuals authorized between 4-6k units have annual expenditures ranging from $0 to $60k, indicating high variance in expenditures not explained by authorized units. This spread varies by service but is consistent across all 58 service categories, with few exceptions.

ALVAREZ & MARSAL

A&M recommends a brick methodology to modernize rate setting in New Hampshire.

Sample "Brick" Rate Model (waterfall)



For services with multiple iterations (for example residential services with multiple service types and setting sizes) a matrix of rates is developed. The table below shows how a single rate would be used to build and operationalize a rate matrix for 24/7 residential group home services.

Sample "Brick" Rate Model (table)

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

LOS	Level Description	1 person	2 person	3 person	4 person	5 person
1	Low support needs	--	--	--	--	--
2	Moderate support needs	--	--	--	--	--
3	High support needs	--	--	--	--	--
4	Extraordinary behavioral support needs	--	--	--	--	--
5	Extraordinary medical support needs	--	--	--	--	--

Recommendation

BDS should invest in and develop a comprehensive information technology system with capabilities of managing ISP development, case management record keeping, service authorization and service billing.

Findings

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

Observations: Critical to effectively managing the complexities within I/DD services is an agile, comprehensive information technology (IT) infrastructure that allows system managers to (a) have adequate access to reliable data for decision-making, (b) provide standardized data input that is collated into a comprehensive view of both the individuals served within the system and the programs operated by the Bureau and (c) provide access to data which supports authorizing and monitoring services to ensure quality and compliance with program regulations.

COVID Impact: COVID-19 has shifted the way in which individuals receive and service providers provide services. Due to the movement away from congregate-based settings to a more de-centralized service approach (i.e. more individuals living independently, day services being provided remotely, etc.) there is a greater need to have access to reliable data to track how individuals are utilizing services during the pandemic. Further, through the State's approved Appendix K, the Centers for Medicare and Medicaid Services (CMS) has provided significant flexibilities in how states render and fund services. However, with these increased flexibilities, as well as additional federal funds to support these flexibilities, will come enhanced audit requirements pushing systems to reliably track and report back to CMS utilization and spending data to avoid future penalties.

Benefits

Increasing the access to and reliability of data flowing through BDS would have significant impacts on not only the agency operations and management of services but also quality of services. BDS would be better positioned to monitor service authorizations against provider billing in more real time. Such action is critical for ensuring the right amount of service is provided to a participant, service provider fraud is monitored and mitigated if detected, and the Bureau's overall budget and spend is controlled. Beyond that, however, well-managed data and systems also drive quality of care for those accessing BDS services. It is critical to have a strong IT infrastructure to manage case management activities including service planning, case notes and outcomes, structures for collecting, tracking and mitigating allegations of abuse or neglect, and general trends in utilization to guide decision-making related to incentivizing or disincentivizing services to best meet the needs of participants.

	Low	High
Savings	*variable*	*variable*
Costs*	$0.1M *$0.2M^*	$0.2M *$0.3M^*
Net Benefit	*variable*	*variable*
Timeframe	4 years	
Complexity	High	

^Includes one-time costs

DD | IT Systems Development | Summary (2 of 2)

Recommendation

BDS should invest in and develop a comprehensive information technology system with capabilities of managing ISP development, case management record keeping, service authorization and service billing.

Implementation Requirements

People

Given the complexity of building a ground up IT structure, BDS will require IT Manager (1 FTE), a Waiver Manager (1FTE), and an IT Project Manager (1FTE – time limited).

Process

BDS will need to develop and release an RFP to select an IT vendor to assist in the planning and implementation of a new structure.

Technology

BDS should invest in a case management module with the capability to interface with MMIS. BDS should ensure provider systems have the capacity to integrate with the case management module to avoid duplicity and data misalignment.

Prep. Work

To develop an IT RFP and develop initial build criteria, BDS should review and update the PCG recommendations and scoring based on current needs and benchmarking.

Statute

n/a

Timeline Outline

Target Start Time:

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

Risks

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

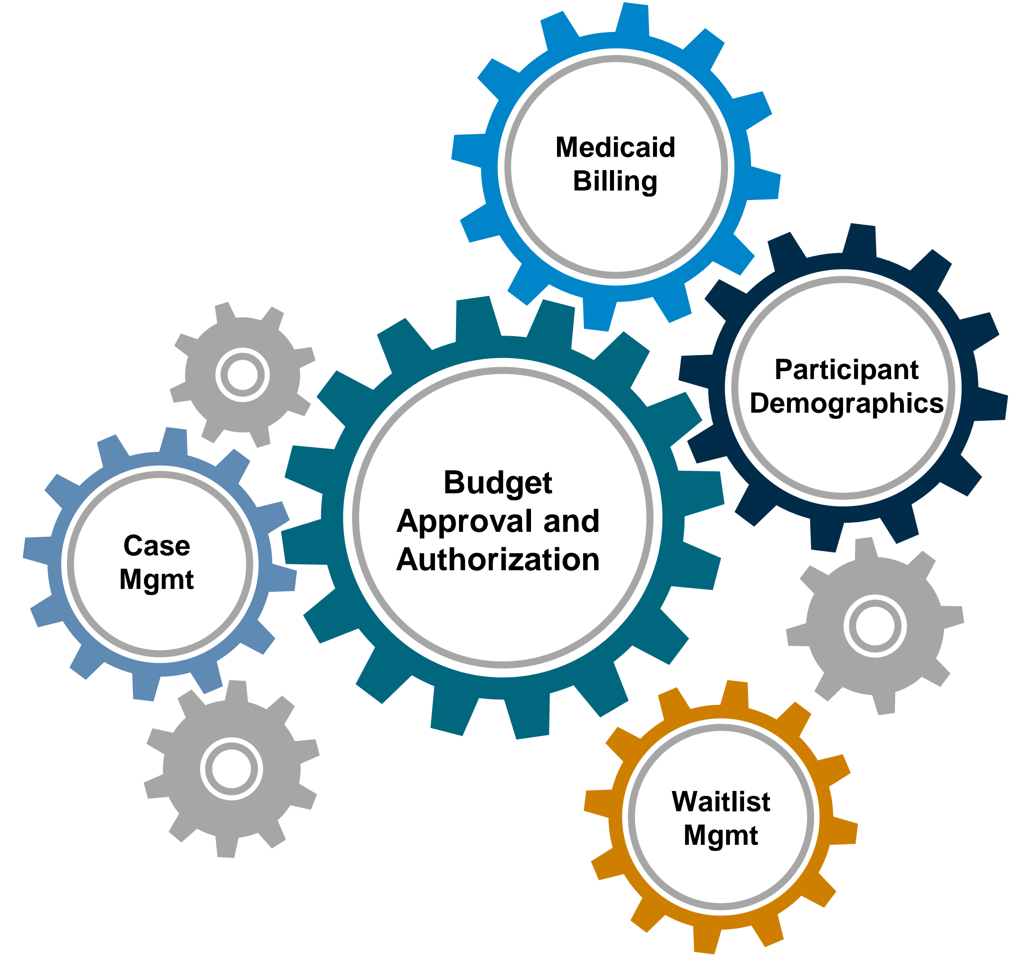
DD | IT Systems Development | Analysis (1 of 2)

The IT structures currently operated by BDS constrain division staff's ability to monitor, oversee, and make incremental, data-driven changes.

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

Recommendations 1 and 2 in this section cannot occur at current staffing levels without investments in IT.

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



DD | Wait List Funding | Summary (1 of 2)

Recommendation

Reduce the available funding for waitlist participants to more closely align allocated funding with trends in spend.

Findings

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

Observations: There is a significant $47,564,869 fund availability for the FY21 Wait List despite only $14,664,476 in projected need. As a result, the FY21 net carryforward amount is projected to be $32,900,393 to be used in FY22 assuming no change to funding requests and anticipated WL expenditures at historical levels. For FY21, however, BDS has indicated there are several factors which would elevate that year's expenditures above historical levels:

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

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

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

^ based on 7-1-20 projection of SFY21 BDS Waiver Maintenance Wait List Analysis

Benefits

Of BDS' projected year-end WL surplus, A&M is recommending reducing the FY22 appropriations request by the projected FY21 projected carryforward of $8.2M. This would total $4.1M in General Fund savings for the State of New Hampshire after FMAP reimbursement.

By reducing the FY22 appropriations request, the State would save General Funds at minimal impact to the DD waitlist, which has in recent history been funded beyond historical need.

	Low	High
Savings*	$4.1M	$4.1M
Costs	$0	$0
Net Benefit*	$4.1M	$4.1M
Timeframe	0 years (savings realized in FY22)	
Complexity	Low	

*Anticipated general fund savings after FMAP reimbursement

DD | Wait List Funding | Summary (2 of 2)

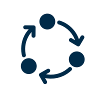
Recommendation

Reduce the available funding for waitlist participants to more closely align allocated funding with trends in spend.

Implementation Requirements

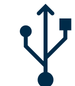
People

n/a



Process

Due to the change in nature and structure of the funding request, increased collaboration and coordination between BDS program and fiscal staff and HHS fiscal staff will be required.



Technology

n/a

Prep. Work

n/a – analysis has been completed

Statute

n/a

Timeline Outline

Target Start Time: n/a

Risks

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

DD | ITS Residential Options | Summary (1 of 2)

Recommendation

Develop in-state Intensive Treatment Service (ITS) residential options to reduce or eliminate the need for out-of-state placement of individuals with complex care needs currently at an average cost per person of $385,000.

Findings

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

Observations: BDS currently serves (primarily through the DD waiver) 38 individuals who require high-cost intensive care needs. However, BDS lacks access to adequate in-state residential placement options within the current provider network and therefore contracts with out-of-state providers to support these individuals. These individuals, while having a primary diagnosis of I/DD also often have complex mental health diagnosis, increasing the cost of care.

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

Benefits

All stakeholders are in general agreement that out-of-state placements are not ideal for NH individuals with I/DD and families. Individuals placed out of state lose access to their friends, families, community, and the comfort of a familiar environment. Developing in-state intensive treatment service (ITS) options will improve individual and family quality of life while also saving the State significant per-individual costs through increased oversight and monitoring.

	Low	High
Savings	**$0.7M**	**$2.6M**
Costs	***$4.9M^***	***$6.5M^***
Net Benefit*	**$0.7M**	**$2.6M**
Timeframe	4 years	
Complexity	High	

^one-time costs; *Net benefit excludes one-time costs

DD | ITS Residential Options | Summary (2 of 2)

Recommendation

Develop in-state Intensive Treatment Service (ITS) residential options to reduce or eliminate the need for out-of-state placement of individuals with complex care needs currently at an average cost per person of $385,000.

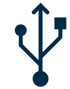
Implementation Requirements

People

The complexity inherent with moving individuals with complex needs will require BDS to hire a Transition Coordinator (1FTE) responsible for planning, coordinating and tracking individuals transitioning back to NH.

Process

BDS should implement an RFP process for providers to access grant funds for new property development will be needed, as well as grant tracking capacity.



Technology

n/a

Prep. Work

Initial residential site development should begin one year prior to the first person transitions back in-state. Concurrent development may occur depending on the projected pace.

Statute

n/a

Timeline Outline

Target Start Time:

	Year 1	Year 2	Year 3	Year 4
Provider Selection and Contracting				
Residential Site Development				
Implementation				

Risks

- If no current in-state providers identify as willing and able to partner in this effort BDS may be unable to build adequate capacity.
- Some individuals currently residing in out-of-home placements may choose not to return to New Hampshire for various reasons, the state may have to continue out-of-state placements for a portion of this group.
- A potential lack of adequate access to housing may delay infrastructure development and transition.
- After initial transition, cost per person may be higher to ensure full wrap-around support is in place to support the major life change. While it is anticipated that this cost would decrease, it may be a lasting expense if trauma from a move occurs.

Children, Youth, and Families (DCYF)

DCYF | Executive Summary | Overview

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

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

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

Stakeholder Engagement

Key Personnel Interviewed

DHHS Stakeholders

- Joe Ribsam– Director, Division for Children, Youth and Families
- Erica Ungarelli, Director, Bureau for Children's Behavioral Health
- Michael Donati– Bureau Chief, Community, Family and Program Support, Division for Children, Youth and Families
- Hannah Glines – Revenue Director, Division of Finance
- Rebecca Lorden
- Pauline Cote, Fiscal Specialist Supervisor, DHHS Finance
- Gayleen Smith, Finance Data Analyst, Division for Children, Youth and Families
- Michael Valcic, Planning Analyst/Data Systems, Division for Children Youth and Families

Data Request

Key Data Reviewed

- Title IV-E B4-496 Forms
- Title IV-E Foster Care Financial Allocation Activity Report
- DCYF Placement Data
- DCYF Databook
- DCYF 2020-2024 Child and Family Services Plan
- DCYF 2020 Annual Progress and Services Report
- High level Title IV-E process
- DCYF LEAN Reports
- DCYF Program Improvement Plan
- DCYF Services Overview
- DCYF Service Array
- Foster Care Rate Schedules

Alvarez & Marsal

DCYF | Executive Summary | Recommendations (Short-Term)

The A&M Team identified the following short-term recommendation in DCYF (potential to implement within six to twelve months). All figures are general fund; costs reflect one-time and annual; savings are annual.

			Est. Costs ($M)		Est. Savings ($M)	
#	**Recommendation**	**Description**	**Low**	**High**	**Low**	**High**
C.1	Maximizing Federal IV-E Funding – Foster Care	In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.	$0.05M	$0.05M	$1.1M	$4.5M

DCYF | Maximizing Federal IV-E Funding | Summary (1 of 2)

Recommendation

In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.

Findings

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

Observations:
For the past three years, 27% of eligible IV-E foster care placements were collecting IV-E funding, compared to the average 41% of neighboring New England states. Of the top five reasons for IV-E ineligibility, four of those items were process related, and one systems related:

1. Failure to Provide Financial Data
2. Unable to Capture Wage Data
3. Systems Did Not Interface Accurately
4. Imminent Risk/Reasonable Efforts
5. Contrary to the Welfare

Additionally, the lack of IT Integration between DCYF and the Fiscal Specialist unit in the current infrastructure contributed to process and system related inefficiencies.

Benefits

Using the most recent placement data (FY20 Q2), New Hampshire can realize the following annual cost savings by increasing their current penetration rate

- 5% penetration rate increase → $1.1M annual cost savings
- 15% penetration rate increase *(NE State Avg.)* → $3.4M annual cost savings
- 20% penetration rate increase → $4.5M annual cost savings

	Low	High
Savings	**$1.1M**	**$ 4.5M**
Costs[1]	**$0.05M**	**$0.05M**
Net Benefit	**$1.1M**	**$ 4.5M**
Timeframe	6 months – 12 months	
Complexity	Medium	

1.$.05M costs were calculated assuming initial manual review of ineligible children would take one FTE reviewing 25 cases a day 68 days x 8 hours a day x $100 / hour

Recommendation

In order to maximize federal IV-E revenue, DCYF will need to evaluate policies/procedures to identify current process-related problems and develop new procedures to ensure that all eligible youth are identified, and appropriate documentation is established to maximize IV-E funding.

Implementation Requirements

People

1-3 Fiscal specialist unit (FSU) staff to assist in reviewing manual cases. 8-10 people that can serve as a workgroup from all stakeholders (DCYF, Courts, FSU, IT) to drive new process/system changes.

Process

DCYF will need to make changes and modifications to the current processes FSU staff follows to identify IV-E funding.

Technology

Bridges 2.0 will need to integrate to allow for utilization by FSU staff. New Heights needs an additional field to be able to tag reasons for child ineligibility so that performance metrics can be tracked moving forward.

Prep. Work

Manually review 300 cases to identify the magnitude of each of the reasons for ineligibility.

Statute

N/A

Timeline Outline

Target Start Time:

Time Range	Basic Tasks
Week 1-6	Manually review 1,700+ current cases to identify IV-E Eligible children
Week 6-7	Prioritize reasons for ineligibility by size
Week 7-10	Identify necessary process/system changes necessary
Week 10-30	Implement process/system changes necessary to increase IV-E eligibility

Risks

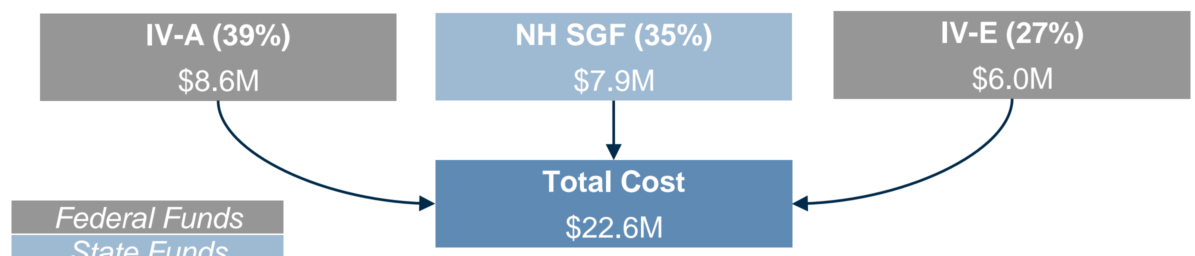
- Manually reviewing 1,700+ cases is a time-consuming process that will require dedicated time from the Fiscal Specialist Unit
- Buy-in from outside stakeholders (courts) is necessary for some process opportunities

DCYF | Maximizing Federal IV-E Funding | Analysis (1 of 3)

DCYF can realize annual cost saving opportunities ranging from $1.1M to $4.5M by increasing their penetration rate.

