STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

FINANCIAL AND COMPLIANCE
AUDIT REPORT
FOR THE FISCAL YEAR ENDED
JUNE 30, 2007

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

Reporting Entity And Scope

The reporting entity of this audit and audit report is the Bureau of Elderly and Adult Services of the New Hampshire Department of Health and Human Services, Division of Community Based Care Services for the fiscal year ended June 30, 2007.

The following report describes the financial activity of the Bureau of Elderly and Adult Services, as it existed during the period under audit. Unless otherwise indicated, reference to the Bureau, BEAS, or auditee refers to the Bureau of Elderly and Adult Services. Reference to the Division or DCBCS refers to the Division of Community Based Care Services and reference to the Department or DHHS refers to the New Hampshire Department of Health and Human Services.

Organization

In accordance with RSA 126-A:4, the Commissioner of the Department of Health and Human Services has the authority to "establish, reorganize, or abolish such divisions, offices, bureaus, or other components of the department as may from time to time be necessary to carry out the mission and duties of the department." During fiscal year 2007, the Bureau of Elderly and Adult Services was established within the Department's Division of Community Based Care Services.

The Bureau is organized into five operational units and one administratively attached organization.

1. Adult Protective Services and Field Operations Unit provides protection to incapacitated adults who are abused, neglected, or exploited and arranges for in-home support services to incapacitated adults to prevent abuse, neglect, or exploitation and to enable them to remain at home independently as long as possible.
2. Community Operations Unit manages the daily operations of the State-wide Home and Community Based Care for the Elderly and Chronically Ill program, including clinical eligibility and service authorization.
3. Community Services Policy and Program Development Unit develops and implements the ServiceLink Resource Centers, the N.H. State Plan on Aging, and the programs and services funded by the Administration on Aging and the Social Services Block Grants.
4. Medicaid Management Unit manages the Bureau's portion of the Medicaid Program.
5. Bureau of Finance Unit provides oversight and management of Medicaid and social service financial management functions including rate setting and business system operations.

The Office of the Long Term Care Ombudsman is administratively attached to the Bureau and supports the rights of people who live in licensed nursing homes and residential care facilities.

Responsibilities

RSA 161-F:2 establishes the Department of Health and Human Services as responsible for the administration of RSA Chapter 161-F, Elderly and Adult Services. In addition, RSA 151-E outlines the Department's involvement in the provision of long-term care services in the State.

The Bureau describes its mission as the "shared leadership within New Hampshire in developing and funding long term supports and advocating for elders, adults with disabilities, and their families and caregivers. The BEAS envisions a long-term system of support that:

- Promotes and supports individual and family direction
- Provides supports to meet individual and family needs
- Provides high quality care and support
- Promotes efficiency."

Funding

The financial activity of the Bureau is accounted for in the General Fund of the State of New Hampshire. A summary of the Bureau's revenues and expenditures for the fiscal year ended June 30, 2007 is shown in the following schedule.

Summary Of Revenues And Expenditures
For The Fiscal Year Ended June 30, 2007

	General Fund
Total Revenues	$ 293,121,795
Total Expenditures	386,686,727
Excess (Deficiency) Of Revenues Over (Under) Expenditures	**(93,564,932)**
Other Financing Sources (Uses)	
Net General Fund	93,564,932
Total Other Financing Sources (Uses)	**93,564,932**
Excess (Deficiency) Of Revenues And Other Financing Sources Over (Under) Expenditures And Other Financing Uses	**$ -0-**

Prior Audit

There have been no previous financial and compliance audits of the Bureau. Certain aspects of the Bureau's operations were included in the scope of a fiscal year 2002 audit of the Department of Health and Services' Medicaid Program.

Audit Objectives And Scope

The primary objective of our audit was to express an opinion on the fairness of the presentation of the financial statement of the Bureau of Elderly and Adult Services for the fiscal year ended June 30, 2007. As part of obtaining reasonable assurance about whether the financial statement is free of material misstatement, we considered the effectiveness of the internal controls in place at the Bureau of Elderly and Adult Services and tested its compliance with certain provisions of applicable State and federal laws, rules, and contracts. Major accounts or areas subject to our examination included, but were not limited to, the following:

- Revenues and expenditures.

Our report on internal control over financial reporting and on compliance and other matters, the related observations and recommendations, our independent auditor's report, and the financial statement of the Bureau of Elderly and Adult Services are contained in the report that follows.

Auditor's Report On Internal Control Over Financial Reporting And On Compliance And Other Matters

To The Fiscal Committee Of The General Court:

We have audited the Statement Of Revenues And Expenditures-General Fund of the Bureau of Elderly and Adult Services (Bureau) of the New Hampshire Department of Health and Human Services for the fiscal year ended June 30, 2007 and have issued our report thereon dated April 10, 2008, which was qualified as the financial statement does not constitute a complete financial presentation of the Bureau. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Bureau's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statement, but not for the purpose of expressing an opinion on the effectiveness of the Bureau's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Bureau's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses. However, as discussed below, we identified certain deficiencies in internal control over financial reporting that we consider to be significant deficiencies.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the deficiencies described in Observations No. 1 through No. 28 to be significant deficiencies in internal control over financial reporting.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the entity's internal control.

Our consideration of the internal control over financial reporting was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in the internal control that might be significant deficiencies and, accordingly, would not necessarily disclose all significant deficiencies that are also considered to be material weaknesses. However, we believe Observation No. 1, Observations No. 2, 3, and 4 in combination, Observations No. 9 and 10 in combination, Observations No. 13 and 14, and Observations No. 17 and 18 in combination are material weaknesses.

Compliance And Other Matters

As part of obtaining reasonable assurance about whether the Bureau's financial statement is free of material misstatement, we performed tests of the Bureau's compliance with certain provisions of laws, rules, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*. However, we noted an immaterial instance of noncompliance which is described in Observation No. 29.

The Bureau's response is included with each observation in this report. We did not audit the Bureau's responses and, accordingly, we express no opinion on them.

This report is intended solely for the information and use of the management of the Bureau, others within the Bureau, and the Fiscal Committee of the General Court and is not intended to be and should not be used by anyone other than these specified parties.

Office Of Legislative Budget Assistant

April 10, 2008

Internal Control Comments
Significant Deficiencies

Observation No. 1: Form And Format Of State Plan Document Should Be Revised For More Efficient Use

Observation:

The New Hampshire State Medicaid Plan (State Plan) is not in a form that allows quick research and review. Bureau employees and others are not able to access State Plan information in an efficient manner.

The State Plan is a compilation of provisions describing the operation of the Medicaid Program in New Hampshire. The State Plan is published and maintained by the Department in a large three-ring binder without a comprehensive table of contents, index, or other aid to allow for easy access to specific plan provisions. The Department has not made an electronic version of the State Plan available to its employees or users external to the Department. The Centers for Medicare & Medicaid Services (CMS) on-line copy of the New Hampshire State Plan has not been available for more than a year.

Because the form of the State Plan document makes it difficult to access and use, there is an increased risk that the specifics of the State Plan will be unknown to employees and other stakeholders. While the State Plan provides the specific detail operating description of the New Hampshire Medicaid program as approved by CMS, it appears that Department employees and others may rely upon process experience for program direction and not a regular review and utilization of the State Plan document.

Recommendation:

Critical operational information such as goals and objectives, policies and procedures, administrative rules, plans, etc., including New Hampshire's State Medicaid Plan should be in a form and format that promotes the communication and utilization of that important information.

- The Department should formalize the State Plan document to include a detailed table of contents and index that would allow for ready access to provisions of the State Plan.
- The Department should publish the State Plan in an electronic format to allow for wider and more efficient access to State Plan provisions both by Department employees and interested parties outside the Department.

Auditee Response:

We do not concur.

The Medicaid State Plan is organized and formatted pursuant to the standard identified by the federal Centers for Medicaid & Medicare Services (CMS) though the organization and format which was outlined a long time ago. The NH Medicaid State Plan is a living, evolving document that represents the ongoing and constantly metamorphosing agreement between CMS and the

State of New Hampshire for the provision of medical assistance to eligible individuals. In accordance with 42 CFR 430.10, "the state plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for FFP [federal financial participation] in the state program."

The format of the NH Medicaid State Plan is similar to that of other states. The structure of the state plan is set by 42 CFR 430.12 which describes the format as "preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular state's program." The NH Medicaid State Plan is not a general-purpose document designed for public use, but it is a contract between CMS and the State Medicaid Agency. The NH Medicaid State Plan is not intended to be a document that employees use to conduct the day-to-day business of the Department in the administration of the Medicaid program. Administration of the program at that level is conducted using the guidance in policy manuals and administrative rules which are readily available to employees.

In recent years, CMS removed state plans from their website because it was incapable of keeping the various plans current given their fluidity. As such, while the plans were on-line, the information at the website was not reliable and gave rise to confusion.

LBA Rejoinder:

The State Plan is arguably the most important document controlling the State's operation of the Medicaid Program, including the Bureau's Medicaid activities. Nothing in the auditee response precludes the Department from making the State Plan more accessible to users by providing better indexing through a more informative table of contents and publishing the State Plan in an electronic format.

Observation No. 2: Nursing Facility Rate-Setting Process Should Be More Transparent

The Bureau's nursing facility rate-setting process is nearly incomprehensible to an outsider of the Bureau's Rate Setting and Audit Unit (Unit). The rate for each nursing facility providing service to Medicaid clients is calculated semi-annually and is made up of over 30 different components obtained from varied sources inside and outside the Bureau. The flowchart and summary of the acuity-based rate calculation process the Bureau uses to educate the Legislature and general public is a high-level overview of the complete process. Each component on the flowchart may have five (or more) components feeding into the rate calculation.

According to the Medicaid State Plan Title XIX Attachment 4.19-D, Section 9999.8(b)(1)(d), "rate calculation work sheets are maintained by the Bureau and are available for inspections on the premises by contacting the Division of Elderly and Adult Services." While in fact the statement is true, the complexity of the current rate setting system makes it nearly impossible for an outsider to the rate-setting process to truly understand the rate calculation. There are few people in the State who would have sufficient knowledge, experience, and access to information to detect an error in the rate setting process. Although public meetings are held prior to release of final calculations, the Bureau noted no one from the nursing facility industry or the public attended the meeting prior to the February 2007 rates being released and no written comments were received.

In addition to the complexity of the calculations, the Unit was unable to retrieve some information used in the calculations including:

1. *Inflation Factor Calculation* - the Unit said it was not able to get the exact calculation for certain columns in the Access database portion of the system. The Unit stated, "the database is very complicated."
2. *Nursing Minutes Per Day* - shown as "Minutes Per Day", obtained from a federal study of staff time spent with various Resource Utilization Group (RUG) -III category patients. The numbers used to calculate the February 2007 rates have been used since 1998, the date the last federal study was done. The Unit was unable to provide a copy of the federal minutes used in the calculation from the source at the Centers for Medicare & Medicaid Services (CMS). According to an e-mail from CMS to the Bureau, CMS has also been unable to provide the RUG-III nursing minutes because CMS has revised its RUG system and now uses a RUG-44 or the RUG-53 grouper. The Bureau continues to uses the RUG-34 grouper.

According to the Government Accountability Office's *Government Auditing Standards*, "the principles of transparency and accountability for the use of public resources are key to our nation's governing processes."

Recommendation:

The Bureau should re-evaluate the current nursing facility rate-setting process. While acuity-based rates attempt to include the acuity of each facility's patient base in calculating rates to provide a high level of equity and accuracy, the intentions of the Bureau, State, and counties may be moot if calculations are so complex that they cannot be reasonably understood and verified as accurate or challenged as inaccurate by affected parties.

In its review, the Bureau should consider moving to the RUG-44 or RUG-53 grouper currently used by CMS. Becoming current with CMS RUG grouping will allow the Bureau to include current CMS supported data in its nursing facility rate calculation process instead of data that is no longer supported by CMS.

Auditee Response:

We concur.

The nursing facility rate calculator was created and maintained off-site by a contractor from State fiscal year (SFY)1998 until SFY2003 at an annual cost to the state of $175,000. As a cost saving measure the state brought this process in-house beginning with the SFY2004 rate periods, recognizing at the time that the continued use of this system was to be only a short-term measure. The State was seeking to re-procure a new Medicaid Management Information System, with the plan that the rate calculation system would be automated as part of that system.

This re-procurement is currently being done, with the rate setting calculation process being a module in the Medicaid Management Information System being developed by Affiliated Computer Services (ACS) and is scheduled to go into effect January 1, 2009.

Expected Date of Implementation: This issue will be resolved with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009.

Observation No. 3: The Bureau Should Update Policies And Procedures For Nursing Home Rate Setting

Observation:

The policies and procedures manual supporting the Bureau's Rate Setting and Audit Unit (Unit) is outdated and incomplete.

The Unit currently uses a policies and procedures manual that was written over five years ago. While handwritten notes have been included to informally "update" the manual, some Internet links listed as reference to the rate-setting process (such as inflation factors and staff time studies) no longer work. Additionally, guidance, such as the relative weights sheet, included in the manual has not been kept current.