Outcomes from Increasing IV-E Eligibility

Based on the most recent placement data (FY20 Q2) there were a total of 1,624 IV-E eligible placements. A total of $22.6M[2] annually has been spent on Foster Care Maintenance payments.



IV-E Eligibility Requirements

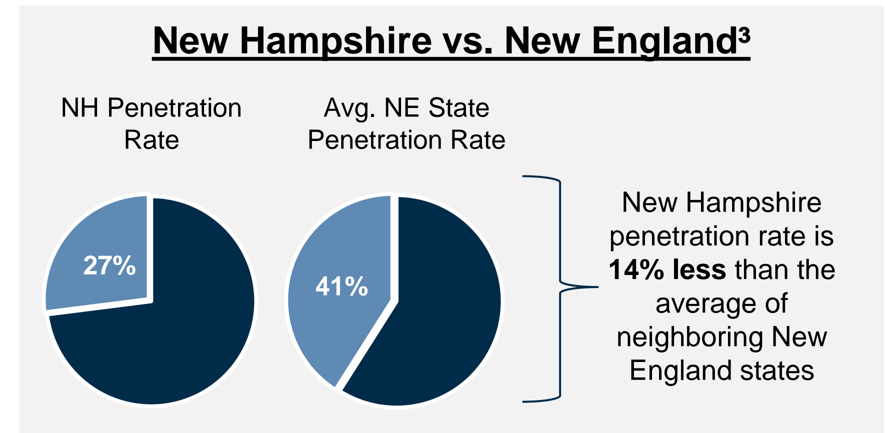
Under Title IV-E of the Social Security Act, states are entitled to claim partial federal reimbursement for the cost of providing foster care, adoption assistance, and kinship guardianship assistance to children who meet federal eligibility criteria. Children eligible for the IV-E foster care program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

1) In out-of-home placements;
2) considered financially "needy" in the homes from which they were removed, based on 1996 AFDC guidelines and;
3) are in a licensed or approved foster care placement.

By increasing the penetration rate by 5% to 20%, DCYF can expect an annual increase in IV-E federal funding from $1.1M to $4.5M. This revenue maximization opportunity would reduce the amount of State General Funds that would be necessary to cover foster care maintenance payments.

	Total Placements*	Penetration Rate	IV-E Ineligible Placements	IV-E Eligible Placements	Quarterly Rev. Max Opportunity	Yearly Rev. Max Opportunity
Current State	1,624	27%	1,207	417		
Low End Opp. *(5% Increase)*		32%	1,110	514	$.29M	$1.1M
High End Opp. *(20% Increase)*		37%	866	758	$1.1M	$4.5M

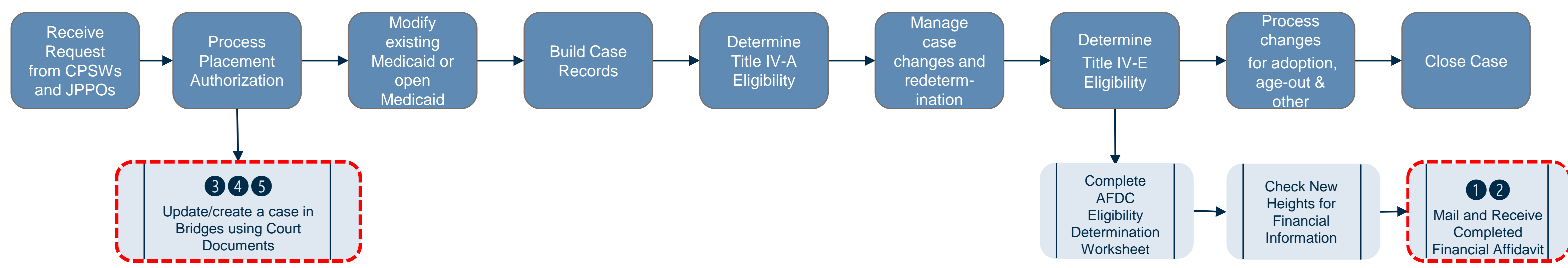
New Hampshire vs. New England[3]



2. $22.6M is the average total spend of FY18/19/20
3. Rosinsky, Kristina, and Sarah Catherine Williams. "Child Welfare Financing.", Child Trends, 2016, www.childtrends.org/research/research-by-topic/child-welfare-financing-survey-sfy-2016.

DCYF | Maximizing Federal IV-E Funding | Analysis (2 of 3)

The team has observed that children in certain placement categories may not be receiving the federal assistance (IV-E) for which they are eligible, likely because documentation requirements have not been met and/or because process inefficiencies exist.



	Reason for IV-E Ineligibility	Process/System Related?	Description	Next Steps / Opportunity
1	Failure to Provide Financial Data	X	Unable to obtain Income/Financial Parent Data	Identify magnitude of the problem by manual review of sample size of 300 cases. Work to create a consolidated financial affidavit document between the Courts and DCYF. Strengthen the responsibility of the CPSWs/JPPOs to collect Income/financial parent data.
2	Unable to Capture Wage Data	X	Parent works out of state, NH cannot obtain parent wage data	Identify magnitude of the problem by manual review of sample size of 300 cases. Work to strengthen current work number process, and/or establish MOAs with neighboring states to be able to share wage data and information.
3	System's Did Not Interface Accurately	X	Cases between BRIDGES and New Heights systems do not accurately interface and talk to one another	Manually review cases where IV-E ineligibility was incorrectly captured and identify reason for failure. Address interface/process gap between the systems.
4	Reasonable Effort	X	Many courts do not check "Imminent Risk" check box on Court Affidavit, making children IV-E ineligible	Identify magnitude of the problem by manual review of sample size of 300 cases. . Increase training for CPSWs/JPPOs/Courts on Imminent Risk/Reasonable Effort.
5	Contrary to the Welfare	X	Caseworkers do not check off contrary to the welfare on documentation, making children IV-E ineligible	Identify magnitude of the problem by manual review of sample size of 300 case Increase training for CPSWs/JPPOs on contrary to the welfare.

DCYF | Maximizing Federal IV-E Funding | Analysis (3 of 3)

The A&M Team identified areas previously established by an Internal Process Improvement Committee that would bring the most benefit to DCYF units and the FSU in order to provide greater efficiency, accuracy, and timeliness within the FSU.

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

Economic and Housing Stability (DEHS)

DEHS | Executive Summary | Recommendations

The A&M team assessed the staffing levels, process, and technology currently in place to support eligibility determination processes for DHHS.

Background: The Bureau of Family Assistance (BFA), responsible for determining eligibility resides within the Division of Economic Housing and Supports (DEHS) and is staffed statewide across thirteen district offices.

Findings: The BFA shows a high number of staff vacancies, primarily in the Family Service Specialist (FSS) position with a total of 32 budgeted vacancies out of a total of 251 positions. The FSS position is responsible for determining initial and continuing eligibility for economic service supports. As a result of high vacancies, FSS workers manage a correspondingly high caseload per staff person (588 cases/month), resulting in increased processing times. Additionally, FSS workers are responsible for managing 50,000 calls/month received by the BFA call center. Lack of self-service technology and a case-based eligibility process, are impacting BFA ability to manage eligibility processing workload.

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

1. Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies;
2. Maximize technology projects to reduce manual functions and improve processing times;
3. Review current business processes including organization of the call center staffing to reduce call volume and FSS workload; and case-based model and consider opportunity to move to a task-based model.

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

Stakeholder Engagement

Key Personnel Interviewed

DHHS Stakeholders

- Chris Santaniello, Director, Division of Economic & Housing Stability
- Deb Sorli, Bureau Chief, Bureau of Family Assistance
- Laurie Snow, IT Manager, NH DHHS

Data Request

Key Data Reviewed

- DEHS Contracts
- SNAP State Plan
- Applications Received
  - Processing Time
  - Caseload Data
- Phone Calls Received
  - Call Time
  - Call Tracking Data
  - Call Caseload Data
- High Level Business Process Model
- Current Call Center Process
- TANF Plan
- Title IV-E Foster Care Financial
- Bureau of Child Support Services Strategic Plan/State Data Report
- High Level New Heights Systems
- CSC Workgroup Presentations
- DEHS COVID-19 Data
- Homeless Population Reports
- Housing Contracts

DEHS | Executive Summary | Recommendations (Short-Term and Long-Term)

The A&M Team identified the following short-term recommendations in DEHS (potential to implement within three to six months). All figures are general fund; costs reflect one-time and annual; savings are annual.

			Est. Costs ($M)		Est. Savings ($M)	
#	**Recommendation**	**Description**	**Low**	**High**	**Low**	**High**
D.1	Increase Workforce Capacity	Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.	$0.10M	$0.16M	*Variable*	*Variable*
D.2	Implement Technology Projects using COVID Dollars	Implement technology improvements to DEHS systems and other areas to alleviate increased workload due to COVID-19 and improve client experience.	--	--	$2.1M	$2.1M

The A&M Team has identified the following long-term recommendation in DEHS (implementation time frame one to two years). Further analysis is necessary to determine estimated costs and savings.

			Est. Costs ($M)		Est. Savings ($M)	
#	**Recommendation**	**Description**	**Low**	**High**	**Low**	**High**
D.3	Redesigning Business Processes	Conduct further analysis into current business processes including call center operations, and case-based eligibility model. Consider implementing enhanced Interactive Voice Technology (IVR) and a triage process within the call center and shifting case-based model to a task-based model.	*Variable*			

Recommendation

Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.

Findings

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

Observations:

- FSS's have a 13 percent vacancy rate compared to a four percent vacancy rate in all other DEHS positions.
- Limited workforce capacity has negatively impacted the ability to meet federal timeliness requirements. The percent of applications processed timely dropped seven percent when comparing November 2019 data to September 2020 data.

COVID Impact: Anticipated workload increase due to COVID-19 benefits disenrollment.

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

Benefits

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

	Low	High
Savings	**N/A**	**N/A**
Costs[1]	**$0.10M one time**	**$0.16M one time**
Net Benefit	**N/A**	**N/A**
Timeframe	3mo-6mo	
Complexity	Medium	

1.$.10-.16 costs were calculated assuming a team of 3 (low) to 5 (high) FTE to conduct a surge hire for working full time on the effort for 4 months at $50 an hour. DEHS has not had any other external recruitment costs. This cost assumes that there is negligible costs associated with hiring the 32 FSS vacant positions.

DEHS | Increase Workforce Capacity | Summary (2 of 2)

Recommendation

Prioritize hiring for budgeted Family Service Specialist (FSS) vacancies to improve caseload metrics and application timeliness.

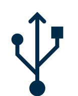
Implementation Requirements

People

Team of 3-5 people within HR/DEHS dedicated to implementing a surge hire effort for FSS positions.

Process

Hiring process will need to be streamlined to allow for a quick onboarding of FSS positions.



Technology

N/A

Prep. Work

Identify current barriers to hiring FSS workers timely.

Statute

N/A

Timeline Outline

Target Start Time:

Time Range	Basic Tasks
Week 1-3	Identify Recruitment Plan and Streamlined Hiring Process
Week 3	Identify Team Responsible for Surge Hiring
Week 4-8	Identify Roles and Begin Recruitment for FSS Worker Position
Week 8-12	Interview FSS Candidates
Week 12-14	Onboard FSS Hires

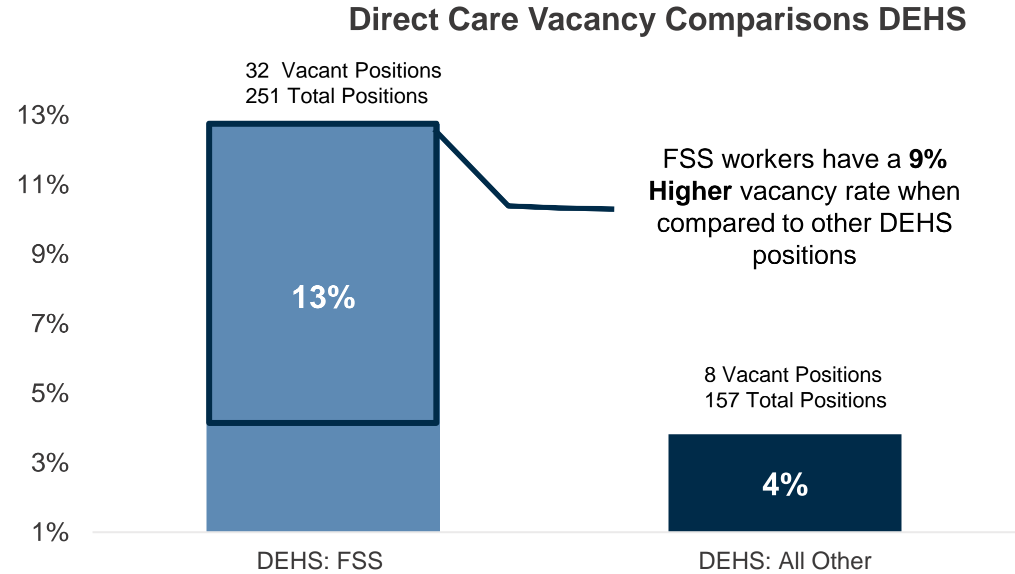
Risks

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

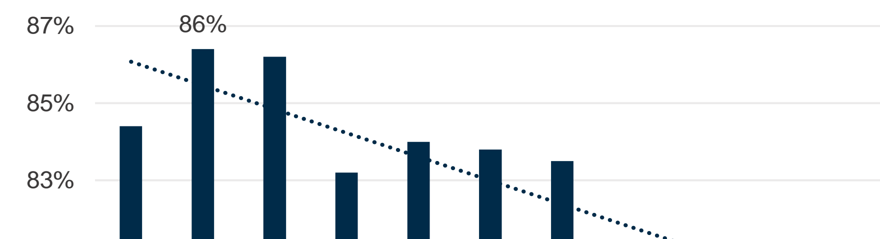
ALVAREZ & MARSAL

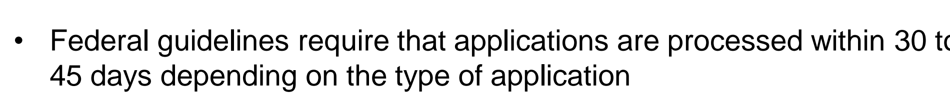
DEHS | Increase Workforce Capacity | Analysis

The A&M team conducted the analysis below that highlight's current high vacancies in the FSS worker position, and the decline in applications processed timely over the last twelve months.



- FSS's are primarily responsible for determining and certifying the eligibility of constituents for programs of assistance, vacant positions are all currently budgeted
- As of (9/11/20) DEHS FSS's had a **9 percent higher** vacancy rate compared to other DEHS positions
- Currently, each FSS receives approximately 588 applications per month, DEHS's internal benchmark is 400-500 applications per month
- DEHS workers are responsible for staffing the call center, which removes them from being able to process applications 1-2 days a week





- Federal guidelines require that applications are processed within 30 to 45 days depending on the type of application
- The **percent of applications processed timely** has **dropped 7 percent** when comparing Nov.19 data to Sept. 20 data
- Over the last twelve months applications processed timely have decreased due to:
  - Increase in applications due to COVID-19
  - Current FSS vacancies/High FSS caseload
  - Cases that have remained opened past the requirement due to the current public health emergency

2. Applications Include FANF, MAGI, OAA, ANB, APDT, QMBs, Food Stamps, Child Care

DEHS | Implement Technology Projects Using COVID Dollars | Summary (1 of 2)

Recommendation

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

Findings

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

Observations:
There are very few avenues for clients to find answers online to simple inquires such as case status. The lack of self-service opportunities has led to an increase in clients calling in with simple inquires.

COVID Impact: All the identified projects can be funded using COVID-19 dollars.