Because of these limitations, the policies and procedures manual is not a comprehensive resource to support the Bureau's rate-setting activity and the Bureau cannot be sure that staff can rely upon the manual to receive proper direction and information to perform the rate setting calculations. Because rate setting is only done twice a year and five auditors share the responsibility for rate setting on a rotating basis, a comprehensive and easy to use policies and procedures manual should be available as an important resource tool to ensure accurate and consistent performance of the calculations.

Recommendations:

The Bureau should immediately revise and update its policies and procedures manual for nursing home rate setting. The Bureau should institute additional policies and procedures for the regular review and update of the manual. Pencil notes in the margins of a manual do not necessarily present evidence of review and approval of changes to and refinement of procedures and cannot be relied upon to provide sufficient direction to staff performing detailed and critical calculations.

Auditee Response:

We concur.

The nursing facility rate calculator was created and maintained off-site by a contractor from State fiscal year (SFY)1998 until SFY2003 at a cost to the state of $175,000 per year. As a cost saving measure the state brought this process in-house beginning with the SFY2004 rate periods, recognizing at the time that the continued use of this system was to be only a short-term measure. The Policies and Procedures Manual originally provided by the vendor was rather sparse, and it has been updated on an ongoing basis. All new staff hired into the Rate Setting and Audit unit since SFY2004 have been cross-trained in rate-setting process and each one has made updates to the manual for better clarification.

The rate setting calculation process will be a module in the Medicaid Management Information System being developed by Affiliated Computer Services (ACS) and scheduled to go into effect January 1, 2009, with appropriate user documentation as a requirement of the vendor contract.

Expected Date of Implementation: This issue will be resolved with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009.

Observation No. 4: System Of Quality Control Review Should Be Established For Each Significant Step In The Rate Setting Process

Observation:

The Bureau's Rate Setting and Audit Unit (Unit) does not have a documented quality control process for its nursing facility rate-setting activities. While according to the Unit, it does "check the rate calculation binder to show that the Unit has randomly verified some of the facilities," the review and verification is ad hoc in nature and as such is subject to varying quality of performance.

The Unit relies heavily on computerized spreadsheets to calculate nursing home rates. There is no quality control review of the formulae in the table, nor is there effective quality control review by the Unit to ensure the resulting numbers are calculated correctly. Previously undetected errors noted by the auditors in the spreadsheets used by the Unit include:

- Special Needs Adjustment Factor.
- Preliminary Medicaid Desk Review, Variance Column Total.

While it does not appear these noted errors had any appreciable effect on nursing facility rates during fiscal year 2007, the errors are indicative of errors that can occur in rate setting and remain undetected.

Recommendation:

The Bureau should formalize the Unit's quality control process. The Bureau should design and implement a system of quality control review for each step in the rate-setting process to ensure rates have been calculated correctly prior to being implemented. The Bureau should review the source documentation it uses to calculate rates to make sure the information is up-to-date.

Auditee Response:

We concur.

The nursing facility rate calculation system was created and maintained off-site by a contractor from State fiscal year (SFY)1998 until SFY2003 at a cost to the state of $175,000 per year. As a cost saving measure the state brought this process in-house beginning with the SFY2004 rate periods, recognizing at the time that the continued use of this system was to be only a short-term measure. The vendor process had no formal quality control component. Since that time, rates have been consistently spot-checked with every rate-setting period. All new staff hired into the

Rate Setting and Audit unit since SFY2004 have been cross-trained in rate-setting process and each has participated in the quality control checks.

The rate setting calculation process will be a module in the Medicaid Management Information System (MMIS) being developed by Affiliated Computer Services (ACS) and is scheduled to be implemented on January 1, 2009, with specific quality control checks built into the system. A dedicated Business Systems Analyst will be assigned by the vendor to perform quality control for each rate setting. For the one or two rate setting calculation periods that occur prior to new MMIS implementation, additional quality control checks will be performed by the Rate Setting and Audit Unit's Business Administrators to help to ensure accuracy of each component of the rate calculation process.

Expected Date of Implementation: This issue will be resolved with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009. For the interim period, additional quality control checks will be added to the process to ensure the accuracy of rates.

Observation No. 5: Controls Over User Access To Rate Calculator Should Be Improved

Observation:

User access controls for the Bureau's nursing facility rate calculator system are not compliant with State information technology (IT) control policies. Users of the rate calculator system share a common user name and password. In addition, the common user name and password is printed in the procedures manual that supports the operation of the system. According to the Bureau's Rate Setting and Audit Unit (Unit), the user name and password have not been changed in the past five years.

The Unit uses the nursing facility rate calculator system to calculate Medicaid rates for payments to nursing facilities.

Allowing a mission-critical system to operate without effective access controls is a significant control weakness. Because of the current sharing of one user name and password, it is difficult to establish accountability for system changes, including accountability for errors or unauthorized access and system changes. Nursing facility rates could be incorrect due to manipulation of the rates. Disgruntled or exiting employees could gain access to the system and manipulate rates or cause other system problems.

Recommendation:

The Bureau should establish user access controls for its nursing facility rate calculator system that are compliant with State IT policies. Unique user names and passwords should be required for all authorized users of the system.

The Bureau should ensure that password security is maintained. Passwords should be compliant with criteria established in State IT policies and users should be directed to properly secure their

passwords. Users should be required to regularly change their passwords to lessen the risk that their passwords become known by others.

Auditee Response:

We concur.

The nursing facility rate calculator was created and maintained off-site by a contractor from State fiscal year (SFY)1998 until SFY2003. As a cost saving measure the state brought this process in-house beginning with the SFY2004 rate periods. The software provided by the vendor does not include a method of changing the passwords. This was not seen as a problem because the system is housed on State-owned and password-protected computers. Furthermore, this system is very technical in nature and it is highly improbable that anybody outside of the Nursing Home Rate Setting and Audit Unit would be able to access and use this software (Audit Observation No. 2 supports this statement).

The rate setting calculation process is being automated as a module in the new Medicaid Management Information System scheduled to go into effect January 1, 2009 and will be in compliance with all State IT policy controls. The Department has not done business with the contractor who designed the system since SFY2004 and it would not be financially feasible to initiate a new contract with them in order to make a software modification for a system that will only be used one or two more times and will become obsolete in less than a year.

Expected Date of Implementation: This issue will be resolved with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009.

Observation No. 6: Controls Should Be Established For Making And Reporting Nursing Facility Rate Changes

Observation:

The Bureau does not have a formal quality assurance process for reviewing the entry of Medicaid rate changes for accuracy, prior to the implementation of the changes.

1. Medicaid rates for nursing facilities are subject to change in February and August of each year. Bureau controls over nursing-facility rate changes are weak.

    - Changes to nursing facility Medicaid rates can be made in the Department's Medicaid Management Information System (MMIS) at any time by either of two Bureau employees. There is no audit trail/system notification to advise management of changes having been made and the system identifier for the person making a nursing-facility rate change in the system is easily spoofed.
    - The operator that inputs Medicaid nursing facility rates is not provided any documentation to evidence that the rates to be entered into the MMIS are the approved rates.
    - There is no formal quality assurance process to review entered rate changes for accuracy, prior to the implementation of the changes.

According to the Bureau, it is reliant upon nursing facility operators to notice and report rate errors. While no errors were noted in rates posted to the MMIS during audit testing, errors in this system would affect amounts paid to the nursing facilities.

2. Other Medicaid rates are adjusted through a Control Memo process. Rate changes are developed and approved at the Bureau and Department level and then submitted to the State's Medicaid fiscal agent for entry into the MMIS. None of these Control Memos originating in the Bureau are signed to evidence appropriate approval having been given to make the rate change. There is the potential for errors to occur as a result of rate changes being based on unauthorized Control Memos. Compounding this weakness is the lack of a review and approval process to ensure that all rate changes made in the MMIS were accurate and supported by approved Control Memos.

3. The lack of effective corrective action to a recognized error in the posting of a Medicaid nursing facility rate indicates a weakness in the Bureau's Rate Setting and Audit Unit's operations over the publishing of nursing facility Medicaid rates.

   - A series of errors occurred in publishing Medicaid nursing facilities rates in the Bureau's regular update to *Appendix A, Nursing Facility Rates* of the Medical Assistance Manual, which is also published on the Bureau's website. The fact that a series of errors occurred with incomplete/incorrect corrective action indicates a lack of controls over the rate-posting process.

     At the time of a rate increase, effective for August 2005, the published Medicaid rate for atypical residents at one county nursing facility was accurately changed but the effective date for the rate change was not updated. At the time of the next rate review six months later, the Bureau employee updating the rates noted the inconsistency between the rate and the effective date and changed the rate back to match the effective date, instead of correcting the erroneous effective date. This subsequent error resulted in the incorrect Medicaid rate being published. At the time of the next rate review, one year after the initial error was made, the incorrect rate was noticed and both the rate and the effective date were corrected.

     There was no documentation made available to indicate the Bureau had any review and approval procedures over the original posting of the incorrect information or the attempts to correct the errors in the posted information. There was no documentation provided to establish who was notified of the errors and what efforts were made to: 1) determine the extent of the errors, 2) correct the errors and, 3) limit future similar errors. There was no documentation provided to enable determination of whether the errors were brought to a supervisor's attention in the Bureau. The Bureau reported that the error affected only the published nursing facility rate and did not affect the actual amounts paid to the nursing facility.

   According to the Bureau's Rate Setting and Audit Unit, there is no formal review of the Medicaid rates entered into the spreadsheets used to publish the rates.

Recommendation:

Controls should be established for the activities of the Bureau's Rate Setting and Audit Unit. All components of controls should be incorporated into daily activities. Policies and procedures should be established and implemented to promote accurate posting of Medicaid rates for nursing facilities in the MMIS, in Appendix A of the Medical Assistance Manual, and on the Bureau's website.

- Change controls over nursing-facility rate changes should be improved. Documents used to support entry of nursing-facility rate changes in the MMIS should have evidence of appropriate approvals and authorization for the rate changes. A formal review and approval process for the rate entered into the MMIS should be instituted to ensure that entered rates are accurate.
- Access control to the rate change function should be improved to ensure that only approved changes are made, management is made aware of all occasions of rate changes, and that individuals making changes are properly identified.
- The Bureau should establish controls to reasonably ensure that errors are detected and corrected in a reasonable time and manner. All significant aspects of Bureau operations should be subject to formal controls including policies and procedures to reasonably reduce the likelihood of errors and to promote the timely detection and correction of errors that do occur.
- All rate changes made in the MMIS, whether input directly by the Bureau or by the fiscal agent, should be reviewed for accuracy and proper documented authorization prior to implementation of the rate change.

Auditee Response:

We concur.

A 'Nursing Facility Rate Change Approval Tracking Form' has been developed to address the recommendations and has been implemented beginning with the February 1, 2008 rate changes. The State is also in the process of reprocurement of a new Medicaid Management Information System that has the rate setting calculation as a module in this system. The Medicaid Management Information System (vendor Affiliated Computer Services) is scheduled to go into effect January 1, 2009, at which times rates will automatically be entered as part of the rate setting process.

Expected Date of Implementation: Completed. A rate change tracking form establishing the recommended controls has been implemented beginning with the February 1, 2008 rate changes.

Observation No. 7: Definition Of Nursing Facility Should Be More Specific

Observation:

There is no specific guidance in the State Plan or in State statute to clarify which patient bed days are to be included in the definition of "nursing facility" services to be included in the calculation of nursing facility Medicaid rates.

According to RSA 151-E:2,V, the definition of a nursing facility is, "an institution or facility, or a distinct part of an institution or facility, whether proprietary or non-proprietary, which is primarily engaged in providing 24-hour care for residents needing:

(a) Skilled nursing care, medical monitoring, and related services;
(b) Rehabilitation services for the rehabilitation of injured chronically disabled or sick;
(c) Medication administration or instruction and supervision; or
(d) On a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities which provide 24-hour care."

Some nursing facilities report acute (hospital-level care) and "other" patient care bed days on their cost report, as well as bed days for regular nursing facilities patient care. The Bureau's Rate Setting and Audit Unit does not include non-regular nursing level care bed days in its Medicaid reimbursement rate calculations for the nursing facilities. According to RSA 151-E:2,V, the definition of "nursing facility" includes "health-related care and services (above the level of room and board) which can be made available to [residents] only through institutional facilities which provide 24-hour care." Because of the breadth of this definition, it is not clear that acute care (hospital) or "other" beds days provided should be excluded from the calculations.

Without clear definitions, it is possible that nursing facility Medicaid rate calculations may be based on incomplete or otherwise inaccurate information.

Recommendations:

The Bureau should seek to clarify the definition of "nursing facility" in RSA 151-E:2,V, and nursing facility services in the nursing facility cost reports used for rate setting purposes. Clearly communicated definitions are essential to ensuring that calculations are performed using complete, consistent, and accurate information.

Auditee Response:

We do not concur.

The process and methodology utilized by BEAS in determining reimbursement rates is set forth in He-E 806, the rules governing Nursing Facility Reimbursement. Within He-E 806 BEAS further defines Nursing Facility by incorporating the federal definition. Specifically, He-E 806.01(z) provides, in part, "Nursing Facility (NF) means an institution or a distinct part of an institution, including ICF-MRs that provide one or more of the following as defined in Section 1919(a) of the Social Security Act". Sec. 1919 of the Social Security Act sets forth the federal Requirements For Nursing Facilities. Sec. 1919 [42 U.S.C. 1396r] (a) defines Nursing Facility. BEAS, in adopting the federal definition of Nursing Facility by incorporating Sec. 1919(a) directly into it's Nursing Facility Reimbursement Rules, insures compliance with federal regulations while maintaining consistent application and treatment of all provider reimbursement.

LBA Addendum: The auditors have discussed with the Bureau the apparent inconsistent application of the definition with respect to information provided on cost reports, licensing of

certain facilities, and the failure of certain facilities to report revenues from nursing facility operations as subject to the Nursing Facilities Quality Assessment (tax). It appears to us the inconsistent application of the definition was perhaps due in part to unclear interpretation of the statute.

Observation No. 8: Nursing Facility Cost Report Should Be Signed By The Preparer

Observation:

The Bureau does not require preparers of nursing facility cost reports to sign the certification section of the cost report prior to using the cost report information in the nursing home rate setting process.

In the detail testing of nursing home rate setting, we found eight facilities out of 16 tested (50%) did not include a preparer's signature in the submission of the cost report. We found no evidence that the Bureau questioned the facility as to why a preparer's signature was not included with the report.

According to the Medicaid State Plan Attachment 4.19-D, Section 9999.3(c), the cost report and all accompanying documents shall bear "original signatures of the NF [nursing facility] administrator or owner, **and** preparer", [emphasis added].

The certification in the cost report above the signature line reads, "whoever knowingly and willfully makes or causes to be made any false statement or representation of a material fact as part of the submission of this report is guilty of criminal conduct under federal and state law and, upon conviction, shall be fined and/or imprisoned."

According to the Bureau, this section of the report does not need to be completed if the cost report is prepared in house. We found no provision in the State Plan (or elsewhere) that allowed this exemption and when asked, the Bureau did not provide documentation to support their position that the certification need not be signed.

Recommendation:

The Bureau should require nursing facilities to provide signed copies of cost reports prior to the Bureau accepting the reports as complete. Nursing facilities that provide unsigned reports should be subject to the same sanctions as nursing facilities that file otherwise incomplete reports.

Auditee Response:

We concur in part.

We concur that the certification page should be checked to confirm that a paid preparer's signature is included if one was used in the completion of the cost report. It should however be noted that nursing facilities are not required to hire paid preparers for this task and this may have been the situation with some or all of the 50% sample where the LBA auditors found no paid preparer's signature.

Expected Date of Implementation: The Department will be making changes to the Medicaid State Plan and Administrative Rules during the quarter ending June 30, 2008 to accommodate changes needed for the ACS automation [new Medicaid Management Information System]. Concurrent with these changes the word "preparer" will be changed to "paid preparer" to eliminate any future ambiguity.

Observation No. 9: Policies And Procedures Should Be Established For The Audits Of Nursing Facilities

Observation:

During fiscal year 2007, the Bureau had not established documented policies and procedures implementing the audit requirements outlined in the State Plan and administrative rules, including the methodology for determining when audits are performed, the objectives and procedures that should be considered for the audit, and the communication of the audit results.

Field audits are a critical control to ensure that costs included in the cost reports and included in the Medicaid daily rates paid to nursing facilities are for allowable costs and activities, reasonable and adequate, and incurred by efficiently and economically operated providers.

According to the Bureau's Rate Setting and Audit Unit (Unit), the Unit relies upon the State Plan, administrative rules, field-audit audit program, and auditor experience for policies and procedures for conducting field audit activities. While the field auditors indicated that the Unit has a book with information on allowable costs, they did not appear familiar with the book. The Unit agreed there are no specific policies and procedures for examining reported costs for Medicaid program allowability.

According to federal Medicaid rules (42 CFR section 447.253) the State Medicaid agency must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements to be established by the State Plan.

According to the State Plan, Policy 9999.3 provides three conditions triggering a field audit: 1) new/major capital improvements, 2) items on cost report that need further clarification/investigation, 3) field audit not conducted for more than 3 years from submitted report. Neither the State Plan, administrative rules, nor field audit programs provide policies and procedures for the conduct of the field audit, including how reports are to be selected and audits conducted, reviewed, approved, and reported.

The Bureau also has not established policies and procedures for its performance of desk reviews/audits. While one of the auditors has reportedly developed guidelines for doing desk reviews, the guidelines have not been formally reviewed, vetted, and accepted as Bureau policies and procedures for the performance of desk reviews/audits.

All significant control activities should be supported by detailed policies and procedures, which are documented, vetted by management, and provide guidance and direction to employees performing the control activities to ensure the controls are performed in a manner consistent with management's intentions for the control activities.

Recommendation:

The Bureau should establish policies and procedures for all significant control activities of the Bureau of Elderly and Adult Services, including the conduct of its Rate Setting and Audit Unit.

Policies and procedures should be established for the:

- Performance and reporting of desk review of cost reports,
- Selection of cost reports for field audits,
- Performance of field audits, including guidance on allowable costs, and
- Reporting of the results of field audits.

The policies and procedures should incorporate the auditor's consideration of the control environment and other components of internal control at the nursing facilities and the assessment of and response to risks of inadequate and incorrect cost reporting by the nursing facilities.

Auditee Response:

We concur in part.

We do not concur with the observation regarding policies and procedures for desk and field audits. Policies and procedures for conducting desk and field audits have always been in place and every auditor hired within the last two decades has been thoroughly and consistently trained by the Field Audit Supervisor who has been with the Rate Setting and Audit Unit for over twenty years as well as a senior auditor who has been with the Unit for over thirty years. Every cost report is reviewed by Unit management to ensure that audits are conducted in a consistent manner.

Regarding written manuals, significant changes to the Medicaid State Plan Nursing Facility reimbursement pages were approved by the Centers for Medicare & Medicaid Services (CMS) on November 7, 2006 with the corresponding modifications to the related Administrative Rules approved by the Joint Legislative Committee on Administrative Rules on May 23, 2007. This necessitated a comprehensive rewrite of the written policies and procedures for both desk and field audits to ensure consistency with both the State Plan and Administrative Rule changes. At the time of the LBA auditor interviews in June to August 2007 these working drafts were under revision and completed copies had yet to be reviewed by management for distribution outside of the Unit. These documents are now complete and can be made available to the LBA auditors for review.

Expected Date of Implementation: Actions pursuant to the recommendations to which DHHS concurs have been completed. Revised policy and procedure manuals are in use regarding desk and field audits.

Observation No. 10: Field Audits Of Nursing Facilities Should Be Performed In Accordance With The State Plan And Administrative Rules

Observation:

As of June 30, 2007, the Bureau was not in compliance with the Medicaid Long Term Care Facility audit requirement in the November 2006 State Plan amendment and N.H. Admin Rules, as 31 (40%) of the 77 nursing facilities subject to the field audit requirement had not been field audited by the Bureau within the prior three years. Two facilities had not been subject to a field audit within the prior five years and the Bureau had no record of having performed an audit at an additional four nursing facilities.

According to the Medicaid State Plan Title XIX Attachment 4.19-D, section 9999.3(s), "a field audit shall be conducted as part of the review of the annual cost report in accordance with MAM 9999.6 [of the State Plan] if the NF [nursing facility] meets one or more of the following conditions:

1. The NF has been newly constructed or has had major capital improvements in the past year;
2. There are items on the annual cost report which need further clarification or investigation as determined by the department; or
3. A field audit has not been conducted on the NF for more than 3 years from the submitted report."

N.H. Admin. Rule He-E 806.02(s) mirrors the three conditions in the State Plan prompting an audit. The administrative rule was effective 1/24/2006.

According to the Medicaid State Plan Title XIX Attachment 4.19-D, section 9999.6(a) and (b), the Bureau shall "conduct on-site audits of the financial and statistical records of participating NF's [nursing facilities]"… "to ascertain whether the cost report submitted by the NF provider meets the requirements as outlined in MAM 9999 [of the State Plan]."

Nursing home rates could be inaccurate if based on incomplete or incorrect data provided by the nursing facilities in the cost reports. Nursing facilities could be paid rates that include costs for activities that are not allowed or otherwise violate allowable cost principles and for costs related to ineligible patients. Facilities could be including inaccurate or inappropriate cost information on cost reports that may not be detected by the Bureau's Rate Setting and Audit Unit on a desk review, but would be picked up on a field audit. Facilities could be reporting inaccurate census data that could also affect rate setting.

Recommendation:

The Bureau should perform field audits in accordance with the State Plan and Administrative Rules.

Auditee Response:

We concur in part.

The audit comment cites the State Plan reference that the field audits should be conducted if "a field audit has not been conducted on the nursing facility for more than 3 years". The Department interprets the phrase "more than 3 years" to mean 4 years. During SFY2004 the Rate Setting and Audit Unit conducted 25 field audits, which were not considered in the audit comment. Inclusion of these audits would mean that field audits in 71 of the 77 nursing facilities were conducted on a timely basis.

The Bureau concurs that field audits for six (6) nursing homes were not conducted within the specified time frame. These audits had been scheduled for June 2007, however a management decision was made to postpone these audits until the following quarter due to two unanticipated projects requiring considerable staff resources from June 2007 to August 2007. These projects were (1) General System Design sessions with the new Medicaid Management Information System vendor Affiliated Computer Services; and (2) an audit of the Rate Setting and Audit Unit by Legislative Budget Assistant Office. These remaining six (6) field audits were conducted in 2007.

The Department has allocated additional personnel from the Bureau of Improvement & Integrity to assist the Unit in completing field audits in a more timely manner.

Expected Date of Implementation: Actions pursuant to the recommendations to which DHHS concurs have been completed. The remaining six (6) field audits were completed in 2007.

Observation No. 11: Evidence Of Medical Eligibility Determination Should Be Retained

Observation:

The Bureau's process for documenting a client's medical eligibility for Medicaid services needs improvement.

The Bureau's current practice of updating a nursing facility patient's medical eligibility determination (MED) only upon a change in patient classification resulted in instances where the Bureau did not retain an MED to support the medical eligibility determination of certain nursing facility patients.

The Bureau does not require a regular and formal review and updating of the MED for all Medicaid nursing facility patients. Because the Bureau does not require an annual MED or other regular update to the medical eligibility files for nursing facility patients considered to be long-term patients, years may go by without file updates. In some instances noted during the audit, the medical eligibility files for certain patients currently in nursing facilities had been destroyed in accordance with the Bureau's seven-year file retention/destruction policy resulting in situations where the Bureau did not retain evidence of having performed an MED for certain current patients.

According to the Bureau, an annual MED has not been required for typical patients who have been determined eligible for nursing facility care on a long-term basis due to the presumed irreversibility of their chronic ailments. A new MED is prepared for an ongoing care patient only if the nursing facility requests the patient be reclassified as needing a different level of care such

as a higher, atypical level care. The Bureau reported it was unaware that its current practices of not preparing regular MEDs resulted in instances where the Bureau retained no medical eligibility files for certain long-term patients.

Additionally, the MED for three out of a sample of 63 (5%) nursing facility patients tested was not signed to evidence the MED had been completed by a registered nurse (RN).

RSA 151-E:3 provides that, "A person is medicaid eligible for nursing facility services if the person is: (a) Clinically eligible for nursing facility care because the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses employed by state or county government using an assessment tool…."

It appears that the lack of a signature could be due to the relatively inconspicuous placement of the form's signature block.

Recommendation:

The Bureau should retain a current medical eligibility file, including a current, compliant MED, for each Medicaid patient receiving services in a nursing facility.

The Bureau should establish policies and procedures to ensure that a current MED is retained to support the Medicaid services provided. Included in those policies and procedures should be criteria to define what constitutes a current MED.

The Bureau should consider relocating the signature block on the MED to better highlight the requirement for an authorizing signature. MED's that do not include the signature of an RN should not be considered sufficiently complete to support a medical eligibility determination.

Auditee Response:

We concur.

As cited in the criteria section above, an annual MED is not required for typical patients who have been determined eligible for nursing facility care on a long-term basis due to the presumed irreversibility of their chronic ailments. A new MED is prepared for an ongoing care patient only if the nursing facility requests the patient be reclassified as needing a different level of care such as a higher, atypical level care.

We concur with the "Recommendations", as follows:

The Long Term Care Unit, under the direction of the Long Term Care Administrator, will keep and maintain the files of people currently receiving Medicaid covered long term care services in a nursing facility. This file will contain the complete initial or most recent medical eligibility determination (MED) documentation.

The Bureau will establish record archiving policies and procedures to ensure that the eligibility determination documentation is retained to support current Medicaid clients receiving services.

Criteria constituting medical eligibility as defined by RSA 151- E:3 will be included in said policies.

The Bureau will highlight the requirement for an authorizing signature on the MED algorithm tool, which serves as the completion of the eligibility assessment process. Additionally, the RN and the applicant will sign the support plan recommendations, which supports the client-centered process.