The projects identified fall under two categories:

1. Funds that have already been incurred or that will be incurred by DHHS related to COVID-19
2. Technology investments that are necessary to maintain pre-pandemic level of services, driven by increased demand caused by COVID-19
    - The implementation of these projects would eventually be a cost incurred by DHHS; the impact of COVID-19 has expedited the need for implementation.

Benefits

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

	Low	High
Savings[1]	**$2.1M one-time**	**$2.1M one-time**
Costs	**--**	**--**
Net Benefit	**$2.1M one-time**	**$2.1M onetime**
Timeframe	3 months	
Complexity	Medium	

1. The cost of the projects is recognized as a savings to DHHS, as all projects will be 100 percent federally funded by COVID dollars, rather than DHHS incurring them as a State General Fund expense

Recommendation

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

Implementation Requirements

People

Current vendor (Deloitte) will need to increase current team resources in order to complete projects by 12/30.

Process

N/A

Technology

Improve self-service applications and backend automation within New Heights and NH Easy.

Prep. Work

Implementation of identified projects have already begun in order to meet the 12/30/20 deadline outlined in the CARES Act (subject to federal legislation).

Statute

N/A

Timeline Outline

Target Start Time:

Time Range	Basic Tasks
Week 1-4	Identify Business Requirements Necessary
Week 4-8	Development Phase
Week 9-12	Implementation of Projects *(ending 12/30/20)*

Risks

- Technology projects are required to inform and get approval from CMS, ACF, FNS for changes to HEIGHTS
  - As of 10/20 FNS has not responded, the project is currently being carried out at risk
- Technology projects need to be completed by 12/30/20 (subject to federal legislation)
- M&O enhancement work and DDI projects (currently being completed by Deloitte) will need to be deferred until the COVID-19 projects are complete

DEHS | Implement Technology Projects Using COVID Dollars | Project List

The A&M team identified technology projects in which COVID-19 highlighted the need to expedite the increase system capabilities. Increasing the capabilities of current systems, will increase the capacity of the current workforce and help the department better serve and meet client needs. The below projects are already in process as to meet current 12/30/20 CARES Act funding deadlines.

All projects identified are designed to reduce FSS worker caseload by
- Allowing the client to be able to do as much possible without needing to call or reach out to a FSS worker;
- Reducing manual processes and maximizing automation.

Expanded project detail provided to A&M on COVID-19 benefits and long-term benefits of each project is provided in the A&M written report.

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

Recommendation

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

Findings

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

Observations:

- FSS workers spend on average two days per week processing eligibility for clients:
  - One day per week is dedicated to admin and processing
  - Two days per week are dedicated to staffing the call center
- Approximately 75% of the calls received in the call center could be handled by IVR, a third-party vendor, or a Family Service Assistant (FSA).
- While a case-based approach theoretically allows for more personal connections between FSS workers and families, recurring high caseloads and high vacancy rates impact FSS workers capacity to complete timely processing of eligibility benefit applications.
- In calls conducted with other two other states (CT,KY) on the shift to a task-based process, both states reported improved performance metrics and increased productivity.

Benefits

States who have shifted from a case-based model to a task-based model have been able to streamline and substantially improve access of benefits in the following areas[1]:

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

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

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

Timeframe	12mo - 24mo
Complexity	High

	Low	High
Savings	*Implementing a business process redesign will require further analysis to determine necessary costs and benefits. **A well-executed business process redesign will improve eligibility application processing times.***	
Costs		
Net Benefit		

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

DEHS | Redesigning Business Processes | Summary (1 of 2)

Recommendation

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

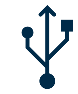
Implementation Requirements

People

Team of 3-5 people within BFA to work part time during the suggested timeline to assist in reviewing current case-based processes and design a plan to potentially move it to task based.

Process

A complete shift of the current eligibility case-based process to a task-based process.



Technology

A more in-depth review of current technology utilized in the current case-based process is necessary. Enhanced IVR would need to be developed within the call center.

Prep. Work

A more in-depth review of the current call center operations and case-based process is necessary. Both a business processing analysis and a cost-benefits analysis should be conducted to inform the decision of shifting business processes.

Statute

N/A

Timeline Outline

Target Start Time:

Time Range	Basic Tasks
Month 1	Conduct a deep-dive into current call center operations and case-based eligibility process
Month 2-4	Conduct both a business processing analysis and cost-benefit analysis to inform DEHS decisions on business processes
Month 5-10	Prepare training plan, communication plan and business processing change management plan and implementation plan to align with business redesign
Month 10-24	Implement redesign, execute training plan, communication plan, and business processing change management plan

Risks

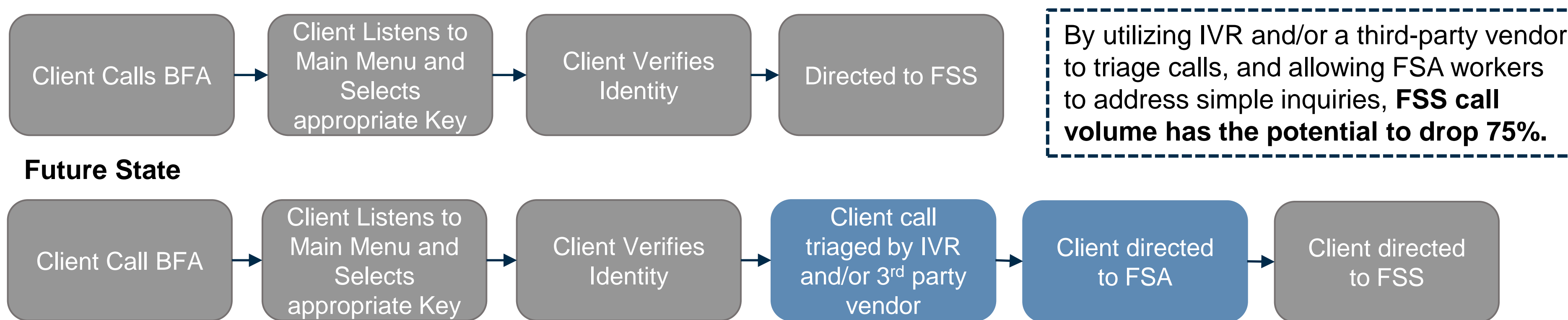
- This would be a lengthy process and require a thorough communication plan and training plan for DEHS staff
- External stakeholders (ex. Unions) have previously disagreed on the use of a third-party vendor to triage calls
- Requires significant preparation for business processing change management
-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

Approximately 75% of the calls could be handled by IVR, a third-party vendor, or a Family Service Assistant (FSA) worker rather than an FSS worker. By triaging calls and directing them to the correct person, FSS workers can limit the amount of time spent on the phone and promote time spent processing eligibility.

In the current call center process FSS workers are responsible for managing all call types:

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

Efficiency and time-saving benefits are felt by both the client and staff. FSS focus is placed back on service delivery and meeting the needs of vulnerable populations as quickly and efficiently as possible.



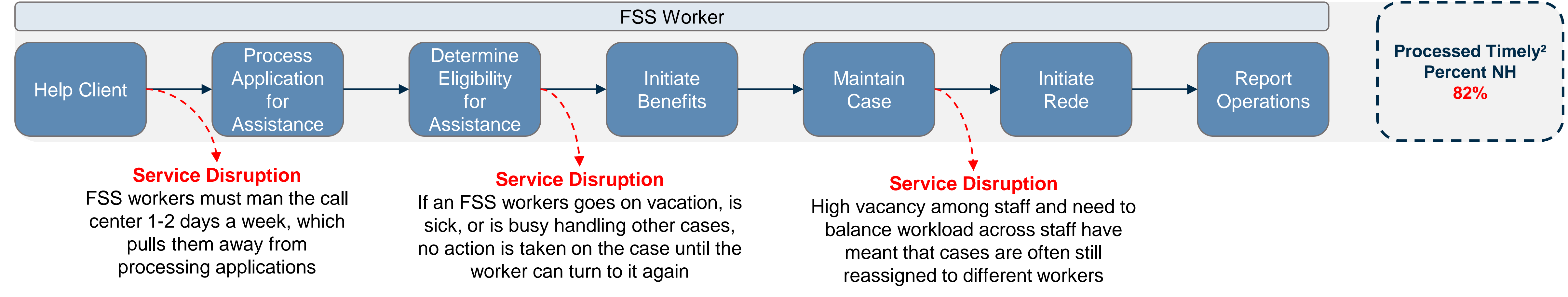
By utilizing IVR and/or a third-party vendor to triage calls, and allowing FSA workers to address simple inquiries, **FSS call volume has the potential to drop 75%.**

ALVAREZ & MARSAL

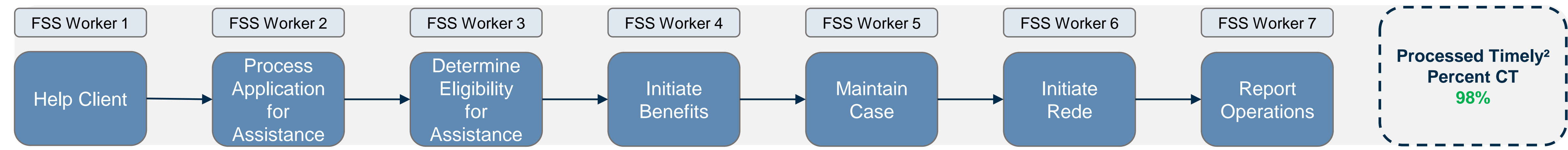
DEHS | Redesigning Business Processes | Analysis (2 of 2)

In the current case-based model, FSS workers experience service disruptions that negatively impacts the ability of applications to be processed timely.

Case-Based Approach ***(Current NH Model)***
An individual caseworker works one-on-one with a family over time to handle all aspects of service delivery, from the initial application to periodic updates on their eligibility status.



Task-Based Approach ***(Current CT and KY Model)***
Organizes workers by function (such as accepting applications, processing applications and renewals, processing case changes) and tasks associated with cases that need action are assigned to workers through a priority queue.



2. Processed timely percentages are an average over last twelve months

Medicaid Care Management

The A&M team identified both short and long-term recommendations related to Medicaid Care Management, impacting eligibility redetermination after the Public Health Emergency ends and performance incentives for contracted health plans, respectively.

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

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

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

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

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

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

The A&M Team identified the following short-term recommendation in Medicaid Care Management (potential to implement within two to three months). All figures are general fund; costs reflect both one-time and recurring; savings figures shown are annual only.

#	Recommendation	Description	Est. Costs ($M) Low	Est. Costs ($M) High	Est. Savings ($M) Low	Est. Savings ($M) High
E.1	Eligibility Redetermination	Develop a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the COVID Public Health Emergency ends.	*Variable*			

The A&M Team has identified the following long-term recommendation in Medicaid Care Management (implementation time two years). All figures are general fund; costs reflect both one-time and recurring; savings figures shown are annual only.

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

Recommendation

Develop a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the COVID Public Health Emergency ends.

Findings

Problem Statement: Federal restrictions on eligibility during the COVID PHE have increased enrollment and expenditures. States are at risk for ongoing enrollment costs after PHE and increased federal funding end.

Recent federal legislation authorizes a 6.2 percentage point FMAP increase to help states respond to the COVID pandemic. Acceptance of the funds is conditioned on not constricting eligibility policy or disenrolling anyone enrolled as of March 18, 2020 through the end of the month in which the PHE ends. The PHE is currently set to expire on January 23, 2021 and the increased FMAP on March 31, 2021.

The impact has been increased Medicaid enrollment nationwide. In NH, for five years prior to COVID enrollment was effectively flat. During March and April 2020, enrollment increased across the board, most notably among Non-Disabled Adults (10.7%), Non-CHIP Children (3.7%), and Granite Advantage (7.4%) populations. Between May and August 2020, enrollment in these groups continued to grow between one and three percent per month.

COVID Impact: The FMAP restrictions are the primary driver of enrollment and expenditure growth since March, and the timeline for redetermining eligibility and disenrolling this group is the primary financial risk to the state.

Benefits

Advance readiness for catching up on renewals and disenrolling ineligible recipients at PHE end will determine how quickly the state recovers from the spending growth driven by the increased FMAP-requirements. Robust implementation planning can increase the speed and efficiency of the effort. A data-driven understanding of the number of people impacted, by eligibility category and cost, can inform strategic thinking. Collaboration among all involved in the renewal process to develop an end-to-end view of tasks and timelines can likewise identify areas of opportunity for streamlining and facilitate creative thinking and innovation.

	Low	High
Savings	*Costs avoided are variable, dependent on when the current PHE ends and the scenario selected. Costs avoided are not to be understood as savings from amounts currently budgeted for the program.*	
Cost Avoided		
Net Benefit		

Timeframe	2 to 3 months
Complexity	Medium

Recommendation

Develop a robust implementation plan for promptly disenrolling Medicaid recipients who no longer meet eligibility requirements when the COVID Public Health Emergency ends.

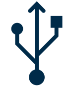
Implementation Requirements

People

Sufficient workforce capacity, i.e., eligibility workers, call centers, mail rooms. Short-term staff augmentation, such as temp workers for less complex tasks, to prevent or reduce backlog from catch up workload.

Process

Targeted policy, procedure and process changes to streamline work, economize administrative effort, and manage catch up workload within workforce constraints.



Technology

Advance design, development and testing of eligibility system changes needed to resume renewals and closures with more automation and less manual effort. Call center (IVR) changes should also be addressed.

Prep. Work

Data analysis and research to inform decision making on a renewal strategy that balances concerns with administrative capacity, cost, and the well-being of vulnerable populations.

Statute

Determine fixed requirements (i.e., advance notice of adverse action) and flexibilities at (i.e., interim verification of critical eligibility factors) the federal and state level that will determine tasks and timelines.

Timeline Outline

Target Start Time:

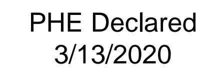
Time Range	Basic Tasks
Month 1	Determine fixed regulatory requirements and flexibilities*
Month 1	Complete data analysis and research to inform strategic decision making, collaboration, innovation
Month 2-3	Develop policy, procedure and process changes
Month 2-3	Design, develop and test system changes
Month 3	Communicate changes for implementation, including workforce training,

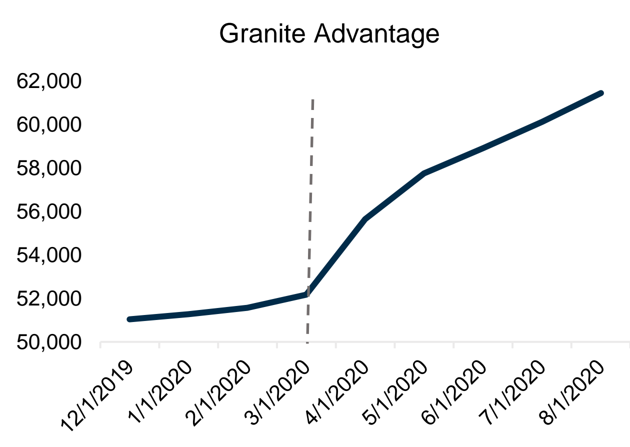
Risks

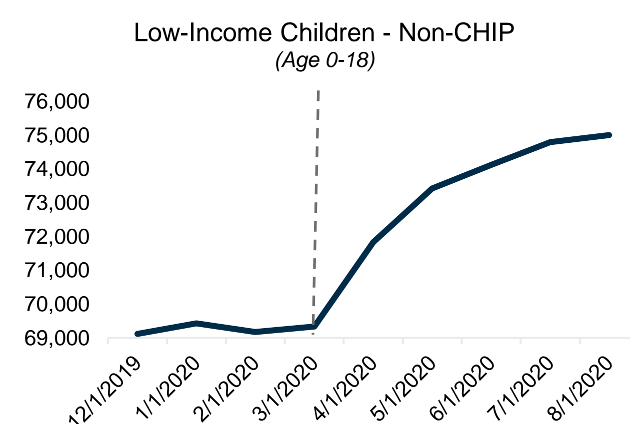
- Delays in issuance of CMS guidance to inform data analysis, strategic decision making, and implementation planning
- Insufficient workforce capacity for temporary workload increase
- Responsibility for the growing state share of the ongoing cost of enrollment from renewals not caught up before the enhanced FMAP ends

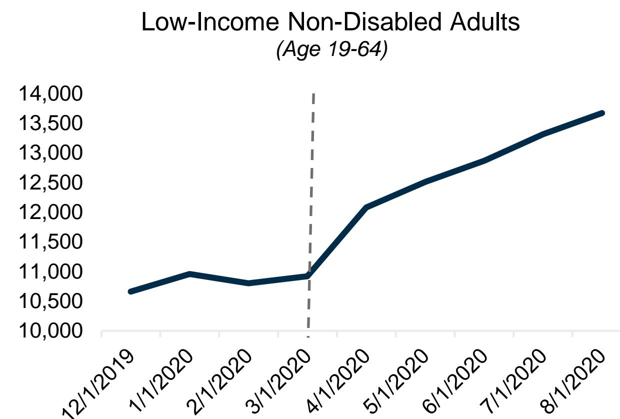
*Time ranges are from the date CMS guidance is issued.

During March and April 2020, enrollment increased across the board, most notably among the Granite Advantage (7.4%), Non-CHIP Children (3.7%), and Non-Disabled Adult (10.7%) eligibility groups. Between May and August 2020, enrollment in these groups continued to grow between one and three percent per month.









Enrollment Numbers by Eligibility Type Percent Increase by Month (2020)

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

Medicaid Care Management | Eligibility Redetermination | Analysis (2 of 2)

The A&M team identified three scenarios of how NH DHHS could recover from the PHE FMAP-driven expenditure growth. Robust implementation planning will increase the speed and efficiency of the effort. All scenarios are based on a PHE end date of 1/23/21 and increased PHE FMAP end date of 3/30/21.

1) **No Change from Pre-COVID Renewal Process:** NH DHHS resumes disenrollment of ineligible individuals on the pre-COVID timeline of annual redetermination. For example, an enrollee whose redetermination was due in March 2020 but who was continuously enrolled through January 23, 2021 when PHE is set to end would be redetermined in March 2021 and, if ineligible, disenrolled that month. This routine monthly process would continue through January 2022, when disenrollment from the PHE FMAP-related enrollment increases would be complete. This scenario assumes historic workload volume and workforce capacity.

2) **Reorganize Renewal Workload to Expedite Disenrollment of Populations with the Highest State Cost:** NH DHHS stages the renewal workload by eligibility group, expediting the disenrollment of groups with the highest per member per month costs considering the state share only. This scenario assumes higher workload volume over a shorter time period, ending in October 2021.

3) **Use Automated Closure Functionality of the Eligibility System:** NH DHHS auto-closes ineligible members of eligibility groups driving the PHE FMAP-related enrollment increases, specifically non-CHIP children, expansion and non-disabled adults. More vulnerable populations, such as long-term care recipients and Medicaid-Medicare dual enrollees would be exempt from auto-closure. The scenario assumes a single batch job in March 2021, a short-term workload spike from the minority of cases that do not auto-close, and all redeterminations and PHE FMAP-related disenrollment completed in the first calendar quarter of 2021.

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

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

Recommendation

Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.

Findings

NH DHHS relies on monetary penalties and a withhold of capitation payments to hold health plans accountable for performance, but NH DHHS cannot use these financial incentives at this time.

NH DHHS currently relies on two performance incentives for its contracted health plans: a withhold of monthly capitation payments and monetary penalties. Currently, it cannot use either of these levers. It waived the contract's withhold provisions for the first contract year due to the disruptive impact of the COVID-19 pandemic. It elected not to assess monetary penalties because a) certain contract requirements are proving aspirational or temporarily unattainable and b) some fines in the liquidated damages table are found to be overly aggressive. While helpful in generating budgetary savings, an adverse consequence of these actions is weaker financial incentives to focus health plan investments and attention on advancing state aims and complying with contract requirements.

The withhold is waived specifically because of the disruptive impact of the COVID-19 pandemic. Capitation rate reductions for plan underperformance are preferable to other means of responding to COVID-19's state fiscal impact, such as reductions to eligibility, covered services, or reimbursement rates that would be harmful to Medicaid beneficiaries and providers.

Benefits

The benefit of implementing a value-based auto-assignment algorithm is the ability to maintain health plans' focus on contract compliance and achieving state aims, particularly when other financial incentives are unavailable. Rewarding higher performers with additional membership has the potential to materially impact market share among competitors. In a managed care environment, annual revenues are the product of member months times monthly capitation payments. The greater the enrollment, the greater the revenue; and, the greater the revenue, the greater the potential for profits to the plan – making auto-assignment a powerful force for engaging health plans in improving health and containing costs in a state Medicaid program.

Savings	N/A
Costs	N/A
Net Benefit	N/A
Timeframe	24 months
Complexity	Medium to High

Medicaid Care Management | Health Plan Performance Incentives | Summary (1 of 1)

Recommendation

Shift NH DHHS's approach to performance incentives for health plans from monetary penalties and a withhold of capitation payments to an auto-assignment algorithm that rewards higher-performing plans with increased membership.

Implementation Requirements

People

Adequate resources to research and develop a value-based auto-assignment algorithm

Process

Health plan contract amendments to implement the change, including updates to the appendix that outlines auto-assignment methods.

Technology

Program changes to the existing auto-assignment algorithm in the member enrollment system

Prep. Work

Understanding of other states' experience with value-based auto-assignment; strategic planning to establish the performance objectives of the algorithm (the values on which its detailed design will be based)

Statute

Identify state or federal law or rule impacting financial performance incentives for NH DHHS-contracted health plans (i.e., SB 313)

Recommendation Timeline Outline

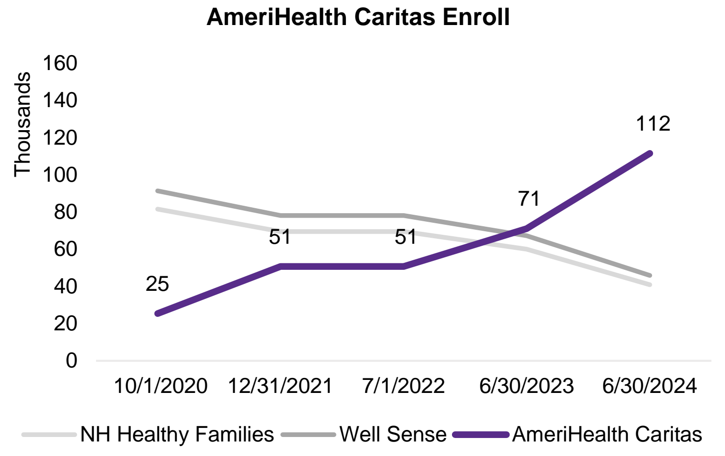
Target Start Time:

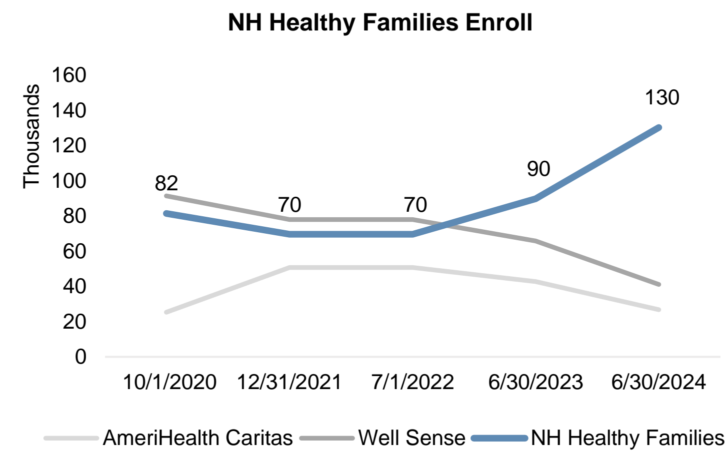
Time Range	Basic Tasks
CY21 Q1	Conduct background research, including on other states' experience and legal constraints
CY21 Q2	Complete strategic planning on auto-assignment objectives
CY21 Q3-4	Design auto-assignment algorithm
CY22 Q1	Amend contract and program system changes
CY22 Q2	Implement value-based auto-assignment

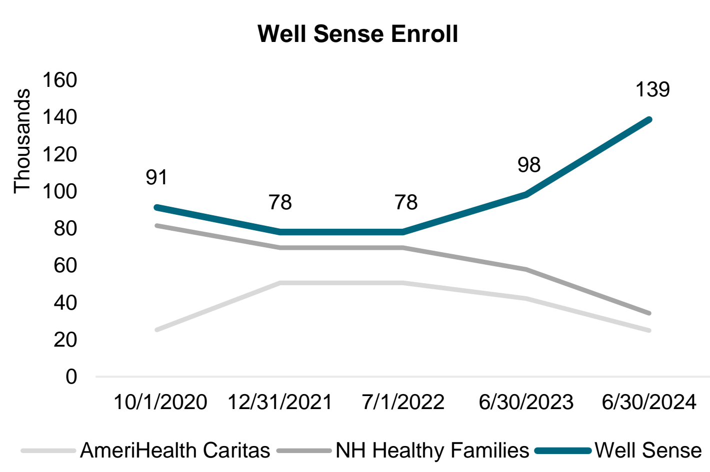
Risks

- Insufficient agency resources for design, development, and implementation
- Ongoing COVID-related disruption to health plan operations, further delaying implementation of financial performance incentives
- Extended duration of commitment to current auto-assignment method to achieve financial viability of new market entrant

Rewarding higher performing plans with increased membership can significantly impact health plan enrollment



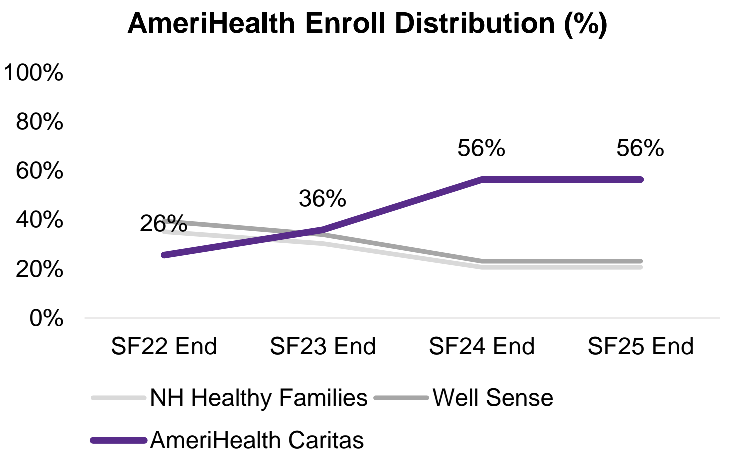


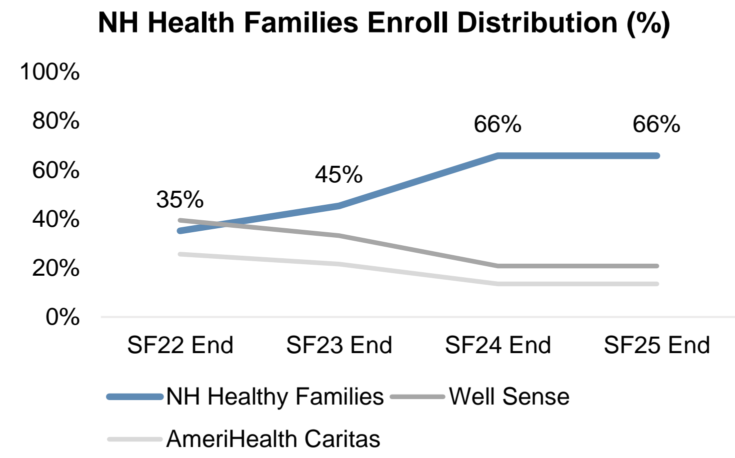


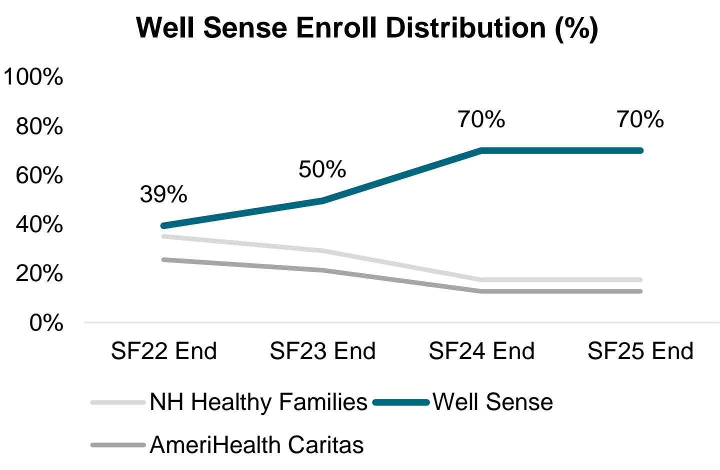
	10/1/2020	12/31/2021	7/1/2022	6/30/2023	6/30/2024
AmeriHealth Caritas	25,354	50,704	50,704	70,984	111,544
NH Healthy Families	81,522	69,574	69,574	60,015	40,897
Well Sense	91,436	78,034	78,034	67,313	45,871
	198,312	198,312	198,312	198,312	198,312

Medicaid Care Management | Health Plan Performance Incentives | Analysis (2 of 3)

Rewarding higher performing plans with increased membership can significantly impact health plan market share

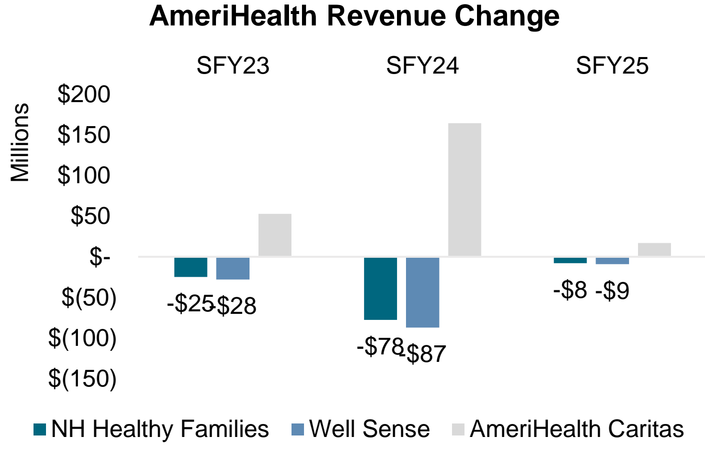


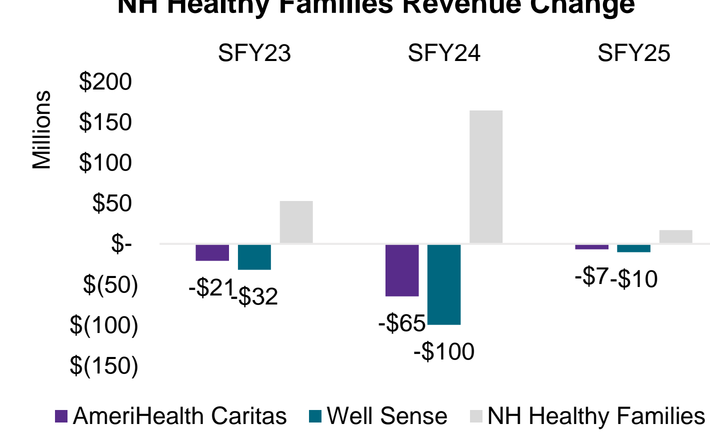


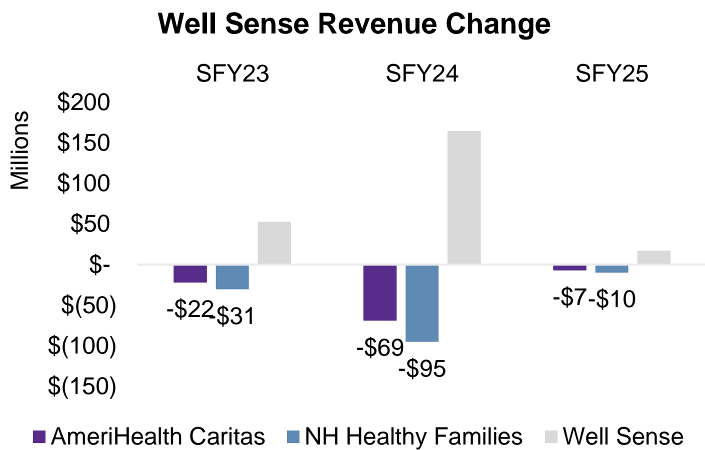


	SF22 End	SF23 End	SF24 End	SF25 End
AmeriHealth Caritas	26%	36%	56%	56%
NH Healthy Families	35%	30%	21%	21%
Well Sense	39%	34%	23%	23%

Rewarding higher performing plans with increased membership can significantly impact Per Member Per Month payments, health plan revenues and profit opportunities







	Oct '20 to Mar '21	SFY23	SFY24	SFY25
AmeriHealth Caritas	$ 93,743,510	$ 52,769,480	$ 164,519,529	$ 17,069,767
NH Healthy Families	$ (44,185,053)	$ (24,872,360)	$ (77,544,612)	$ (8,045,662)
Well Sense	$ (49,558,457)	$ (27,897,121)	$ (86,974,917)	$ (9,024,105)
	$ -	$ -	$ -	$ -

Medicaid Care Management | Health Plan Performance Incentives | Early Adoption Update

Early Adoption

NH DHHS has developed an approach to begin rewarding higher-performing plans with additional membership beginning in January 2021, concurrent with a right-sizing of liquidated damages.