Expected Date of Implementation: June 1, 2008

Observation No. 12: Compliance With Financial Eligibility Controls Should Be Improved

Observation:

The Bureau relies upon the Division of Family Assistance (DFA) for the determination of a client's financial eligibility for Medicaid services administrated by the Bureau. The DFA accumulates and reviews information on client income and assets, insurance coverage, expenses, etc., to determine whether an individual meets the financial criteria of the Bureau's programs. The DFA prepares an initial financial determination at the inception of service to a client and an annual redetermination to ensure that client remains financially eligible.

Audit testing included a review of financial data files supporting a sample of clients participating in the Bureau's programs. That review of 105 case files noted the following issues.

1. The client or authorized representative did not sign the redetermination form for eight (8%) clients tested.
2. One client (1%) was allowed to sign the redetermination form even though the court had appointed a guardian.
3. The financial file for one client (1%) contained evidence of financial resources at the determination date exceeding the eligibility limit. There was no documentation, explanation, or follow up on a $3,000 check drawn on the account which resulted in lowering the account to below program limits.
4. The electronic record for one client (1%) contained evidence of a medical insurance policy, however the paper file did not contain a copy of the policy. We are unable to determine whether this third party (insurance carrier) would have had a liability for the selected claim.

While the Bureau relies upon the DFA for financial eligibility determinations, the Bureau is ultimately responsible for compliance with its program rules.

Recommendation:

The Bureau should review with the DFA the need for compliance with the Bureau's program rules. The Bureau should request that the DFA review the noted issues to determine whether they resulted from a lack of effective policies and procedures or employee compliance. Based on the results of that review, appropriate policies and procedures and employee training should be implemented.

Auditee Response:

We concur.

The LBA auditors made note of four findings. The Division takes these findings seriously. None of these findings have been judged to be systemic in nature, since policies, procedures and data systems are in place that adhere to and promote proper program eligibility operations. Instead, the findings do involve the interface of workers with those policies and data systems.

The Bureau of Elderly and Adult Services, in cooperation with the Division of Family Assistance, will and/or has incorporated the following corrective actions and dates of implementation:

Division of Family Assistance field operations administrators have met or will meet with eligibility Supervisors to effectuate training of all twelve district offices relative to all findings according to the following schedule:

February 20, 2008	Conway, Littleton, Berlin and Laconia District Offices
February 22, 2008	Concord, Manchester, Nashua, Rochester District Offices
February 28, 2008	Portsmouth, Salem, Claremont, Keene District Offices

Furthermore, because Nursing Home/Home and Community Based Care staff are specialists, a separate training has been scheduled for March 12, 2008.

The Division of Family Assistance would like to thank the auditors for drawing attention to our opportunities for improvement, especially since they are presented within the framework of a high success rate of eligibility determinations. Of the voluminous federal laws and regulations, and state laws, rules and policies where eligibility errors might occur, each of three of the findings involved just one case out of a total of 105, for a success rate of 99.05%. The one serious finding involved an accuracy rate of 92.38%.

Expected Date of Implementation: Division of Family Assistance field operations administrators have met or will meet with eligibility Supervisors to effectuate training of all twelve district offices relative to all findings according to the following schedule:

February 20, 2008	Conway, Littleton, Berlin and Laconia District Offices
February 22, 2008	Concord, Manchester, Nashua, Rochester District Offices
February 28, 2008	Portsmouth, Salem, Claremont, Keene District Offices
March 12, 2008	Nursing Home/Home and Community Based Care Staff Specialists

Observation No. 13: Provider Disclosures Should Be Requested And Considered

Observation:

The Department cannot ensure that certain enrolled Medicaid providers are, and remain, eligible for participation in the Medicaid Program (Program).

Federal Program rules preclude payments with federal financial participation from being made to providers who have been suspended or excluded from Program participation.

Federal administrative laws, 42 CFR 455.104 through 42 CFR 455.106 established requirements for provider disclosure of ownership and control information to ensure that state Medicaid agencies are aware of provider identity for consideration of continued eligibility.

While the Department's State Plan is in accordance with Program disclosure requirements, Department practices do not include activities to ensure that State Plan provisions required by 42 CFR 455.104 through 42 CFR 455.106 are met.

The Department uses the provider enrollment process to collect required disclosure information for providers not subject to the Department's survey process. Because the Department does not require enrolled Medicaid providers to re-enroll after their initial application, the enrollment of some providers occurred years ago, prior to the disclosure requirement. As a result, the enrollment applications for some providers do not include the ownership and control disclosures. For example, one provider selected as a sample test item had an enrollment application that was completed in 1985.

Further audit testing revealed that the required disclosures were absent for eight out of 65 (12%) providers tested. The State paid these eight providers $22.2 million during fiscal year 2007 of which $11.1 million was reimbursed by the Federal government. We are questioning the $11.1 million in federal participation.

While the Department's current provider enrollment application requires disclosure of information pertaining to ownership or control interests, adverse legal actions against the provider, and disclosure of ownership of subcontractors with whom the provider had done business, the Department has not taken any steps to obtain the required disclosures from the providers that continue to operate without having made the required disclosures.

According to the Department, all providers will need to re-enroll and required disclosures will be obtained when the new Medicaid Management Information System is implemented, scheduled for January 2009.

Questioned Costs: $11.1 million.

Recommendation:

The Department should implement practices that promote the timely receipt and consideration of provider ownership, control, and other information necessary to ensure enrolled providers remain eligible for continued Program participation.

The Department should use the disclosure information in its fraud detection and investigation program as intended by 42 CFR Part 455.

Auditee Response:

We concur.

Providers do not get enrolled unless they provide the required documentation and the Department does monitor licensure information and works with Health Facilities Licensing and the professional licensing boards to obtain the updated information. Letters and reminders are sent to providers that the licensure information is required. As part of the National Provider Identifier (NPI) process, we are currently contacting all providers that have not provided their NPI and at the same time verifying Tax ID information. No medical provider will be mapped to the old provider number without a NPI.

There is currently no mechanism, however, to terminate providers or stop payment to a provider who does not provide the requested updated license. This will be included in the development of the new MMIS system scheduled for implementation January 1, 2009.

As part of the Medicaid Management Information System (MMIS) Implementation project, a provider re-enrollment process will be implemented through which all Medicaid providers will need to submit a current NH Medicaid provider application and all required supporting documentation.

As part of the enrollment validation process, the provider will be checked against the Medicare Exclusion database as one validity check.

Following re-enrollment, the system will monitor each licensed provider's license expiration date and will generate letters to the provider to remind the provider of the upcoming license expiration date and to encourage a renewal of the license. If a license date expires and the provider has not renewed the license, claims for dates of service after the expiration date will be set to suspend for a period of time, to allow Department staff to outreach to that provider to review the license status.

The fiscal agent will conduct Direct Source validation with the licensing entities to validate that the provider's license has been extended.

The Surveillance and Utilization Review System (SURS) unit will continue to monitor Centers for Medicare & Medicaid Services (CMS) correspondence regarding any action taken against NH Medicaid providers based on Medicare exclusion activity and will continue to advise the fiscal agent on steps that need to be taken on the provider's enrollment record.

Expected Date of Implementation: This issue will be resolved with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009.

Observation No. 14: The Bureau Must Participate In Controls Over NFQA Revenue

Observation:

Information available to the Bureau indicates that some nursing facilities may not be paying the Nursing Facility Quality Assessment (NFQA) in accordance with statute, either by not filing or not accurately reporting net patient services revenue. The Bureau has taken only limited action to encourage complete and accurate tax filing by nursing facility operators.

While the Department of Revenue Administration (DRA) is primarily responsible as the State's tax collector to ensure the accurate and full collection of certain State taxes, including the NFQA, the Department of Health and Human Services and the Bureau, as the regulator of nursing facilities, shares that responsibility with DRA. The proof of that shared responsibility is shown in the revenue being budgeted in the Bureau's accounts, the Bureau receiving copies of the tax filings, and the Bureau being most knowledgeable of the existence and operating levels of all nursing facilities in the State subject to the assessment. During fiscal year 2007, the Bureau had no current policies and procedures or administrative rules to support the Bureau's involvement in the NFQA reporting process and asserted that it was not involved with the assessment process.

The Bureau has relied completely upon the DRA for the collection of the NFQA. Even though information accumulated by and available to the Bureau indicates that certain nursing facilities may not be paying the assessment in accordance with statutory requirements, there has been limited communication with the DRA regarding entities providing nursing facility services, including the extent of operations of these nursing facilities (number of beds, etc.) and other information that could assist the DRA in determining the population of expected taxpayers and the collection of the assessment.

For example, the Bureau has not utilized available information to review provided copies of nursing facility tax returns and has not questioned why certain nursing facilities appear to be failing to report all net patient services revenue. The Bureau has not used this and other information to review whether net patient services revenue may be under reported with the result that:

1. Assessments may be under collected resulting in underpayment of Medicaid Quality Incentive Payments (MQIP), and
2. Assessment/tax may not be applied and collected in a uniform and broad-based manner, which could jeopardize the Medicaid-approved status of the tax.

By choosing not to become involved in the NFQA process, the Bureau is placing the controlled operations of the MQIP program at risk by placing near complete reliance upon the DRA for the collection of a Medicaid qualified tax.

Recommendation:

The Bureau should accept some degree of responsibility for controls over NFQA revenue to ensure that the MQIP program is not placed in jeopardy due to the assessment being judged unqualified due to lax collection efforts.

- The Bureau should review NFQA for reasonableness and consistency with known data. The Bureau should require nursing facilities to provide NFQA information in the annual nursing facility cost reports and include a review of the NFQA paid by nursing facilities in field and desk audits of those facilities' cost reports.
- The Bureau should improve communications with the DRA. The Bureau should provide the DRA with data to assist the DRA in determining entities subject to the NFQA and the relative size and activity of those entities. The Bureau should review the definitions of relevant terms with the DRA to ensure that nursing facilities are provided with

comprehensive and consistent information on the determination of revenues subject to the assessment.

- The Bureau should improve communications with the nursing facility community. Appropriate rules and policies and procedures should be established that encourage accurate reporting of net patient services revenue and payment of assessments.

Auditee Response:

We concur in part.

The Department of Revenue Administration by state statute is solely responsible for implementing, directing, and enforcing tax policy in the State of New Hampshire. Taxpayer information is protected by statute and not available to the Department of Health and Human Services. The Department of Health and Human Services does agree that communications should be improved between the state agencies, specifically in regularly providing a list of licensed and certified nursing facilities at least semi-annually to the Department of Revenue Administration. In addition, the Department will provide information to the Department of Revenue Administration on any federal changes that may affect health care-related provider taxes as disseminated or promulgated by the federal Centers for Medicare and Medicaid Services. To this end, the Department recently forwarded the new federal regulations on health care-related provider taxes to the Department of Revenue Administration that was published in the Federal Register on February 22, 2008 (Vol. 73, No. 36, pp. 9685-9699).

Expected Date of Implementation: As noted in the prior paragraph, DHHS will provide a list of licensed and certified nursing facilities at least semi-annually to the Department of Revenue Administration. In addition, the Department will provide information to the Department of Revenue Administration on any federal changes that may affect health care-related provider taxes as disseminated or promulgated by the federal Centers for Medicare and Medicaid Services.

Department of Revenue Administration Response:

The Department of Revenue Administration generally agrees with the LBA's audit comments. State agencies should work together to advance the effectiveness and efficiency of government. The receipt of information from the Bureau of Elderly and Adult Services would be welcomed. To the extent that this can be done without violating the confidentiality rights of taxpayers, the recommendations have the Department's support.

However, independence of the taxing authority is paramount. While working in concert with the Bureau may enhance efficiencies in determining who and what is taxable, the Department disagrees with the characterization of a shared responsibility in the collection of the tax. Tax administration requires an independent analysis of all relevant facts and must be separated from other administrative functions.

Observation No. 15: Medicaid Payments Should Not Exceed Upper Payment Limit

Observation:

The Bureau is paying some atypical care accounts at a rate in excess of the Medicare upper payment limit (UPL), in apparent noncompliance with the State Plan and Medicaid rules.

State Medicaid payments are generally limited to the maximum amount that would be paid for similar care under the Medicare program. The Medicare rates are based on a resource utilization grouping (RUG) and are commonly referred to as an UPL for patient care in the Medicaid Program.

The Bureau has established an atypical patient daily rate for each nursing facility that has been designated as a provider of care for atypical patients, as defined by the State Plan. The State Medicaid program pays the facility the atypical rate for each atypical patient day of care, without consideration of whether the atypical rate is in excess of the Medicare UPL rate for the individual patient. As a result, nursing facilities are regularly paid a daily rate in excess of the UPL for a patient occupying an atypical patient bed when the patient's RUG-based rate is less than the nursing facility's atypical rate. This payment in excess of the UPL is not noticed or reviewed by the Bureau.

Per the Bureau, a comparison of the Medicaid atypical rate to the Medicare UPL is performed annually for patients in county nursing facilities. The Proshare payment made by the Bureau to county nursing facilities providing care to atypical patients is reduced to adjust for Medicaid payments made in excess of the UPL for these patients. No similar comparison/adjustments occur for patients in non-county nursing facilities providing care to atypical patients.