Implementation Resources

People

The Medicaid agency dedicated scarce staff resources to creative thinking that enabled the use of value-based auto-assignment a year earlier than initially thought possible.

Process

Agency leadership took advantage of current contract negotiations to achieve the early implementation, including the development of detailed programmatic guidance.

Technology

The lump sum method chosen to award lives obviates the need for changes to the existing auto-assignment algorithm in the member enrollment system.

Prep. Work

The agency reviewed MCO performance challenges to date and chose a limited set of high priority objectives to test the effect of value-based auto-assignment in focusing health plan investments and attention.

Statute

This “toe in the water” approach offers a concrete path forward on the broad-brush direction provided in SB 313.

Early Adoption Timeline Outline

Target Start Time:

Time Range	Basic Tasks
FY21 Q2	Finalize contract amendment to begin implementation of value-based auto-assignment effective January 1, 2021
FY21 Q3	Begin performance measurement period
FY22 Q1	1,000 lives to be awarded for health risk assessment performance in October 2021
FY22 Q3	1,000 lives to be awarded for encounter data performance in January 2022
FY22 Q4	3,000 lives to be awarded for psychiatric boarding performance in April 2022

Medicaid Services (MMIS)

Medicaid | MMIS Executive Summary | Overview

Scope: A State's Medicaid Management Information System (MMIS) is the critical claims processing and data storage system that all states are required to operate to be eligible for Federal funding. The MMIS is the centerpiece of any state's Medicaid IT infrastructure. The A&M team conducted an in-depth review of NH DHHS's MMIS contract, architecture, and costs in order to:

a) Review the strategy and operations of the current MMIS implementation
b) Compare DHHS's spend on its MMIS versus peer states
c) Characterize the value and functionality derived from the current MMIS
d) Identify opportunities to increase MMIS value and functionality while minimizing cost

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

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

a) DHHS has not adopted a consistent strategy for its MMIS, maintaining an aging system in an ad hoc fashion
b) DHHS spends more on its MMIS than peer states (i.e., states in New England and with similar Medicaid enrollment)
c) Current MMIS uses obsolete software and requires extensive manual workarounds to function

Based on these findings, A&M recommends the following steps:

a) Adoption of a long-term strategy and vision for the State's MMIS
b) Exploration of a "modular" procurement and implementation approach for a new MMIS system*
c) Improvement to contract terms around DDI spend and product upgrades during procurement

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

** Note that DHHS has previously reviewed the possibility of adopting a modular approach to its MMIS*

The A&M Team has identified the following long-term recommendations (implementation time frame ten years). All figures are general fund; costs and savings reflect cumulative savings over the duration of the timeframe.

#	Recommendation	Description	Est. Costs ($M) Low	Est. Costs ($M) High	Est. Savings ($M) Low	Est. Savings ($M) High
F.1	New MMIS Strategy Adoption	Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time.	*variable**	*variable**	$5.5M	$21.6M

* *See subsequent slides for long-term implementation plans*

Stakeholder Engagement

Key Personnel Interviewed

DHHS Stakeholders

- Henry Lipman – Medicaid Director
- David Wieters – Director, Bureau of Information Services
- Andrew Chalsma – Director, Data Analytics and Reporting
- Meredith Telus – Director, Program Planning and Integrity
- Athena Gagnon – Medicaid Finance Director
- Grant Beckman – Medicaid Business Administrator
- Hannah Glines – Revenue Director, Division of Finance

MCO Stakeholders

- Amy Lauzon – Business Systems Analyst, Division of Finance
- AmeriHealth management team
- BMCHP management team
- Centene management team

Data Request

Key Data Reviewed

- High-level systems and applications architecture
- MMIS architecture and system components
- Federal match rates for IT systems
- List of active Medicaid IT contracts "owned" by State IT agency
- Replacement schedule for IT systems
- Current status of HIE and related investments
- CMS 64 reports and activity reports on IT and MMIS expenditures
- Advanced Planning Documents
- FY22-23 Capital Improvement Project Request
- Montana MPATH (Claims Management) RFP
- Wyoming Implementation Advanced Planning Document for WINGS
- DHHS expenditure data from New Hampshire accounting system (Lawson)

Alvarez & Marsal

Recommendation

Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time, including a modular approach to procurement and implementation; new, competitive contract terms; and a business case for MMIS re-procurement.

Findings

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

Observations:

- NH spends more on MMIS on PMPM basis than comparable states; spend averaged $7.1M over last 5 years.
- Ongoing support for software applications from 2007 are at risk
- Manual workarounds implemented to satisfy reporting requirements create difficulties accessing and producing reports – e.g., 3 staff members are required to produce the quarterly CMS 64 report.
- BIS is building manual workarounds for nearly all required functionality "enhancements."
- There are limited DDI capabilities and limited resources to fund them.

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

Benefits

- Creates consistency and accuracy of data across various DHHS systems
- Risk allocation across multiple vendors
- Reduces manual workarounds created for a limited, archaic, MMIS system
- Enables more competitive contract terms including:
  - DDI spend apportioned in contract
  - Base product upgrades (e.g., Federal compliance at vendor's cost.)
  - Advantageous contracting vehicles (e.g., NASPO) to minimize MMIS cost and provide more consistent / competitive pricing point of view.
  - CMS's shift from checklist certification criteria to outcome-based criteria eliminates requirements for IV&V costs

	Low	High
Savings*	**$5.5M**	**$21.6M**
Costs*	**$81.5M**	**$97.4M**
Net Benefit	Data to make informed decision and drive efficiencies	
Timeframe	*See subsequent slides for implementation timeline*	
Complexity	High	

** General Fund costs and savings over a 9-year period*

Medicaid | MMIS | Summary (2 of 2)

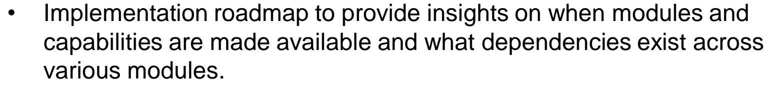
Recommendation

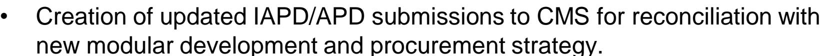
Develop a comprehensive, long-term MMIS strategy and vision to maximize MMIS value and minimize cost over time, including a modular approach to procurement and implementation; new, competitive contract terms; and a business case for MMIS re-procurement.

Implementation Requirements

People

- Communication plan to inform key stakeholders of future state MMIS strategy and to ensure buy-in from DHHS and State leadership.
- Internal IT/other staff selected to drive strategy and business case development for modular approach.





Process

- Implementation roadmap to provide insights on when modules and capabilities are made available and what dependencies exist across various modules.
- Creation of updated IAPD/APD submissions to CMS for reconciliation with new modular development and procurement strategy.
- Procurement and implementation.

Technology

- Definition of modular DDI and O&M requirements as DHHS procures various modules.
- Identification of access to and clarity around current MMIS and surrounding applications and functionality (e.g., DoIT, Conduent, etc.).
- Current state inventory to assess modules, applications, licenses/access.

Prep. Work

- Determination of program expectations for service delivery transformation.
- Modular development will require ongoing integration of systems.
- Current system may need to coexist as new modules are implemented.

Statute

- DHHS must determine whether procurement is allowed through the NASPO vehicle.
- DHHS must require EVV use for all Medicaid-funded PCS by 1/1/2020 and HHCS by 1/1/2023.

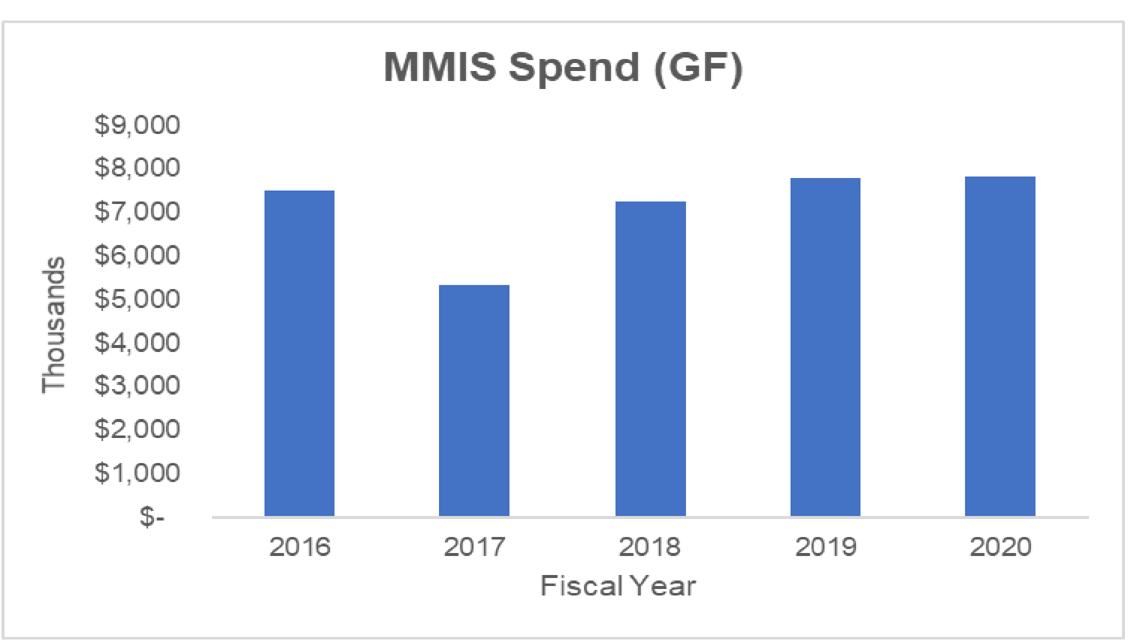
Timeline Outline

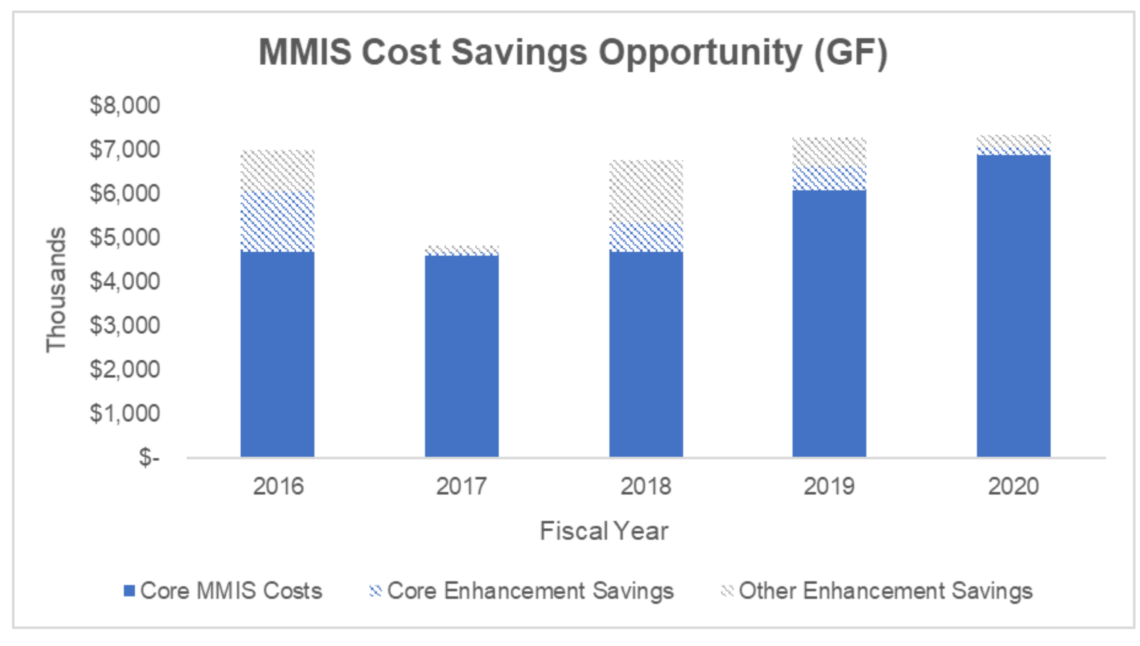
Target Start Time:	
Time Range	**Basic Tasks**
See subsequent slides for implementation timeline	

Risks

- **Other state MMIS projects have high fail rates**
- **Lack of strong program management capabilities** - effective management and monitoring will be needed to minimize risk to current operations
- **Lack of clear definition of Medicaid strategy and vision, including delivery and care management systems** - proposed modules and implementation are dependent on broader DHHS Medicaid strategy
- **Inability to manage "transitional state" for 5 years** as DHHS shifts to new MMIS
- **Complex data sources and relationships** may need to be configured manually during implementation

DHHS's current MMIS contract places basic MMIS product enhancement costs on the State; these should be shifted to the vendor in any future state MMIS.





New Hampshire's GF annual expenditures on MMIS between FY 2016 and FY 2020 averaged $7.1M, and totaled $7.8M in 2020, including O&M and DDI costs.

New Hampshire currently bears the cost of updates to a monolithic system that in a modular approach is shared across a vendor's clients. IT infrastructure must meet regulatory requirements to avoid penalties (i.e., loss of FMAP due to EVV delays).

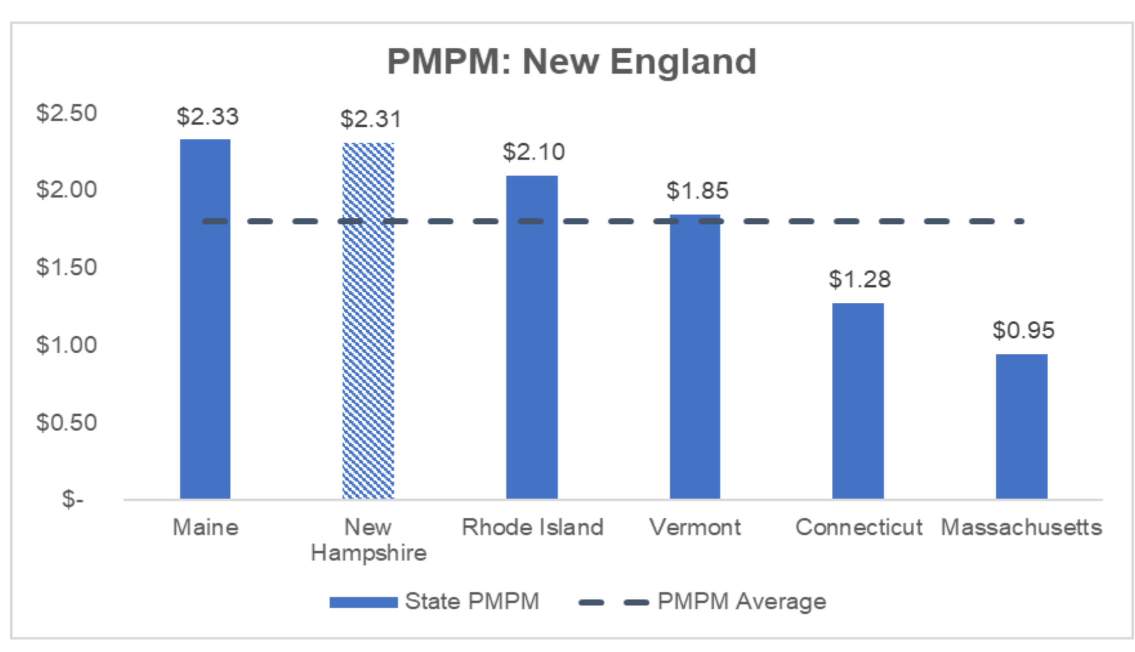
$6.3M in GF expenditures (or 18% of all GF expenditures on MMIS over this timeframe) **could have been saved by DHHS by:**

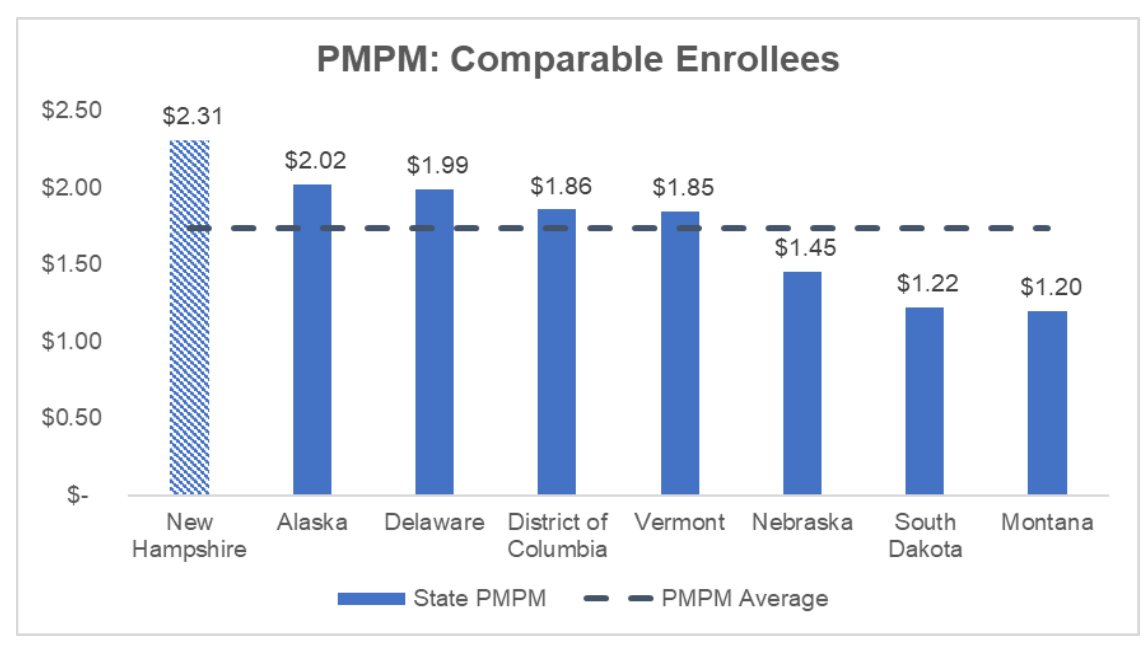
- Requiring MMIS vendor to perform core system enhancements (e.g., HIPAA, ICD-10 upgrades, as "cost of doing business")
- Building in contractual obligation of vendor to support pre-defined/agreed enhancement services in anticipation of DDI needs (assume $500K/year or approximately 2,500 development hours)

Source: New Hampshire CMS 64 Activity Reports

Medicaid | MMIS | Assessment Findings Highlight (2 of 2)

DHHS spends up to 33% more on its MMIS (on a General Fund PMPM basis) than comparable states; cost minimization should be a core part of any future state MMIS strategy.





Based on CMS data:

- New Hampshire's average MMIS PMPM (GF) between 2008 and 2018 (calendar year) is higher than all other New England states except Maine: $2.31 vs. $1.80 average, or nearly 30% higher
- New Hampshire has the highest average PMPM for its MMIS system among states with comparable enrollee size: $2.31 vs. $1.74, 33% higher.

Based on New Hampshire's CMS 64 Reporting:

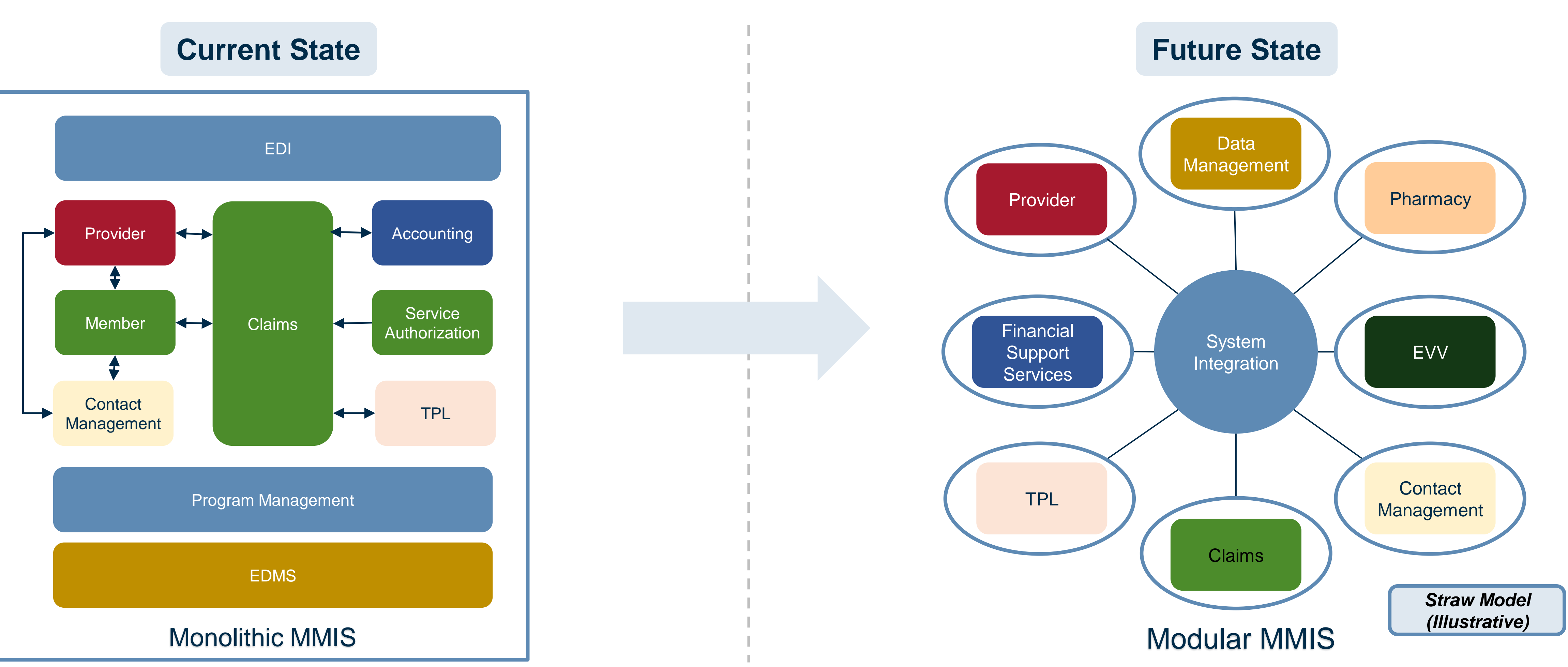
- Review of New Hampshire's MMIS spend from FY 2016 to FY 2020 shows a PMPM of $3.47 in 2020 versus the $2.31 above – a 35% increase.[2]

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

ALVAREZ & MARSAL

Medicaid | MMIS | Modular Architectural Overview

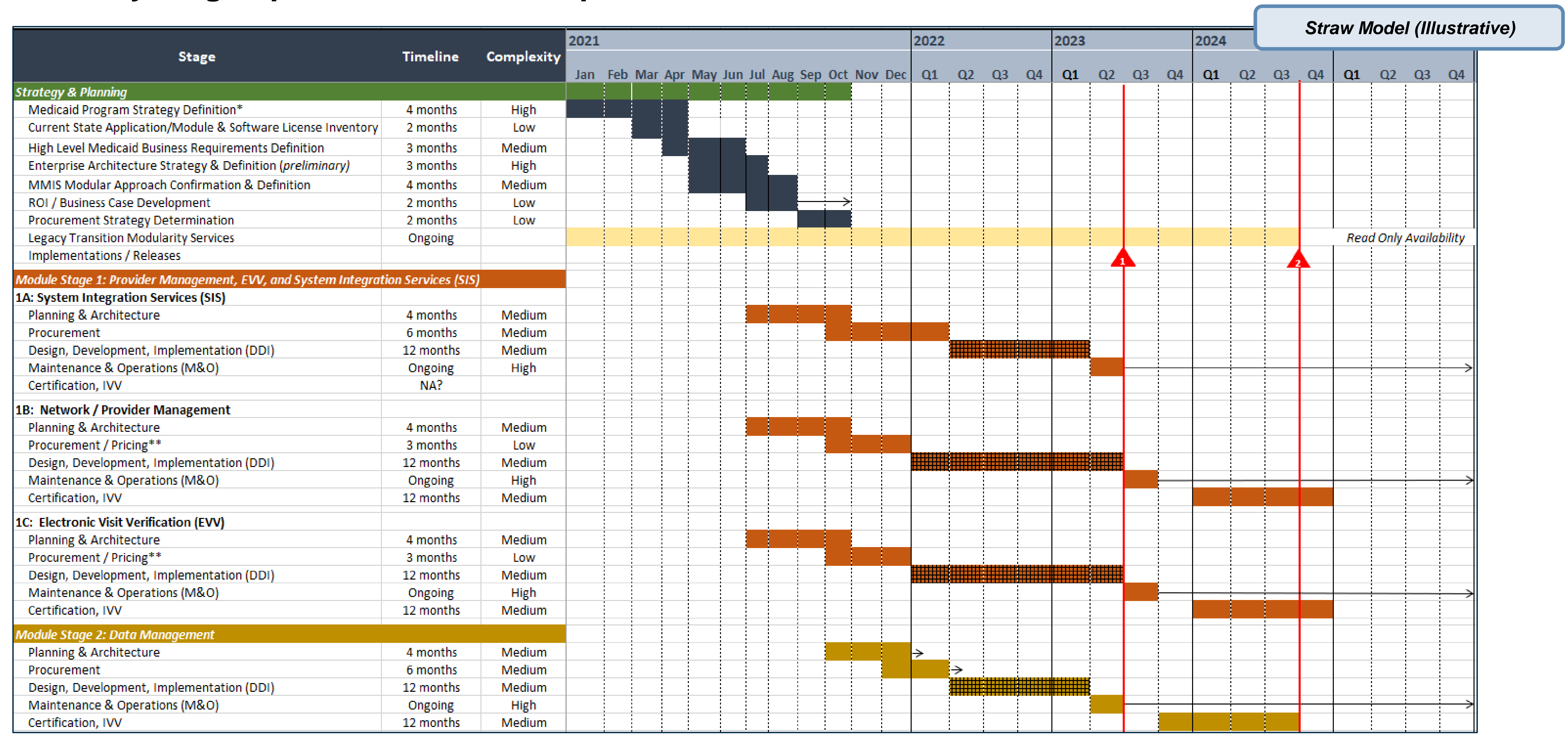
A modular MMIS approach would enable the State to procure "best of breed" functionality from multiple vendors. This modular approach also may enable competitive bidding from multiple vendors and allow a phased procurement and implementation timeframe.



ALVAREZ & MARSAL

Medicaid | MMIS | Modular Implementation Timeline (1 of 2)

Effective implementation of a modular approach would first require strategy and plan development, followed by staged procurement and implementation of select MMIS modules.



Stage	Timeline	Complexity
Strategy & Planning		
Medicaid Program Strategy Definition*	4 months	High
Current State Application/Module & Software License Inventory	2 months	Low
High Level Medicaid Business Requirements Definition	3 months	Medium
Enterprise Architecture Strategy & Definition *(preliminary)*	3 months	High
MMIS Modular Approach Confirmation & Definition	4 months	Medium
ROI / Business Case Development	2 months	Low
Procurement Strategy Determination	2 months	Low
Legacy Transition Modularity Services	Ongoing	
Implementations / Releases		
Module Stage 1: Provider Management, EVV, and System Integration Services (SIS)		
1A: System Integration Services (SIS)		
Planning & Architecture	4 months	Medium
Procurement	6 months	Medium
Design, Development, Implementation (DDI)	12 months	Medium
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	NA?	
1B: Network / Provider Management		
Planning & Architecture	4 months	Medium
Procurement / Pricing**	3 months	Low
Design, Development, Implementation (DDI)	12 months	Medium
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium
1C: Electronic Visit Verification (EVV)		
Planning & Architecture	4 months	Medium
Procurement / Pricing**	3 months	Low
Design, Development, Implementation (DDI)	12 months	Medium
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium
Module Stage 2: Data Management		
Planning & Architecture	4 months	Medium
Procurement	6 months	Medium
Design, Development, Implementation (DDI)	12 months	Medium
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium

Medicaid | MMIS | Modular Implementation Timeline (2 of 2)

Straw Model (Illustrative)

Stage	Timeline	Complexity
Module Stage 3: Financial Support Services		
Planning & Architecture	3 months	Medium
Procurement	6 months	Medium
Design, Development, Implementation (DDI)	6 months	Medium
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium
Module Stage 4: Core Operations (Claims, Member, Service Authorization) and Pharmacy		
5A: Core Operations Claims/Encounter Processing, Member, & Service Authorization		
Planning & Architecture	6 months	Medium
Procurement / Pricing**	3 months	Low
Design, Development, Implementation (DDI)	15 months	High
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium
5B: Pharmacy		
Planning & Architecture	6 months	High
Procurement / Pricing	6 months	Medium
Design, Development, Implementation (DDI)	12 months	High
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium
Module Stage 5: Contact Management		
Planning & Architecture	6 months	High
Procurement / Pricing**	3 months	Low
Design, Development, Implementation (DDI)	12 months	High
Maintenance & Operations (M&O)	Ongoing	High
Certification, IVV	12 months	Medium
*Module Stage 6: Third Party Liability (TPL)****		
Planning & Architecture	3 months	Low
Procurement / Pricing**	3 months	Low
Design, Development, Implementation (DDI)	6 months	Medium
Maintenance & Operations (M&O)	Ongoing	Medium
Certification, IVV	12 months	Medium

Timeline columns: 2021 (Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec); 2022 (Q1, Q2, Q3, Q4); 2023 (Q1, Q2, Q3, Q4); 2024 (Q1, Q2, Q3, Q4); (Q1, Q2, Q3, Q4)

Footnotes:

* Substantive shift in role and capabilities required by MCOs will impact requirements and overall approach and pricing to MMIS roadmap

** Procurement phases are anticipated to leverage NASPO timelines (or NHDHHS specific timelines) that reflect accelerated procurement / pricing cycles

*** Timeline includes integration with existing systems, e.g., New Heights, COTs, etc., but does not include any "additional COTS" package development, build, or implementation

Complexity Level Assumptions:

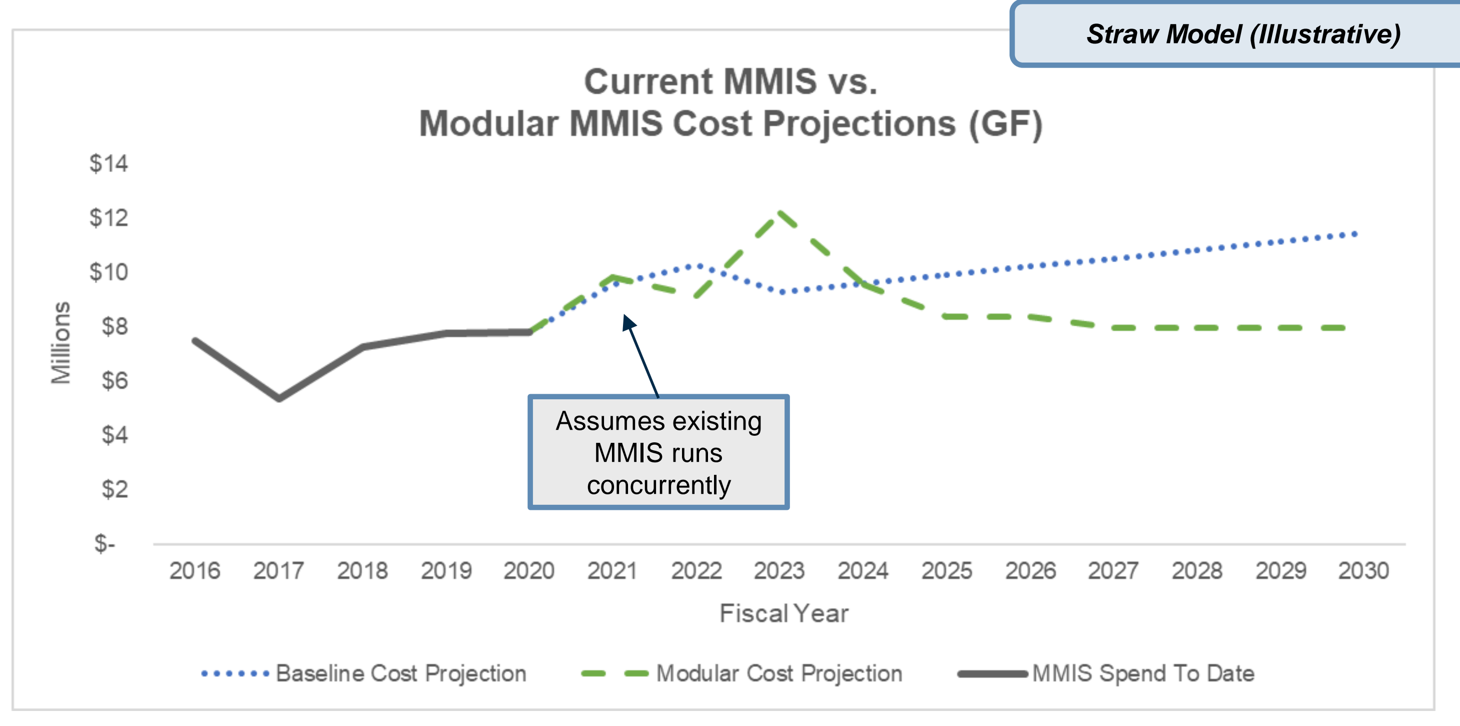
High: Significant number of critical stakeholders required to sign off, policy required for decision making, multiple integration - department or system, funding determination required

Medium: Critical stakeholders are varied by primarily within the Medicaid Department; decision making does not require significant policy changes or modifications; funding source is identified by requires work

Low: Limited number of critical stakeholders involved or decision makers required to move initiative forward; funding source within budget and/or source is known

Medicaid | MMIS | Modular Cost Projections (1 of 2)

A modular MMIS could save New Hampshire $13.5M in GF expenditures between 2022 and 2030, or an average of $1.5M per year.