While the Bureau indicated it considers it has the authority to pay for atypical patient care at a rate in excess of the UPL, the Bureau provided no documentation to support its contention that the Centers for Medicare & Medicaid Services (CMS) approved the violation of the primary Medicaid tenet that Medicaid payments cannot exceed the Medicare UPL.

Questioned Costs: Indeterminable

Recommendation:

The Bureau in consultation with the CMS should review the State Plan and the Medicaid rules to determine whether there is support for the Department's payments to providers of care to atypical patients in excess of the UPL.

The Bureau should ensure controls are in place to prevent payments in excess of the UPL. The Bureau should regularly monitor for payments in excess of the UPL to review for apparent billing errors, including misclassification of patients and patient services.

If the Bureau in consultation with CMS determines that the State Plan and the Medicaid rules allow the payments in excess of the UPL, that determination should be documented for future support of the decision.

Auditee Response:

We concur in part.

We concur that a consultation was needed with CMS regarding this issue. DHHS met with CMS auditors on November 20, 2007 in conjunction with an ongoing audit, at which time CMS confirmed that the upper payment limit calculation applies in the aggregate for all facilities over a fiscal year period. We have completed those calculations for 2007, 2006, and 2005 and find that the nursing facility payments do not exceed, in the aggregate, the upper payment limits. Follow-up questions by CMS on December 4, 2007 and January 30, 2008 have referenced specific aspects of the UPL analyses but have not questioned the methodology.

We do not concur with auditor's comments regarding atypical care rates. CMS is aware of the Department's atypical care rate structure. Those rates were established to provide a cost-effective method to keep residents with greater needs in a nursing home level rather than a hospital placement at far greater cost to the Medicaid program.

Expected Date of Implementation: Actions pursuant to the recommendations to which DHHS concurs have been completed.

Observation No. 16: Support For Proshare Calculations Should Be Better Understood And Documented

Observation:

Bureau employees are not sufficiently knowledgeable about all significant transactions for which the Bureau is responsible. The Bureau is dependent upon a key Department employee for performing elements of what should be a relatively routine transaction.

The Bureau has placed its controlled operations at risk by allowing itself to become dependent upon a key employee for the performance of regular Bureau activities. This weakness in the control environment combined with a lack of relevant policies and procedures has contributed to the condition where the Bureau has become dependent upon the continued performance of certain key personnel for the calculation of the Medicaid Proshare payments made to the county nursing facilities.

Procedures have been allowed to follow prior practice without regard of whether prior practice was, or continues to be, correct. Significant aspects of Bureau operations would be negatively affected if this key employee was no longer available to perform these regular functions.

On two occasions, the Bureau indicated that it could not provide information related to the calculation of Proshare payments and required consultation with/information from a key Department employee. The information requested related to the mechanics of determining the allocation of payment amounts and should have been a routine and understood process for the Bureau responsible for the Proshare payments.

1. In one of the noted instances it appears the incorrect base period was used to determine the number of patient days used to allocate the Proshare amounts to the county nursing facilities during fiscal year 2007. Per the State Plan Attachment 4.19D f. Proportionate Share Adjustment paragraph 3., "The payment to each facility is in proportion to the facility's Medicaid days, **during the cost reporting period used to set its current rates** [emphasis added], relative to the sum of Medicaid days for all eligible facilities." For the fiscal year 2007 Proshare payment, the days used to distribute the payment were the actual Medicaid patient days during first 10 months of fiscal year 2007 annualized to a 12-month period. The cost reporting period used to set the 2007 rates was the 2005 cost reporting year. It appears that the 2005 Medicaid patient days should have been used to distribute the 2007 payment and not the 2007 patient days. The Department was requested to estimate the effect of using the incorrect patient days in the calculation of the fiscal year 2007 Proshare payments but, as of April 10, 2008, had not done so.
2. In the second instance, the number of atypical patient days was excluded from the Proshare distribution calculation without explanation. All other things being equal, had the atypical days been included in the distribution calculation, three county homes each would have received $81,458 (5%), $95,684 (14%) and $105,417 (9%) more in Proshare distributions. The remaining county facilities would have received between $19,303 and $65,116 less in fiscal year 2007 Proshare.

The key Department employee indicated that while the calculation has always been done that way it is not clear why certain data was used/excluded from the calculation.

Recommendation:

The Bureau should not remain in a condition where it is dependent upon the personal performance of key employees for the completion of significant but regular Bureau activity. Sufficient employee understanding reinforced by appropriate training, policies, and procedures should support all significant Bureau processes and provide for an improved control environment.

- The Bureau should further review the fiscal year 2007 Proshare calculation to determine whether the above noted issues require correction.
- The Bureau should ensure that employees have sufficient understanding and training for their assigned responsibilities. Employees should not be placed in a position where they perform important responsibilities based largely upon prior practice and without a sufficient understanding to allow the employee to exercise a control consciousness.
- The Bureau should establish policies and procedures for performing the Proshare calculations that will promote the accurate and consistent calculation of the payment amounts and help ensure continuity of operations.

Auditee Response:

We concur in part.

We do not concur with the audit recommendation to further review and correct fiscal year 2007 Proshare calculations. The Department believes it correctly used the 2007 actual and estimated

patient days to compute the 2007 ProShare payments. The Department will review the calculations to determine if certain atypical days were overlooked in the calculation.

We do concur with the recommendation regarding the establishment of policies and procedures. The Department will continue developing formal documentation of procedures for the ProShare calculations.

The Department concurs that cross-training of employees is necessary. This issue has been raised on a broader level regarding successorship planning. Hiring freezes, State pay levels, and an aging workforce have resulted in a condition where many important functions are dependant upon key employees who are nearing retirement date. This issue has been discussed. With respect to the ProShare calculation, other employees will be cross-trained on this function.

Expected Date of Implementation: Actions pursuant to the recommendations to which DHHS concurs have been partially completed.

Review fiscal year 2007 Proshare calculation - The atypical days review will be completed before May 1, 2008, prior to the next calculation of ProShare using data through April 30, 2008.

Establish policies and procedures - The formal documentation of the ProShare process is complete.

Employee training - Training of employees has been completed.

Observation No. 17: Controls Should Be Established To Limit HCBC Services To Plan Of Care

Observation:

The Bureau does not review Home and Community Based Care–Elderly and Chronically Ill (HCBC-ECI) Medicaid Waiver Program service claims for compliance with approved client plans of care prior to payment of the claims.

HCBC-ECI services provided to Medicaid clients must be made in compliance with an approved, client plan of care in order for the expenditure to be allowable under the HCBC-ECI Medicaid waiver. The plan of care may be amended as a client's condition or situation warrants. All amendments are initiated by the client's case manager and must be approved by a Bureau nurse, prior to becoming effective.

During fiscal year 2007, there was no automated or formal manual review process to ensure that HCBC-ECI payments to providers were limited to payments for services authorized by a client's plan of care.

While client service plans and amendments are initially recorded in paper files and input by the Bureau into the OPTIONS information system, the OPTIONS system was not effectively linked to the Medicaid Management Information System (MMIS) during fiscal year 2007. Client plans of care and amendments recorded in OPTIONS were not accessible to the MMIS and could not

be used as a control to prevent payments for services not included on a client's plan of care. HCBC-ECI claims submitted to the MMIS like all other Medicaid program claims for payment are checked against enrolled provider lists, eligible client lists, and allowable services lists; however, the MMIS does not have access to information to check HCBC-ECI claims against a client's plan of care. While client plans of care could be set up as prior authorizations in MMIS to provide a control on payments in excess of the plan of care, they were not during fiscal year 2007. As a result, the MMIS systems could not detect/prevent payments for services that exceeded client plans of care.

The effect of not limiting payments to services and service levels on a client's plan of care is an increased risk that the HCBC-ECI Medicaid Program may pay for services in excess of or outside of the clients' approved plans of care. Payments in excess of or outside of the plans of care would be unallowable for federal participation. For example:

- Payments to service providers in excess of client plans of care were noted in two out of a sample of 42 (5%) HCBC-ECI clients tested. According to the services billed and payments made, these clients received services that exceeded the plan of care in effect for the month tested. The total monthly payment exceeded the plan of care by $376 for one client and $2,354 for another client. The Federal government reimbursed the State for half of those costs, $1,365 therefore we question that amount.

Questioned Costs: $1,365

Recommendation:

The Bureau must establish formal controls to ensure that HCBC-ECI expenditures are limited to payments for services that are intended by approved client plans of care as amended.

The controls established by the Bureau should include all aspects of controls including control environment, risk assessment, control activities, information and communication, and monitoring.

The Bureau should institute reasonable interim controls pending the integration of information in the OPTIONS system with the MMIS to limit the risk of payments in excess of the client plans of care.

Auditee Response:

We concur.

The LBA observed this need in its Performance Audit Report of April 2003. DHHS' response at that time was:

"The current Medicaid Management Information System (MMIS) does not have edits that automatically compare claims submitted to services authorized on plans of care, and is therefore unable to limit payment to services that have been authorized. BEAS has initiated discussions and will continue to work with the management of the MMIS to determine what can be done to address these issues through new automated system controls. In the interim, BEAS will continue

to manually review claims to make sure that inappropriate payments are not being made and if necessary to recoup such payments."

Since that time, DHHS has planned for two levels of control: through a Centers for Medicare & Medicaid Services (CMS)-approved Quality Management Strategy and through a contract with a Medicaid fiscal agent for a restructured MMIS. The first level of control is the nurse supervisor and case management supervisor, both of whom check authorizations for appropriateness. A nurse within BEAS compares MMIS payment information, which she can access directly online, to the plan of care. If a discrepancy is discovered, the discovery is referred to the Medicaid Surveillance and Utilization Review System (SURS) Unit, who pursues payment recovery.

The second, automated, control will be included in the implementation of the new MMIS scheduled for January 1, 2009. BEAS has prepared for this change by completing system modifications to its system, Options. All service authorizations are now entered into the Options database by BEAS nurses and by HCBC-ECI case managers. From January 2009, forward, the service prior authorizations in Options will be transmitted through a nightly feed to the MMIS. All HCBC-ECI procedure codes within the MMIS will require a prior authorization. Claims will be denied if a corresponding service authorization is not present or if it exceeds the units available in the current authorization.

Expected Date of Implementation: In accordance with the LBA recommendations, DHHS has implemented (in March 2008) a level of control through a Centers for Medicare & Medicaid Services (CMS)-approved Quality Management Strategy to ensure that HCBC-ECI expenditures are limited to payments for services that are intended by approved client plans of care as amended. A second level of control, a restructured MMIS, is scheduled to go into use January 2009 in response to the LBA's recommendations regarding the current OPTIONS system.

Observation No. 18: Quality Control Should Be Implemented For Case Manager Activities

Observation:

The Bureau has not established policies and procedures for monitoring the activities of case management agencies to ensure case managers are providing quality monthly oversight of services needed and received by Home and Community Based Care-Elderly and Chronically Ill (HCBC-ECI) clients.

The Bureau hires case managers to administer and monitor HCBC-ECI clients' plans of care. Case management responsibilities include monthly contact with the client to assess the delivery of plan of care services and to make recommendations if changes to services or service levels are needed. In addition to recommending changes to service levels, the monthly client visit also provides the Bureau with a control review of service provider performance. While the monthly case manager client contact helps identify changing client needs, the regular client contact also provides the Bureau with its primary opportunity to recognize whether quality services are being delivered to the clients. However, because neither service providers or case managers sign in or otherwise provide evidence of having performed client services, other monitoring efforts by the Bureau are necessary to ensure provider performance. According to the Bureau, it did not

proactively monitor case manager performance to ensure case managers are providing monthly contact with clients during fiscal year 2007.

The new HCBC-ECI Waiver, effective July 2007, includes a Quality Management (QM) Process and Team program that would include case manager oversight efforts. According to the Bureau, the QM process has yet to be implemented.

Recommendation:

The Bureau should implement the quality control management policies and procedures required by the new HCBC-ECI Waiver for monitoring the case management services provided to HCBC-ECI clients.

Auditee Response:

We concur.

The Bureau of Elderly and Adult Services management team is responsible for ensuring Bureau operations and program compliance. The Bureau concurs that policies and procedures relevant to Case Management service delivery need to be developed and implemented. The Targeted Case Management rule (He-E 805) was adopted on March 1, 2008 and provides clear service expectations for providers enrolled in the Medicaid program to provide case management services. The Federal Case Management rule (Dec. 4, 2007) provides further clarification.

Policies and procedures will be developed utilizing both Federal and State case management rules recently promulgated. They will include policies that outline quality assurance activities to support Appendix H of the HCBC-ECI waiver, effective July 2007. It was expected that the requirements of Appendix H would be phased in as the Federal and State rules became effective.

The Bureau is seeking resource assistance from the Division of Community Based Care Services for the development for the above referenced policies.

Expected Date of Implementation: November 30, 2008.

Observation No. 19: Reporting Of HCBC-ECI Waiver Costs Should Be Expanded

Observation:

The Bureau, when reporting Home and Community Based Care-Elderly and Chronically Ill (HCBC-ECI) Waiver (Waiver) costs, does not always make it clear that reported waiver costs may not include the costs of some services provided to Waiver clients that would be avoided if the Waiver clients were receiving services in a nursing facility setting.

According to section 8 of the Waiver, the State will refuse to offer Waiver services to any person for whom it can reasonably be expected that the cost of services under the Waiver furnished to that individual would exceed the cost of nursing facility level of care. According to the Department's Division of Family Assistance, the average monthly per-resident cost of a nursing

facility during fiscal year 2007 was $6,814. The definition of costs of services under the Waiver is open to interpretation.

Not all costs for services related to maintaining a Waiver client in an independent or assisted living housing setting are reported as Waiver program costs. The Bureau charges certain services provided to these clients that enable the client to continue living in an independent setting to the State Plan program. In some instances these costs are not recognized and reported as Waiver costs by the Bureau even though the cost for these services would not be incurred had the client been provided services in a nursing facility setting. The result is that not all costs incurred in operating the Waiver program are reported as Waiver costs. For example:

- Provider payments for Waiver services for one client out of a sample of 42 (2%) tested, combined with costs for personal care services paid under the State Plan, exceeded the average cost of a nursing facility by $21,860 for fiscal year 2007. The cost of personal care services paid under the State Plan for this client would not have been incurred had the client been provided services in a nursing facility setting. While in the completion of the HCBC-ECI plan of care for a client the Department's nurse reviews the anticipated cost of care and compares it to the cost of care in a nursing facility setting, the comparison does not include all marginal costs incurred in placing the client in the Waiver program.
- According to the Bureau, approximately $3.7 million of personal services costs necessary to allow certain HCBC-ECI clients to remain in an independent living setting were not reported as Waiver costs but were reported instead as costs incurred under the State Plan. Other additional costs incurred in providing services to HCBC-ECI clients reported as State Plan costs that would likely not be incurred to the same extent if clients were in nursing facilities include certain nursing, transportation, and ambulance costs. Because not all costs of services necessary to keep clients in the Waiver program are reported as program costs, the Bureau is understating the actual cost of operating the Waiver in its financial reporting.

While the Bureau reports to the federal Medicaid program annually a comparison of total Medicaid services costs to average nursing facility costs for Waiver clients, there is no monitoring or cost comparison at the individual client level. Only by understanding the accurate and total costs incurred in providing services to clients in the Waiver program and the costs of providing similar services in a nursing facility setting can a valid evaluation of the financial cost and benefit of the Waiver program be made.

Recommendation:

While the Bureau is required and does report HCBC-ECI costs according to State statute and federal program rules, we recommend the Bureau also review its cost reporting to ensure that all relevant management levels, including policy makers, are aware of the total costs of operating the Waiver. Specifically, when reporting Waiver costs to the State, the Bureau should report total as well as net Waiver costs to allow consideration of the full cost of operating the Waiver.

The Bureau should monitor the costs of providing services to Waiver clients to ensure the Bureau remains in compliance with section 8 of the Waiver. The Bureau should review the cost for payments made in excess of the average cost for nursing facility level of care.

Auditee Response:

We do not concur.

DHHS agrees that all costs of operating the HCBC-ECI program should be reported, and contends that it does so in the annual 372 report.

DHHS follows both state and federal cost comparison instructions: The federal instructions contained in Appendix J of the approved waiver, and State law, RSA 151-E.

The HCBC-ECI Program provides community based long term care services to individuals who are Medicaid-eligible and meet the clinical standards for nursing facility (NF) services. Centers for Medicare & Medicaid Services (CMS) approval of the HCBC-ECI Program, and assurance of federal financial participation, requires an annual demonstration of cost neutrality of this program through a 372 report produced in accordance with Appendix J of the approved waiver. These instructions require that DHHS report the average annual per person expenditure for approved waiver services in addition to, and separately from, the average annual per person expenditure for all other Medicaid-covered services provided to the same individuals. These amounts combined must be less than the cost of all services provided to NF residents. New Hampshire has consistently demonstrated cost neutrality.

RSA 151-E directs DHHS to develop a continuum of care to give people a choice of where they may receive Medicaid-covered long term care services, to the extent that community based care costs are kept significantly lower than the cost of NF placement. This law also defines how DHHS must measure costs. RSA 151-E:2 IV defines "home based care" as services provided under HCBC-ECI. RSA 151-E:2 VII defines "mid-level care" as services provided in an assisted living, residential care facility or in a congregate care setting under HCBC-ECI. RSA 151-E:11 directs DHHS in how it identifies long term care costs. In I., it requires DHHS to designate specific class lines within the budget for mid-level, home care and NF services. In II., it directs DHHS in how to compare HCBC-ECI costs to NF costs as follows:

"For the fiscal year beginning July 1, 2003, and each fiscal year thereafter the average annual cost for the provision of services to persons in the mid-level of care shall not exceed 60 percent of the average annual cost for the provision of services in a nursing facility. The average annual cost for the provision of services in home-based care shall not exceed 50 percent of the average annual cost for the provision of services to persons in a nursing facility. *Average annual costs shall be the net medicaid costs exclusive of provider payments.* No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services." [Emphasis added.]

Although these instructions reference comparing averages, they also require an awareness of the costs of each approved individual to ensure that the Commissioner's approval is obtained as required. The instructions do not address measuring the costs of long term care services that are covered in addition to the NF rate or HCBC-ECI waiver services, nor do they address the professional costs of maintaining a long term care program, such as nurses and office expenses.

Observation No. 20: Policies And Procedures Should Be Established For Documenting HCBC Client Status

Observation:

The Bureau is placing its controlled operations of the Home and Community Based Care-Elderly and Chronically Ill (HCBC-ECI) Medicaid Waiver Program at risk by placing reliance upon employees' understanding of undocumented responsibilities.

Bureau Management is responsible for ensuring that all significant aspects of Bureau operations are subject to formal controls, including the aspects of control environment, risk assessment, control activities, information and communication, and monitoring.

The Bureau has not established policies and procedures for significant aspects of controls related to the HCBC-ECI Medicaid Waiver Program. The Bureau recognizes that the continued secure performance of these activities is largely dependent upon the practice and experience of the incumbents performing these responsibilities and activities. For example,

1. There are no policies and procedures describing the required contents of HCBC-ECI client files. The Bureau indicated it relies upon employee experience and judgment to recognize if a HCBC-ECI client file is missing required content, etc.
2. There are no formal review and approval policies and procedures for HCBC-ECI file contents or for the input of information into the OPTIONS information system. Errors in input of file information into the OPTIONS system would likely go unnoticed.

The Bureau has become dependent upon incumbent employee experience for the performance of regular Bureau activities. A lack of formal policies and procedures has contributed to the condition where the Bureau has become dependent upon the employees' understanding of management's intentions, based on a combination of the employees' experience and informal direction. Significant aspects of Bureau operations would be negatively affected if the employees misinterpreted management's intentions or otherwise misapplied management's intended control activities.

Recommendation:

The Bureau should establish controls for all significant aspects of its operations. The Bureau should provide formal policies and procedures to employees for performing important control functions, including documentation of client status in HCBC-ECI files and the review of data input from the files into the OPTIONS information system. All significant Bureau processes should be supported by sufficient policies and procedures to provide for employee guidance and continuity of operations.

Auditee Response:

We concur.

The Bureau of Elderly and Adult Services (BEAS) management team is responsible for ensuring Bureau operations and program compliance. Furthermore, the Bureau recognizes that operations

and program compliance are subject to formal controls. The Bureau concurs that established policies and procedures relevant to Home and Community Based Care (HCBC) client documentation needs to be developed and implemented. These policies, once developed, will include controls for all significant aspects of HCBC program including risk assessment, environment, activities, information, communication and monitoring. In addition to identification of formal controls, the Bureau will develop policies and procedures that identify required contents of HCBC client files.

The Bureau will also establish formal policies and procedures, specifically for Long Term Care Unit employees working with HCBC clients. Procedures will include instruction for performing control functions including client status documentation contained in HCBC files and the review of data input contained in the OPTIONS information system files. The Bureau will provide employees with formal reviews, education, and ongoing support to ensure continuity of operations and program compliance regarding client files and control measures.

The Bureau is seeking resource assistance from the Division of Community Based Care Services for the development of the above referenced policies.

Expected Date of Implementation: November 30, 2008.

Observation No. 21: Client Liability For Cost Of Care Should Be Collected

Observation:

The Bureau did not require home-based clients receiving services under the Home and Community Based Care-Elderly and Chronically Ill (HCBC-ECI) waiver to contribute toward their cost of care during fiscal year 2007, contrary to waiver requirements.

Federal administrative law, 42 CFR 435.735 (a), requires the Bureau to reduce its payment under the HCBC-ECI waiver by the amount that remains after deducting certain specified amounts from the individual client's income. The Bureau's process for determining a client's cost share is included in N.H. Admin. Rule He-E 801.06.

According to the Bureau, during fiscal year 2007 it did not have current policies and procedures or systems in place to collect a home-based client's required contribution toward cost of care. While the Bureau's plan included billing and collecting a home-based HCBC-ECI client's cost of care liability, the Bureau reported it had not collected on a home-based client's cost of care liability since January 2004. The Bureau estimates that it did not collect $38,000 during fiscal year 2007, $19,000 of which would have reduced the Bureau's draw of federal financial participation.

While the Bureau was aware that it was not complying with this requirement during fiscal year 2007, it did not take action to resolve the noncompliance until the issue was raised by the auditors.

According to the Bureau, payments for HCBC-ECI clients living in a residential setting are reduced according to the federal program and administrative rule requirement.

Questioned Costs: $19,000

Recommendation:

The Bureau should adhere to the federal HCBC-ECI waiver requirements and reduce payments for services by the amount of the client's cost of care liability.

The Bureau should develop and implement a system supported by appropriate policies and procedures that will allow and promote the accurate collection of a home-based HCBC-ECI client's cost of care liability.

The Bureau should review why senior staff did not react sooner to this known issue of noncompliance. Failure to act in a timely manner to known noncompliance issues indicates a weakness in the Bureau's control environment that should be addressed.

Auditee Response:

We concur.

In July 2004, the Bureau of Elderly and Adult Services (BEAS) was reorganized under the Division of Community Based Care Services and a new Bureau Administrator was recruited. Senior staff developed a corrective action plan that corresponds with the recommendations cited above in September 2007. Due to the sensitive nature of implementing a collection process, the initial step was to seek legal consultation to ensure that all necessary steps would be included in the process and that BEAS would follow the most appropriate timing. BEAS trained case managers and staff prior to implementation. A new process for calculating and collecting client contribution toward their cost of care was implemented on October 1, 2007.

BEAS will maintain the current process of the calculation and collection of cost share liability that is consistent with Centers for Medicare & Medicaid Services (CMS) requirements, section 1902 (a)(19). These procedures will be incorporated into a procedures manual to promote the accurate collection of a client's cost of care liability on a consistent and on-going basis.

BEAS has requested resource assistance from the Division of Community Based Care Services to assist in the development of policies and procedures regarding client cost of care. BEAS will incorporate defined measures within the context of these policies to address timely reaction to noncompliance issues.

It should be noted that the estimate of $38,000 of contribution potentially not received is a gross figure. When additional costs of administering the program are accounted for, there will be little or no net cost reduction to the program.

Expected Date of Implementation: The plan was completed with its implementation, with written procedures to be developed by November 30, 2008.

Observation No. 22: Residential Care Provider Bills Should Be Reviewed For Client Contribution Credits

Observation:

Claims from facilities providing residential care to Home and Community Based Care-Elderly and Chronically Ill (HCBC-ECI) clients are not reviewed prior to payment to ensure that the amounts billed are net of any required client contribution toward the cost of care. The only check on the billed amount performed by the Medicaid Management Information System (MMIS) is a check to determine that the amount billed is not in excess of the maximum residential care amount.

HCBC-ECI clients receiving residential care are required to contribute, based on their ability to pay, toward their monthly cost of care. The Bureau determines a client's monthly contribution toward care as provided in federal administrative law, 42 CFR 435.735 and N.H. Admin. Rule He-E 801.06(d) and (e). While the client's plan of care is entered into the OPTIONS information system and provides information on expected monthly client contribution, circumstances can cause monthly variations from the expected amount. The residential care facility is responsible for collecting the client's share of the cost of care, maintaining documentation of any client-based purchases of medically necessary services not covered by Medicaid, and billing the HCBC-ECI program for the difference between the maximum residential care amount and the balance of the client's cost of care liability.

The Bureau does not post client liability data to HCBC-ECI client records in the MMIS. As a result, the MMIS does not have criteria necessary to allow an automated edit to ensure that amounts billed by residential service providers are net of the expected client liability amount. Client liability data is posted to the records of clients in nursing facilities and this data is used to control amounts billed by nursing facilities.

Because the MMIS only compares the amount billed by the residential care provider to a maximum allowed rate, there is a risk that residential care facilities may bill incorrect amounts, resulting in over/under payments for provided services. These over/under payments may not be detected due to the lack of review of the billed amounts. While the Bureau reported that residential service provider's bills were monitored to ensure that amounts billed and paid were net of client contributions, the Bureau was not able to describe that monitoring effort.