- Hypothetical modular approach ("Modular Cost Projection") yields higher near-term DDI costs but lower long-term O&M costs versus forecast of current MMIS spend ("Baseline Cost Projection").
- Savings over 9-year period total $13.5M versus continuing current MMIS contract and approach.
- Forecast of current MMIS spend suggests steadily rising costs unless alternative action is taken.

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

NB – assumes that 2021 is final year of existing Conduent contract; runs in parallel with procurement of new modular approach for that year; "Modular Cost Projection" also includes transition, vendor management, program management, and legacy integration costs.

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

ALVAREZ & MARSAL

Medicaid | MMIS | Modular Cost Projections (2 of 2)

A modular approach of "best of breed" modules could be based on New Hampshire's existing MMIS architecture; long-term MMIS strategy must come first, however, in order to determine module selection.

Possible MMIS Modules with Mid, High, and Low GF Cost Estimates

Straw Model (Illustrative)

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

- Module cost projections are tiered ("Mid", "High", "Low") based on A&M research.
- Modular approach cost projections in previous slide are based on "DDI Mid" and "O&M Mid" projections; costs are staggered according to implementation timeline.

DDI costs represent 10% of total costs (90/10 Federal match) and are one-time
O&M costs represent 25% of total costs (75/25 Federal match) and are calculated for a ten-year period

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

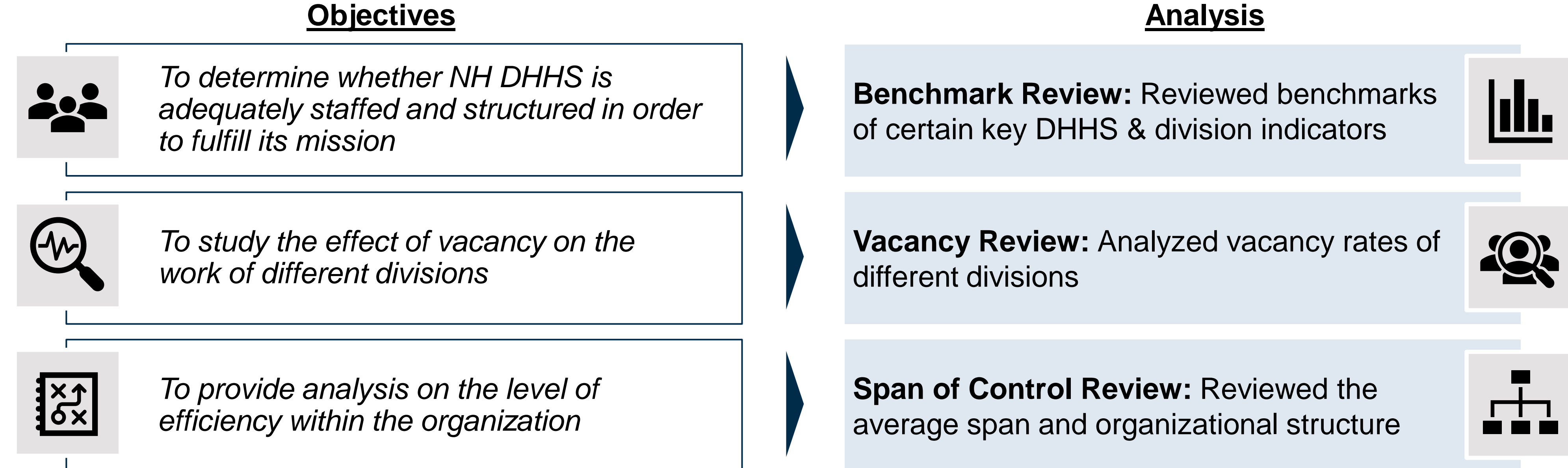
ALVAREZ & MARSAL

Key considerations as DHHS develops its MMIS system strategy should include:

1. The success of any future state, modular or otherwise, will hinge to some degree on the engagement and capabilities of the State's current MMIS vendor.
2. CMS does not have a prescribed set of modules, meaning DHHS will need to tailor their MMIS modular procurements to meet the unique needs of the State's Medicaid program and business processes. The more unique the needs and business processes of the State, the more customized the modules, with a corresponding increase in associated costs.
3. DHHS should evaluate utilizing NASPO for procurement of MMIS modules. NASPO currently has the provider enrollment module available to procure and will have the claims module by the end of 2020.
4. A system integrator will be required to integrate MMIS modules and other DHHS systems (e.g. New Heights, Salesforce, etc.). DHHS will need to determine if this can be done in-house or a vendor should be procured.
5. Proposed modules, and the modular approach in general, are dependent on the broader DHHS Medicaid strategy (e.g., ACO/HH; FFS versus MCO; etc.). A consistent, long-term strategy – and consistent funding to execute that strategy – will facilitate the success of a modular implementation.
6. Scope and funding varies based on the environment, e.g. FFS or MCO. Some provider management functions will be shifted to MCOs. EVV has several models that vary considerably in implementation cost and complexity.
7. Cost is dependent on transformation strategy. If transformation occurs in a modular time-phased manner, the legacy MMIS must co-exist with newly-introduced modules, requiring an interface with the legacy system and O&M costs for both new and old modules.
8. The sample timeline provided on previous slides is *one option* for a modular implementation. Other states (e.g., Georgia) are adopting multiple modules simultaneously in a "sand box" system and then converting upon completion (the "big-bang“ approach). DHHS will need to determine the best go-forward option as it develops its MMIS system strategy.
9. Cost projections are highly subjective and may be higher than current MMIS expenditures due to extensive module implementation, integration, or rework. These cost projections are preliminary and illustrative.
10. BIS staff vacancies are the highest among DHHS divisions, particularly within the MMIS team. Proper staffing levels will be crucial to the successful implementation of a new MMIS. See Information Services and MMIS report in the “Staffing” analysis for further detail.

Staffing

A&M examined and analyzed the organizational structure and staffing levels across DHHS. A&M's entering hypothesis was that DHHS is lean relative to the functions it performs, informed in part by the vacancy rate of 26 percent across all full-time funded positions as of September 2020 and qualitative accounts of large workloads.



Findings

A&M identified through benchmarking that NH DHHS was not overstaffed relative to its peers. Our review of vacancies revealed that significant transactional and operational vacancies impeded DHHS from achieving transformational projects. A&M determined through the span of control review that while the near-term efficiency of the organization would be unlikely to change through an overhaul of the organizational structure, NH DHHS could use span data to identify divisions for further study.

Staffing Review | Overview | Stakeholder Engagement and Data Request

Stakeholder Engagement

Key Personnel Interviewed

- Kerrin Rounds, CFO
- Lori Weaver, Deputy Commissioner

Data Request

Key Data Reviewed

Human Resources Data as of:

- September 2020 (FY21 Post-COVID)
- March 2020 (FY20 Pre-COVID)
- June 2019 (FY19)
- June 2018 (FY18)

Other Data

- Compensation Data for the above timeframe
- Organizational charts by division

A&M performed a relative benchmarking exercise for NH DHHS in order to determine if NH DHHS is overstaffed or understaffed. A&M used relative benchmarking rather than absolute benchmarking for reasons outlined below.

Absolute Benchmarking

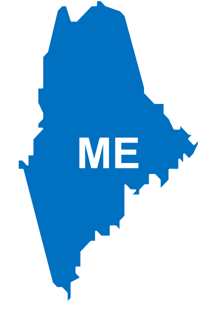
Absolute benchmarking exercises evaluate the difference between the current state of an organization against a universal metric. The result of an absolute benchmark informs organizational leadership whether they are meeting a standard or not. Absolute benchmarks may be set into statute by a governing body (like a federal agency) or suggested by an organization (like an association).In state government department-wide staffing, absolute benchmarks are often either not available or not useful. Availability is limited because the inputs to absolute benchmarks must be somewhat static to draw utility from comparison.

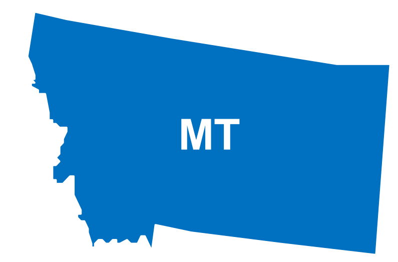
Relative Benchmarking

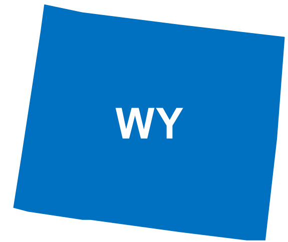
A&M utilized relative benchmarks for this analysis, comparing NHDHHS staffing levels to peer states to evaluate the starting hypothesis that NHDHHS was relatively lean. Relative benchmarks at the department level have limitations. For appropriate comparison between two states' health and human services agencies, the agencies must be functionally equal in types of services performed, types of facilities operated, and types of programmatic decisions made. Department-level aggregate indicators can provide enough information for decision-makers to determine whether an agency is widely outside a normal range.

Benchmark States

to



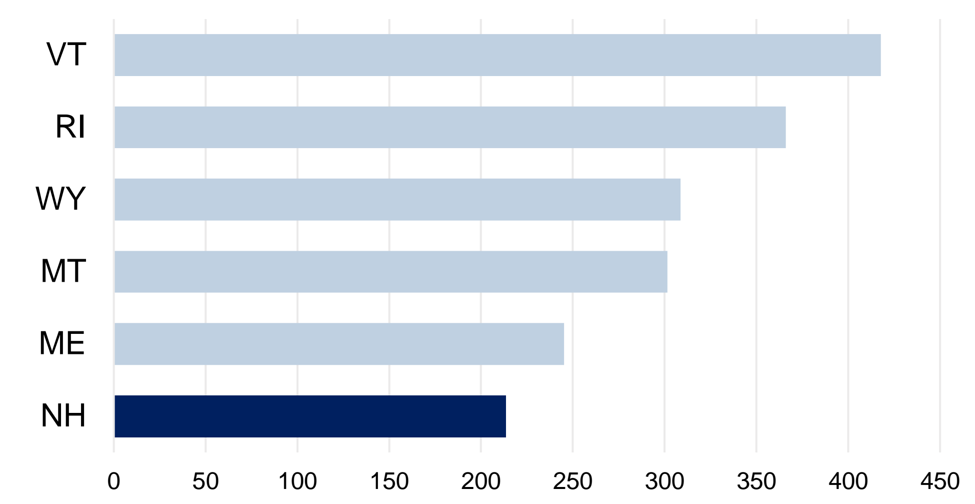




A&M engaged in this benchmarking exercise to evaluate the hypothesis that NH DHHS is understaffed (or, at the very least, is not overstaffed). First, A&M compared the relative size of each HHS agency per resident in the state (rounded to the nearest 100) to other HHS agencies.

Staff Count per 100,000 Residents

State	Staff	Population	per 100k
VT	2,508	600,000	418
RI	3,696	1,009,000	366
WY	1,786	578,000	309
MT	3,223	1,068,000	302
ME	3,300	1,345,000	245
NH	**2,930**	**1,371,000**	**214**



Findings

New Hampshire DHHS has fewer staff members for the total population served than all peer states examined. Using this metric does not suggest that these contemporary agencies are overstaffed, as **it is entirely plausible that all of these agencies are understaffed**. This approach can, however, show that **NH DHHS is not overstaffed relative** to peers based on the total state population served.

A&M hypothesized numerous reasons for discrepancies, like the fact that each agency has a certain level of fixed costs that it must cover. A complete root cause analysis, however, was outside the scope of this review. While these should not be discounted, using multiple state examples alleviates some of the issues with making one-off comparisons. In conclusion, **comparing the total number of staff per total population served suggests that NH DHHS is not overstaffed.**

Staffing Review | Benchmarking | Department-Wide (2 of 2)

A&M engaged in this benchmarking exercise to evaluate the hypothesis that NH DHHS is understaffed (or, at the very least, is not overstaffed). Second, A&M also compared the total staff count to the number of beneficiaries served (Medicaid & CHIP)[1].

Staff Count per 10,000 Beneficiaries

State	Staff	Coverage %	Beneficiaries	per 10k
WY	1,786	10.2%	58,764	304
VT	2,508	26.5%	159,344	157
NH	**2,930**	**14.0%**	**192,026**	**153**
ME	3,300	17.2%	230,811	143
MT	3,223	23.0%	246,033	131
RI	3,696	29.9%	302,288	122

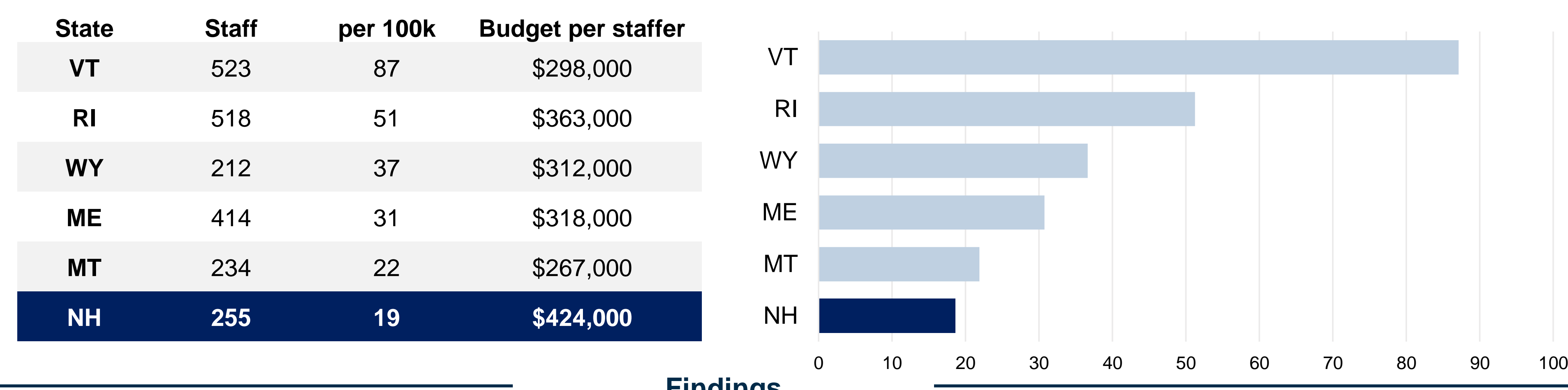
Findings

New Hampshire rests in the middle of the distribution of states and between its geographical neighbors. In contrast to the previous indicator examined in which only staff was an adjustable variable, the two variables in this calculation (staff and beneficiaries) are both influenced by policymakers. **Wyoming and New Hampshire have the lowest and second-lowest percentage of beneficiaries while having the highest and third-highest number of staffers per beneficiary**. Increased staff count per beneficiary is associated with decreased beneficiary percentage, but this data does not provide enough information to be conclusive. As such, **this indicator neither proves nor refutes the hypothesis that NH DHHS is not overstaffed.** As with other indicators, it is important to understand the context of these peer states. For instance, Wyoming is one of the few states in which Medicaid is primarily Fee-For-Service as opposed to Managed Care, and states that deliver Medicaid through Managed Care shift much of the administrative burden MCOs.

[1]CMS as of May 1, 2020

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

Public Health Staff Count Per 100,000 Residents



State	Staff	per 100k	Budget per staffer
VT	523	87	$298,000
RI	518	51	$363,000
WY	212	37	$312,000
ME	414	31	$318,000
MT	234	22	$267,000
NH	**255**	**19**	**$424,000**

Findings

Compared to other New England states, **NHDPH has 58 percent of Maine's PH staff per resident**, 35 percent of that of Rhode Island, and 21 percent of that of Vermont. This relatively lean position is borne out in the budgeted division spend managed per staffer. NHDPH employees are responsible for managing 37 percent more budgeted spend than the next closest state of Rhode Island.

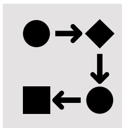
In interviews with stakeholders, A&M theorized why NH DPH is so dramatically lower in staff per resident than peers; namely, DPH contracts out a significant number of services. However, these contracts, vendors, and grants must be managed, which also requires human resources. This explanation, however, does not completely explain the root causes which were outside the scope of this study. Based on these two high-level indicators, **A&M can project that it is likely that NHDPH is understaffed relative to its peers.**

[1]CMS as of May 1, 2020

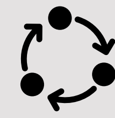
A&M also examined the vacancy rates and the administrative functions of DHHS to understand how DHHS' operations current state compares to the previous periods, with special focus on the effects of the COVID-19 pandemic. While many areas were included in this analysis, a particular division's omission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

Approach: A&M used a framework as a heuristic to evaluate DHHS' effectiveness in various functions and identify areas where vacancy rates impede its ability to progress along with the framework. The framework includes three categories, and analysis checks the ability of an organization to fulfill the objectives of the category. The categories are as follows:

Transactional: Does the organization complete the transactions in a timely and accurate manner?



Operational: Does the organization evaluate and continuously refine processes, protocols and systems to maintain and improve operational efficiency?



Transformational: Does the organization have the capacity to transform programs and services to achieve better outcomes and prepare for future conditions?

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

Staffing Review | Vacancies | By Division

Understanding the levels of vacancies within DHHS provides a roadmap to identify the areas where DHHS is most acutely experiencing transactional constraints.

Top-Line Results: Examining the vacancy rates at the division level helps point to the most acute needs of an organization. At DHHS, the overall full-time vacancy rate is 15.6% and the part-time vacancy rate is 54.8%. When blended, the vacancy rate is 20.6%

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

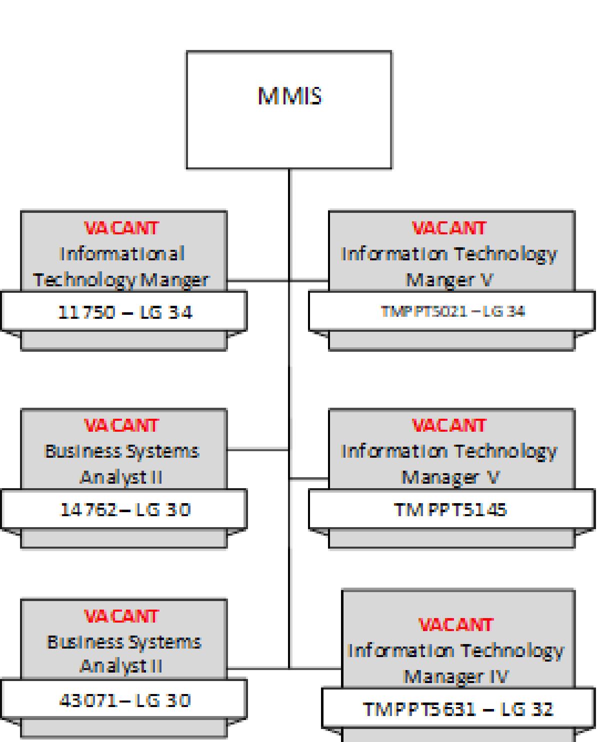
The vacancy rates shown here point to the impediments DHHS faces as it aims to both react to the COVID-19 pandemic and forge forward to become a transformational organization. **Many of the highest vacancy rate divisions and functions are the most critical divisions and functions for managing transactions,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

The Bureau of Information Services and the Division of Medicaid Services are experiencing the highest and second-highest vacancy rates (at 26.3% and 22.2%), respectively, among all DHHS divisions.

IT Functional Vacancy Rate Over Time

FY	Vacancy
FY18	5.7%
FY19	11.8%
FY20 (Mar.)	18.0%
FY21 (Sep.)	23.8%

MMIS Vacancies



Findings

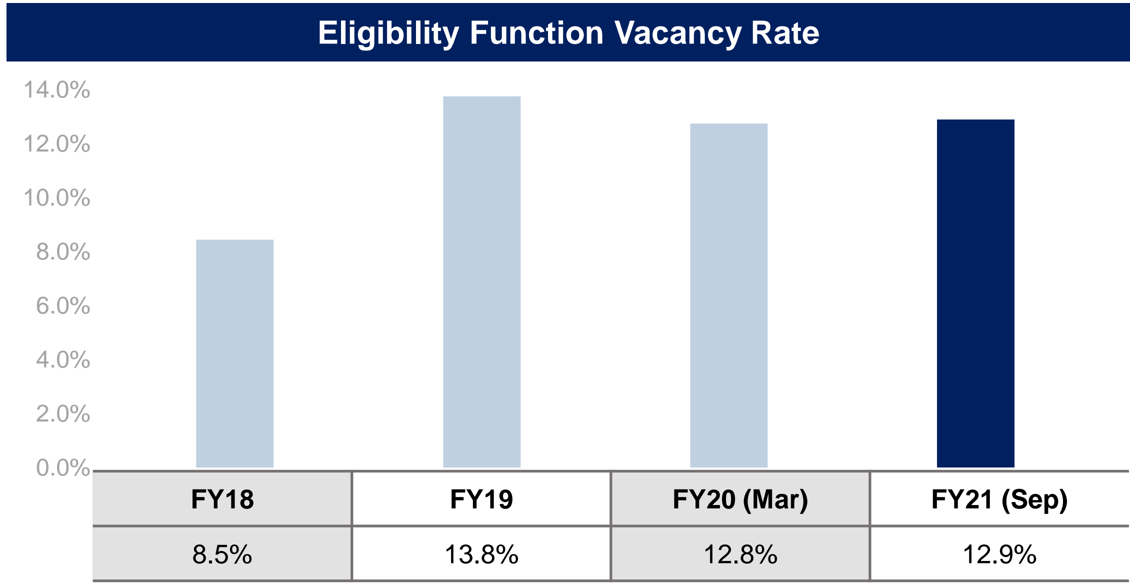
This IT functional vacancy rate of 23.8% understates the magnitude of the IT staffing issues faced by NH DHHS. As seen here in the MMIS organizational chart, the totality of the MMIS department is vacant. Not only must this minimum staffing capacity be addressed for DHHS to mitigate risk of transactional and operational issues, but also **these vacancies preclude DHHS leadership from using timely and accurate data necessary for strategic decision-making and planning**.

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

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

Other vacancy areas are creating pressing needs for DHHS. This list is not exhaustive of all the areas experiencing operational difficulty but offers brief highlights of other pressing vacancy issues in DHHS.

Eligibility Function Vacancy Rate



FY18	FY19	FY20 (Mar)	FY21 (Sep)
8.5%	13.8%	12.8%	12.9%

Findings

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

Finance & Program Quality and Integrity

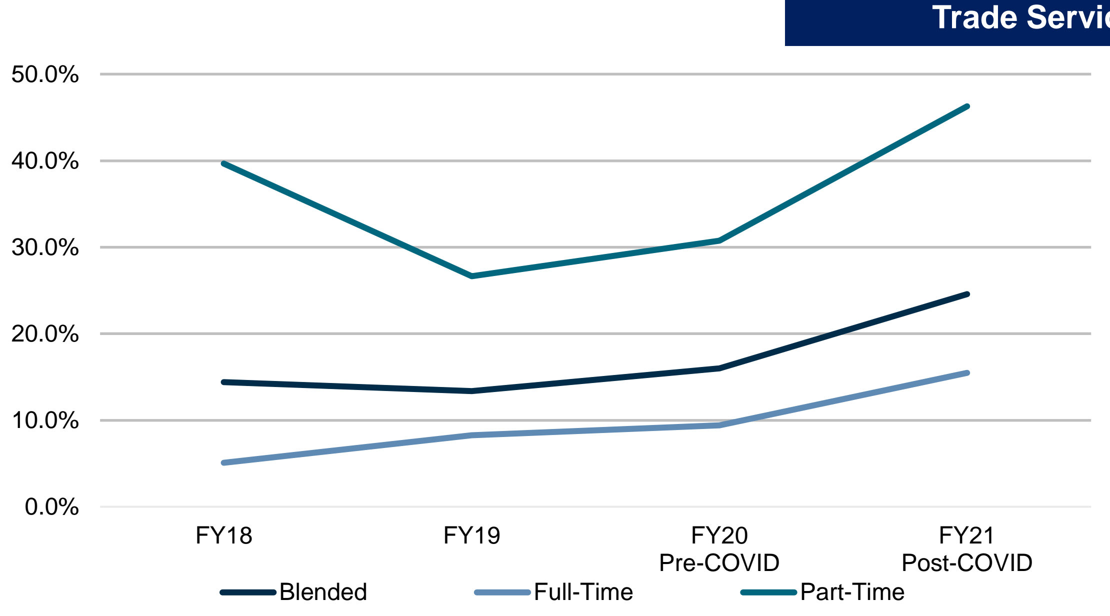
Division	FY20 (Pre-COVID)	FY21 Post-COVID	% Change
Office of Finance	12.0%	20.8%	73.1%
Division of Program Quality & Integrity	14.9%	17.0%	14.3%

Findings

The functions completed by these offices, while not direct care, have downstream effects on the ability of DHHS to fulfill its transactional needs, operate smoothly, and initiate transformational projects. For example, the full staffing of the Office of Finance functions within divisions would help enable for improved capacity to execute cost control, manage contracts, and perform forecasting or other tasks (which realize increased value for DHHS). Likewise, a fully staffed Division of Program Quality and Integrity could provide DHHS more resources to proactively solve issues and mitigate risk of single audit findings. High vacancy rates in these offices, therefore, has negative downstream effects on DHHS' ability to do transformational work.

Other vacancy areas are creating pressing needs for DHHS. This list is not exhaustive of all the areas experiencing operational difficulty but offers brief highlights of other pressing vacancy issues in DHHS.

Trade Services Vacancy Rate



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

Findings

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

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

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

A&M examined the average span of control within DHHS to determine if any management functions or divisions should be studied for further organizational redesign.

The "span of control" – or ratio of supervisors to staff – is the measurement commonly used to assess distribution of human resources between management and frontline personnel. The optimum span of control for a given public sector department will vary based on the complexity of its functions and other factors.* On a department-wide basis, DHHS' Span of Control ratio of direct reports to managers is a median of 1:4 and an average of 1:5

Approach

The traditional approach to such an exercise identifies middle management with low spans and uses those divisions as an opportunity for consolidation, which is neither what A&M recommends nor is the approach taken in this analysis. The goal of increasing span of control within DHHS should be to shift roles from supervisors to outcome-influencing front-line staff through the natural process of attrition.

As supervisors leave employment with DHHS, efforts should be made to backfill their vacancies with front line staff level positions. Increasing the number of front-line staff not only generates savings associated with reduced salaries, but also streamlines the organizational structure and increases the level of service to citizens. A&M used human resources data to quantify the total number of direct reports per person. For this exercise, A&M did include part-time positions within the span of control analysis (though the difference when excluding these part-time positions was immaterial).

Staffing Review | Span of Control | By Division

A&M calculated the average span of higher-staffed divisions of DHHS.

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

Approach

On a department-wide basis, DHHS' Span of Control ratio of direct reports to managers is a median of 1:4 and an average of 1:5. As a percent of a whole, the direct report data indicates that approximately 19.8 percent of total DHHS staff have at least some supervisory responsibilities. This span is lower than a commonly-used heuristic of 1:6, but, **rather than using the 1:6 as an absolute indicator that all DHHS divisions must attain, DHHS should first begin by focusing on the divisions below their own median.**

Span of control is influenced by multiple factors, as some of these departments could be experiencing a lower span of control because many services are contracted out (as in the case of the Division of Public Health). The vacancy rate also influences the span of control. In all divisions, the span increases (in some areas by a significant factor) if the division were fully staffed. This finding implies that part of the relatively lower span of control is tied to the vacancy rates.

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

Appendix
A&M

Appendix | Other Areas Reviewed

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

#	Opportunity	Determination
Behavioral Health		
1	Maximize efficiency of service delivery through State-operated facilities / programs (e.g. New Hampshire Hospital, Glencliff Home).	Given time constraints, the A&M team de-prioritized this opportunity relative to the potential to enhance Medicaid funding for services through an SMI IMD Waiver.
2	Maximize administrative funding drawn on block grants.	Further review is required.
3	Minimize usage of State General Funds to support and oversee New Hampshire's Community Mental Health Center (CMHC) system.	Further review is required.
Developmental Disabilities		
1	Case Management	Case management is a complex, intertwined process not only within I/DD services, but in the network of other case workers and service systems individuals may access. While case management is a significant component of BDS services, a more in-depth review and analysis is needed prior to making recommendations at this time.
2	CARES Act Funding	The COVID-19 pandemic significantly impacted the I/DD service system within New Hampshire and nationally. Program closures due to the pandemic destabilized provider networks and heightened the risk of individuals with I/DD becoming isolated. While this analysis reviewed the impact COVID-19 had on BDS and identified potential opportunities to leverage CARES Act Funding to stabilize programs, additional analysis and structures are needed prior to making recommendations at this time. Specifically, opportunities identified include: growth and stabilization of Enhanced Family Care services (including network growth and access to PPE), expanding access to technology for virtual supports, and enhanced training and credentialing activities to strengthen the Direct Support Professional workforce.
3	Autism Spectrum Disorder (ASD) Waiver	Nearly 900 participants in BDS services have Autism Spectrum Disorder (ASD) and no other I/DD. This sub-population places new stresses on I/DD service structures. Primarily, rates of ASD diagnosis have grown exponentially over the past two decades. Persons with ASD often have significantly higher therapy-based services which are not currently available under the DD Waiver. Given these differences in service needs, BDS may wish to explore an Autism-specific waiver for targeted for people with ASD.

Appendix | Other Areas Reviewed

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

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

Behavioral Health | Appendix | Sources

A&M reviewed the following data sources and documentation in order to build out its recommendation to pursue an SMI IMD waiver.

- CMS Expenditure Authority #11-W-00321/1 for Substance Use Disorder Treatment and Recovery Access for New Hampshire DHHS (dated August 3, 2018).
- NH DHHS Request for Amendment #1 to CMS Expenditure Authority #11-W-00321/1 for Substance Use Disorder Treatment and Recovery Access for New Hampshire DHHS (dated August 21, 2020) and supporting materials. Provided by Henry Lipman.
- CMS Expenditure Authority #11-W-00331/3 for Behavioral Health Transformation for District of Columbia (dated December 19, 2019).
- CMS Waiver Authority #11-W-00194/1 for Global Commitment To Health Section 1115 Demonstration for Vermont AHS (dated January 28, 2020).
- CMS State Medicaid Director Letter SMD # 18--011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (dated November 13, 2018).
- Medicare Cost Reports for New Hampshire Hospital (CCN 30-4000) for Fiscal Years ended June 30, 2017, June 30, 2018, and June 30, 2019. Provided by Joe Caristi.
- James A. McClure, Psychiatric Boarding in New Hampshire: Violation of a Statutory Right to Treatment, 14 U.N.H. L. REV. 197 (2016). Available at http://scholars.unh.edu/unh_lr/vol14/iss1/6.
- Shawn V. LaFrance & Daniel J. Walsh, HELP: People Seeking Mental Health Care in New Hampshire, Foundation for Healthy Communities (February 2013). Available at https://www.healthynh.com/images/PDFfiles/BehavioralHealth/HELP_Rpt_FINAL_02_22_13.pdf.
- Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. Emerg Med Int. 2012;2012:306–8. Available at http://downloads.hindawi.com/journals/emi/2012/360308.pdf.
- Emergency Department Boarding of Psychiatric Patients in Oregon: Report Briefing Oregon Health Authority Public Health Division, February 1, 2017. Available at http://www.mentalhealthportland.org/wp-content/uploads/2018/11/OHA-Psychiatric-ED-Boarding-Full-Report-Final.pdf.
- New Hampshire Hospital Report on Medicaid Charges and Payments for Dates of Service between 07/01/2019 and 06/30/2020. Provided by Joe Caristi.
- New Hampshire 10-Year Mental Health Plan, January 2019.
- ED Waitlist Pivot tables. Provided by Joe Caristi.
- Centers for Disease Control and Prevention. (2020, August 14). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. Morbidity and Mortality Weekly Reports. Available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.
- Panchal, Nirmita *et al*, The Implications of COVID-19 for Mental Health and Substance Use, (KFF, Aug 21, 2020). Available at https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

Alvarez & Marsal Holdings, LLC. All rights reserved. ALVAREZ & MARSAL®, ® and A&M® are trademarks of Alvarez & Marsal Holdings, LLC.

© Copyright 2020-21