Recommendation:

The Bureau should implement controls to promote the detection of inaccurately billed amounts from HCBC-ECI residential service providers. The Bureau should institute a formal control process, such as incorporating a consideration of the client liability amount in the MMIS, to monitor the residential care facility claims for payment. While monthly fluctuations in residents' needs may preclude exact determination of amounts to be billed by service providers, the Bureau should consider establishing an expected or average amount as a payment control criteria and require service providers to support amounts that exceed that criteria.

Auditee Response:

We concur.

BEAS system limitations under the present Medicaid Management Information System (MMIS) prevent the Bureau from processing claims from residential care facilities in the same manner as nursing facilities. Residential Care, a Home and Community Based Care (HCBC) waiver service, is processed under a different system module than nursing facilities. Modifying the residential care module to operate in the same manner as the nursing facilities module would require a substantial and costly system change. A new Medicaid Management Information System from Affiliated Computer Services (vendor) is scheduled to go into effect January 1, 2009. The new MMIS system will have the ability to tie patient's liability for cost of care to the amount billed by the residential facility. During the interim, BEAS will conduct monthly reviews of claim submissions from residential facilities and match the claims to the patient's liability for cost of care maintained in the New Heights system. BEAS will conduct follow-up with service providers to review billings that exceed the maximum allowed less patient liability.

Expected Date of Implementation: A monthly review has been implemented.

This issue will be resolved with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009.

Observation No. 23: Security Of Confidential Client Information Should Be Monitored

Observation:

The Bureau has not established a formal process to monitor employee compliance with the Department's policies and procedures for securing confidential client information.

Federal administrative law, 45 CFR 164.308, Administrative Safeguards (a)(8), requires the Department to perform a periodic review based on implemented standards when employees use or disclose a client's health and other private information.

General privacy training is provided for all Bureau employees and advanced privacy training is provided for employees who regularly access and utilize client health and other private information. Each employee and the employee's supervisor signs a *General Workforce Training Acknowledgement* form signifying completion of this training.

According to the Bureau, there is no formal monitoring performed subsequent to training to ensure staff is adhering to the Department's privacy policies and procedures for protecting client information. Reportedly, while a Department-level in-house process to audit compliance with the privacy policies and procedures has been drafted, the process has not been implemented due to staffing shortages.

For example, the Department's current policies were not followed in an employee's email requesting a client's file which was noted during audit testing. The email contained a system screen print, which included the client's social security number and date of birth as well as the

recipient identification number (RID). The RID is a system-generated number used to identify a client without using the client's name or other confidential client information. In this instance, the RID by itself would have been sufficient to identify the requested file.

Recommendation:

The Bureau should continue in its efforts to maintain secure, confidential client information. In addition to providing initial training to employees, the Bureau should provide regular training updates and reminders to promote the information security consciousness of its employees.

The Bureau should also implement monitoring procedures to reasonably ensure that employees follow Department policies and procedures for protecting confidential client information, as required by federal regulation.

Auditee Response:

We concur.

BEAS has discussed these findings with the Department's HIPAA [Health Insurance Portability and Accountability Act] Privacy Officer and learned that a HIPAA compliance audit has begun Department-wide. Findings from this audit will dictate where and how the Department, including BEAS, will monitor the use and disclosure of client protected health information more closely. The Privacy Officer has requested that BEAS staff re-take the HIPAA Training and will assist in scheduling same. BEAS and the Privacy Officer will work together to monitor the use and disclosure of client protected health information, prior to the development and implementation of a Department HIPAA Monitoring Plan.

Furthermore, BEAS is working with the Office of Information Technology to identify the security measures currently in place or available to secure electronic information through email or other electronic medium. All appropriate information technology methods will be employed to ensure client information is kept confidential.

Expected Date of Implementation: Pending the HIPAA Privacy Officer's schedule, appropriate BEAS staff will re-take the HIPAA Training by May 8, 2008.

Observation No. 24: Administrative Rules Should Be Kept Current

Observation:

The Department and Bureau have allowed administrative rules to expire even though the Department's and Bureau's programs rely upon continued compliance with the expired rules.

Proposed and current administrative rules and the waiver for the Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) program reference expired administrative rules. The expired N.H. Admin. Rule He-P 803, Nursing Home Regulations, is referenced in the proposed N.H. Admin. Rule He-E 805, Targeted Case Management Services. The expired N.H. Admin. Rule He-P 809, Home Health Care Providers, is referenced in the new March 2007

HCBC-ECI waiver and the expired N.H. Admin. Rule He-W 521, General Payment Information, is referenced in N.H. Admin. Rule He-E 801.09, Provider Participation.

Allowing administrative rules to expire places at risk the controlled operations of programs subject to the expired rules.

Recommendation:

The Department and Bureau should ensure that the administrative rules necessary for the operation of their programs remain current.

The Department and Bureau should review with legal counsel the expected effect on operations resulting from the expiration of program rules and the options available to provide interim rule coverage for the period prior to the adoption of final rules.

Auditee Response:

We concur.

There is recognition within the Department and the Bureau that expired rules exist and there has been reliance upon some expired rules for program compliance. With this recognition, both the Bureau and the Department have engaged in efforts to update expired rules. While progress has been made in this effort, renewed efforts are underway within the Administrative Rulemaking Unit of the Department to update rules prior to expiration and to efficiently process those rules that are already expired.

The Administrative Rulemaking Unit has adopted several new measures over the past several months to ensure more comprehensive and timely rulemaking. Past practices have been reviewed and refined. For example, interim rulemaking has been utilized in the past to extend rule coverage but will be utilized more sparingly in the future as this practice actually requires nearly double the administrative rules staff and resources necessary for regular rules processing.

Another new measure implemented by the Administrative Rulemaking Unit is compilation of a Quarterly Rules report that is sent department-wide to program managers and rules staff to provide notice of all rules in the rulemaking process and intra-agency impact of each rule. This reporting tool will serve to involve agencies with a rule interest or impact to be involved earlier in the process, allow contribution coordination and avoid delays further down the administrative rulemaking process.

As cited in the criteria above, a number of expired rules are identified. Various divisions and units within DHHS bear responsibility for the expired rules identified. He-W 521 rules are managed and updated by the Office of Medicaid Business and Policy. The Bureau of Health Facilities Licensing manages He-P 803 rules. BEAS bears responsibility for the He-E rules. Each of the expired rules referenced is currently in the process of being updated. In addition, although the He-E 805 rules (draft) previously referenced an expired rule, the adopted rule incorporated a correction with compliance ensured through reference to the statute and not to the expired rule.

A review of expired rules indicates that the Bureau currently has only one expired rule. This one rule has not been updated for a specific reason; it is awaiting a statutory resolution of a state-federal law discrepancy. The Bureau has also properly allowed several rules to expire over recent years where the substance covered by the rule is covered by another new or updated rule. For example, He-E 200 was a rule promulgated by the Bureau, which covered administrative hearings. This topic is now covered globally by a Department rule on administrative hearings.

New measures have been identified to ensure timely rulemaking. Department rulemaking efforts include focus on a comprehensive rule expiration identification process that will effectively notify the Administrative Rulemaking Unit of rule expiration and if necessary, utilize the use of interim rulemaking as a temporary measure. The rule identification/expiration process will include measures to notify staff within the Department and BEAS, provide measurable timelines for rule revision/completion and staff assignment identification. Rulemaking efforts will be prioritized within BEAS to target expired rules and identification of rules that are nearing expiration.

Expected Date of Implementation: November 30, 2008.

Observation No. 25: County Billing Weaknesses Should Be Mitigated

Observation:

The process used by the County Billing Unit to bill the county share of the Bureau's Medicaid Program costs requires manual input to relatively unsophisticated spreadsheets and, as a result, is prone to error.

The County Billing Unit (Unit) in the Department's Office of Finance is responsible for billing county governments for their respective share of the Medicaid Program costs administered by the Department, including the Bureau. The Unit uses a computer-based spreadsheet to accumulate data and calculate a net amount owed by each county. The information entered into the spreadsheet includes:

- County liabilities for the month, based on the reports generated by the Medicaid Management Information System (MMIS),
- County liabilities for nursing home audit cost (Rate Setting) based on a calculation performed in another spreadsheet (Rate Setting Spreadsheet), using information from the MMIS and the State accounting system (NHIFS),
- Amounts previously received from counties,
- Estate recoveries credited to counties,
- Supplemental billing for the costs not included in MMIS reports, and
- Other adjustments.

Because the county billing process relies upon the accumulation of data from disparate sources and the manual keying of this data and the further accumulation of the data in a relatively unsophisticated spreadsheet, errors are likely to occur and go undetected. For example, the Unit failed to detect the following errors in the spreadsheets during fiscal year 2007.

Input errors

1. $86,348 of estate recovery that should have been recorded as a credit against billing to applicable counties was recorded as a receipt from a single county.
2. June 2007 receipt of $540,955 from a county was not recorded on the spreadsheet. This error was not discovered during the monthly reconciliation procedures due to an error in querying the computer data.

Formula errors

1. A formula error in the fiscal year 2007 summary spreadsheet resulted in an accounts receivable understatement of $3,096,090. The Department was unaware of the error prior to the auditors bringing it to their attention.
2. A formula error was noted in the March 2007 calculation of total receipts from counties. While the effect of this error was inconsequential, it is indicative of the type of error that can occur and go undetected.
3. Formula errors in the Rate Setting Spreadsheet in October and November 2006 resulted in a $9,800 overcharge to the counties. The error in the November spreadsheet was discovered by the Department and corrected in the following month.

The Office of Finance indicated that the type of errors noted above resulting from the manual accumulation and input of data and the unsophisticated nature of the spreadsheets should be minimized upon the implementation of the new MMIS county billing module.

Recommendation:

The Department and the Bureau should take steps to mitigate the recognized weaknesses in the process used to accumulate amounts used to bill county governments for their respective share of Medicaid Program costs.

Pending the implementation of the MMIS county billing module, the Unit should improve the current spreadsheet format so formulas and the results of the formulas are sufficiently evident to allow for efficient and effective review and detection and correction of errors.

Users of the spreadsheet data should be aware of the types of errors that may occur in the spreadsheet data to promote early detection and correction of errors.

Auditee Response:

We concur with the LBA Recommendations and the formula errors found in the Excel spreadsheet.

The Bureau of Finance's Billing Unit has been able to automate some components of the County billing process over the past several years but the administrative burden comes with the manual processes required to account for the settlement of invoices and receipts transacted between the State and County accounting systems that reports a cumulative outstanding amount brought forward from prior State fiscal years.

The Bureau of Finance Billing Unit and Billing Unit Supervisor have implemented a check and balance with an additional staff person keying and a second person reviewing the information entered into the excel spreadsheet for billing and revenue collections.

Once the new MMIS County billing module is implemented the current process will no longer be required and manual intervention will be 99% reduced.

Expected Date of Implementation: As stated above, the Bureau of Finance Billing Unit and Billing Unit Supervisor has implemented a check and balance with an additional staff person keying and a second person reviewing the information entered into the excel spreadsheet for billing and revenue collections.

The new MMIS County billing module will be included with the implementation of the new Medicaid Management Information System scheduled to go into use January 1, 2009.

Observation No. 26: Policies And Procedures Should Be Established For Administering Title III And Title XX Programs

Observation:

The Bureau does not maintain written policies and procedures to ensure continued compliance with certain Aging Grant (Title III) and Social Services Block Grant (Title XX) requirements including Cash Management, Maintenance of Effort, Reporting, and Subrecipient Monitoring. The Bureau is dependent on the experience of key personnel to maintain federal fund compliance.

Federal administrative law, 45 CFR 1321.11 states, "The State agency on aging shall develop policies governing all aspects of programs operated under this part, including the ombudsman program whether operated directly by the State agency or under contract. These policies shall be developed in consultation with other appropriate parties in the State. The State agency is responsible for enforcement of these policies."

The Bureau is at increased risk for Title III and Title XX federal fund noncompliance due to the lack of written policies and reliance on key personnel. The Bureau is dependent on key personnel to execute routine monthly transactions, ensure matching and maintenance of effort requirements are met, prepare annual and semi-annual reports, and respond effectively to on-site review findings.

Formal policies and procedures would reduce the risk of noncompliance due to staff unfamiliarity with undocumented policies and procedures due to employee turnover or other reasons.

Recommendation:

The Bureau should establish policies and procedures for the administration of the Title III and Title XX programs. The policies and procedures should be sufficiently comprehensive to allow for the continued controlled operation of the programs without over reliance on incumbent, key

employees. Compliance requirements and activities for these programs should be documented and communicated to personnel responsible for their execution. The policies and procedures should include monitoring activities to ensure that the compliance activities operate as intended.

Auditee Response:

We concur.

The Bureau of Elderly and Adult Services (BEAS) policies and procedures for both Title III and Title XX services were developed long ago. They have been incorporated over time into contracts from which the majority of services under Title III and Title XX are delivered and paid. It is the Bureau's intent during the next year to review and develop written comprehensive policies and procedures for both Title III and Title XX services.

BEAS has maintained compliance with Title III requirements including Cash Management, Maintenance of Effort, Reporting, and Subrecipient Monitoring. BEAS does concur that the documentation should be sufficiently comprehensive as to allow for the continued controlled operations of the program without over reliance on incumbent or key employees. In State fiscal year (SFY)2007, the Bureau conducted on-site reviews at ten agencies for subrecipient monitoring. For SFY2008, BEAS, with assistance from the Bureau of Improvement and Integrity, will be conducting ten additional on-site reviews. The Bureau is currently undertaking a pro-active approach in cross-training individuals on the grant requirements of Title III and Title XX service programs.

The Bureau is also seeking resource assistance from the Division of Community Based Care Services for the development of written policies and procedures for the Title III and Title XX services.

Expected Date of Implementation: April 30, 2008 for all reporting functions and November 30, 2008 for final written administrative policies and procedures.

Observation No. 27: Payments For Client Non-Specific Services Should Be Reviewed

Observation:

The Bureau has not established policies and procedures to ensure that certain programs provide services primarily to eligible clients.

The Bureau's operation of the Aging Grants (Title III) and Social Services Block Grants (Title XX) programs allows service providers latitude when providing program services. While the programs envision providing services to eligible clients, certain services determined to be client non-specific are provided to individuals that may not strictly meet client eligibility criteria.
For example:

- While client eligibility for nutrition services (either home-delivered or congregate) is determined by service providers and authorized by the Bureau (this is called 'client specific authorization'), service providers submit monthly invoices for nutrition services in units of

service provided. The invoices do not provide information on clients who received meals (This is called 'client non-specific invoice'). The Bureau has not established procedures to ensure that all meal units that are invoiced by the service providers are provided to program-eligible clients.

- Likewise for transportation and legal assistance services, services are provided without a client authorization process (this is called 'client non-specific authorization'). The Bureau authorizes units of services and service providers are responsible to ensure the services are provided to eligible clients. Again, the Bureau has not established procedures to ensure that all units of service were provided to program-eligible clients.

Because the Bureau relies largely upon the service providers for eligibility compliance for certain program services, there is a risk that Bureau programs may be paying for services provided to ineligible clients.

Recommendation:

The Bureau should review its policies and procedures regarding payments for client non-specific services. The Bureau should assess the risk of its Title III and Title XX programs providing services to ineligible individuals resulting from its service providers exercising inadequate program eligibility controls. Based on this assessment, the Bureau should consider adding control procedures in order to ensure that only eligible individuals receive program services.

Auditee Response:

We concur in part.

Bureau of Elderly and Adult Service procedures allow service providers to determine eligibility for services provided under both the Social Services Block Grant and Title III. Persons wishing to receive these services or their authorized representatives must complete a written application with the exception of Title III Transportation. Individuals applying for Social Services Block Grant services must meet an income level of $900 or less per month to be eligible for these services. Applicants must provide documentation of their income, usually in the form of pay stubs, social security checks, etc.

Title III regulations require the States to serve people who are 60 or older. While States may request individuals applying for Title III services for information about their income and certain health status data, Title III applicants are not required to provide this information, and no one who fails to provide this information can be denied the service.

Some of the eligibility standards under Title III are as follows:

"As per CFR 45, Part 1321 a service provider under the Act [Older Americans Act] may develop a suggested contribution schedule. However, means tests may not be used for any services supported with funds under the Act. No older person regardless of their income and/or assets may be excluded from participation."
Section 315 (b) (3) and 45 CFR Part 1321.67 (c).

"Solicitation of voluntary contributions added for participants at 185% or more of federal poverty level based on self-declaration of income."

The subrecipient monitoring process that the Bureau currently utilizes does focus on client eligibility. Client eligibility is reviewed against the original application and those monitoring procedures have been documented. To expand the audit sample of client eligibility, BEAS will conduct on site reviews on 15 providers per year instead of the current ten.

In order to determine that Title III enrolled clients are actually receiving delivered units by the agency, the Bureau will add to our subrecipient process the following:

- BEAS will review the agencies' original source documents by client for service units delivered for a month.
- BEAS will randomly choose the month to review during the on-site review.
- BEAS will review units reported by individual clients against the program eligibility for that individual.
- BEAS will determine if the individual client billings from the original source document add up to the 'Client non-specific invoice' total reported.

BEAS will work with providers to convert Title III clients to a 'client specific invoice'.

Expected Date of Implementation: Completion of the four steps identified above will be achieved by August 31, 2008. The implementation plan for client-specific billing, including costs to change, timelines, and training for client specific invoicing of Title III, will be completed by April 30, 2009.

Observation No. 28: Cost Allocation Plan Should Be Established For Bureau Programs

Observation:

The Bureau during fiscal year 2007 did not accurately allocate administrative costs between its Title III Aging Grants (Title III) and Social Services Block Grants (Title XX) programs. While a lack of accurate allocation does not appear to have any effect on program compliance or other operational aspects of the programs, the Bureau cannot accurately understand the relative costs of its programs if it does not accurately allocate the administrative costs.

According to the federal Office of Management and Budget, Circular A-133 Compliance Supplement, "Overall expenditures for administration are limited to the greater of five percent (or $300,000 or $500,000 depending on the aggregate amount appropriated or a lesser amount for the U.S. territories) of the overall allotment to a State under Title III unless a waiver is granted by the Assistant Secretary on Aging (42 USC 3028 (b)(1), (2), and (3))."

The Bureau's Title XX Application for Funds for State fiscal year 2007 states that, "funds will be used to provide or purchase a variety of social services…and to fund administrative expenses." The application defines administrative costs as "Costs allocated to portion of SSBG [Title XX] funding for administrative expenses."

Many of the Bureau's subrecipient contracts contain both Title III and Title XX program activity and the Bureau administers the Title III program in conjunction with the Title XX program. Most administrative procedures, including procurement, vendor payments, and subrecipient monitoring for each funding source transpire concurrently.

Although 52% of combined Title III and Title XX expenditures relate to Title XX, and 68% of combined subrecipients receive Title XX funds, essentially all of the administrative costs for the two programs were charged to the Title III program. While the amount of administrative costs charged to the Title III program ($500,000) was within program limits, it was not possible to determine what portion of the amount charged to the program related to the Title III program and what portion related to the Title XX program.

Recommendation:

The Bureau should accurately allocate all significant costs between Title III, Title XX, and any other applicable programs to provide for the accurate allocation and understanding of program costs necessary to effectively manage the programs. The Bureau should consider developing a formal cost allocation plan based on a reasonable method of allocation.

Auditee Response:

We concur.

A formal, federally approved Public Assistance Cost Allocation Plan (PACAP) containing all utilized allocation methodologies has been in use since 1999 and is currently in process of update by Reporting and Analysis Services (RAS), the unit responsible for the PACAP and the Department's cost allocation process/expenditure reporting. BEAS will, with the assistance of the RAS, analyze the current staffing structure and allocation methodologies used by BEAS, and revise as needed to accurately allocate administrative costs to the applicable programs.

Expected Date of Implementation: The analysis and corresponding revisions will be completed by the end of April 2008 and included in the updated PACAP, scheduled for completion in State Fiscal Year 2008.

Compliance Comments

Observation No. 29: Penalties For Late Cost Reports Should Be Assessed In Accordance With State Plan

Observation:

The Bureau did not consistently assess a penalty for nursing facilities that submitted a late cost report during fiscal year 2007.

According to the Medicaid State Plan Attachment 4.19-D, Section 9999.3(e) and N.H. Admin. Rule He-E 806.02(e)(1), a complete cost report shall be submitted by each nursing facility "no later than 3 months after the end of the facility's fiscal year, unless an extension has been granted by the department."

Requests for extensions must be in writing, submitted to the Department at least ten working days prior to the due date of the annual cost report, and approval of the extension shall be made only if the delay is caused by circumstances beyond the control of the nursing facility such as flood, fire, strikes, earthquakes, or death of owner or administrator.

According to the Medicaid State Plan Attachment 4.19-D, Section 9999.3(q) and N.H. Admin. Rule He-E 806.02(q), "failure to submit the annual cost report or a complete report as required **shall** [emphasis added] result in the following penalties, unless an extension has been granted by the department:

(1) The per diem rate currently in effect shall be reduced by 25% effective on the first day of the month following the due date for filing of the completed annual cost report, and for each successive month of delinquency in filing the completed annual cost report;
(2) There shall be no retroactive restoration of penalty payments or reimbursement of related working capital interest costs upon the submission of a completed cost report;
(3) No determination of a new rate for the next payment period shall be made until an acceptable cost report…is received; and
(4) Reinstatement of the pre-existing rate or the determination of a new rate of payment shall be made subsequent to the receipt of an acceptable annual cost report, but retroactive only to the date of receipt by the department of said report."

During detail testing of nursing facility rate setting, we found one facility out of 16 reviewed (6%) that had submitted its cost report significantly after the due date without a penalty having been applied or the Bureau having granted a timely extension to the nursing facility. A complete and accurate cost report due December 31, 2004 was not received from the nursing facility until April 5, 2005. This report was initially used in setting the rates effective August 2006.

While there was documentation indicating that the late status of the cost report was recognized by the Bureau and efforts were made to assist the nursing facility to submit a complete report, there was no documentation to support that the sanctions required by the State Plan were implemented by the Bureau.

Questioned Costs: $42,820

Recommendation:

The Bureau should comply with the State plan and administrative rule by assessing penalties on those nursing facilities that file late cost reports.

Extensions should only be granted in accordance with the provisions of the State Plan that require circumstances beyond the nursing facility provider's control or events over which the nursing facility provider cannot exercise influence over its occurrence such as, but not limited to: flood, fire, strikes by employees, earthquakes, or death of an owner or administrator.

Auditee Response:

We concur.

We concur that the assessment of a penalty for a late cost report submission was inadvertently missed for one nursing facility during the quarter ended March 2005. As a corrective measure, a letter has been sent to all nursing home providers regarding the cost report submission guidelines and policy for granting of extensions, including a copy of the administrative rule.

Expected Date of Implementation: Actions pursuant to the above recommendations have been completed. A letter has been sent to providers reminding them of the policy and rule regarding late cost report submission. Tracking spreadsheets have been developed and implemented for better monitoring of this area.

Independent Auditor's Report

To The Fiscal Committee Of The General Court:

We have audited the accompanying Statement Of Revenues And Expenditures - General Fund of the Bureau of Elderly and Adult Services (Bureau) of the New Hampshire Department of Health and Human Services for the fiscal year ended June 30, 2007. This financial statement is the responsibility of the management of the Bureau. Our responsibility is to express an opinion on this financial statement based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statement is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Bureau's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 1, the financial statement of the Bureau is intended to present certain financial activity of only that portion of the State of New Hampshire that is attributable to the transactions of the Bureau. The financial statement does not purport to, and does not constitute a complete financial presentation of either the Bureau or the State of New Hampshire in conformity with accounting principles generally accepted in the United States of America.

In our opinion, except for the matter discussed in the third paragraph, the financial statement referred to above presents fairly, in all material respects, certain financial activity of the Bureau of Elderly and Adult Services for the fiscal year ended June 30, 2007, in conformity with accounting principles generally accepted in the United States of America.

Our audit was conducted for the purpose of forming an opinion on the Statement of Revenues and Expenditures of the Bureau. The supplementary information, as identified in the table of contents, is presented for additional analysis and is not a required part of the financial statement.

Such information has been subjected to the auditing procedures applied in the audit of the financial statement. In our opinion, the supplementary schedules are fairly stated, in all material respects, in relation to the financial statement taken as a whole.

In accordance with *Government Auditing Standards,* we have also issued a report dated April 10, 2008 on our consideration of the Bureau's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, rules, regulations, contracts, grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Office Of Legislative Budget Assistant

April 10, 2008

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

STATEMENT OF REVENUES AND EXPENDITURES - GENERAL FUND
FOR THE FISCAL YEAR ENDED JUNE 30, 2007

Revenues	
Federal	$ 188,254,202
County And Other	70,925,572
Nursing Facility Quality Assessment	33,942,021
Total Revenues	**293,121,795**
Expenditures	
Nursing Services	195,273,745
Medicaid Quality Incentive	67,453,660
Home Nursing Services	34,146,415
Provider Payments	25,161,146
Proshare	13,811,954
Social Services Block Grant	10,111,262
Medicare Part D	9,666,636
Administration On Aging Grants	9,189,039
Personnel	7,725,071
Nursing Services Mid-Level Care	3,646,460
Other Nursing Homes	3,362,953
Outpatient Hospital	2,673,374
Other	1,927,988
Other Nursing Services	1,329,910
Congregate Housing	734,234
Medicaid Service Grants	472,880
Total Expenditures	**386,686,727**
Excess (Deficiency) Of Revenues Over (Under) Expenditures	**(93,564,932)**
Other Financing Sources (Uses)	
Net General Fund	93,564,932
Total Other Financing Sources (Uses)	**93,564,932**
Excess (Deficiency) Of Revenues And Other Financing Sources Over (Under) Expenditures And Other Financing Uses	**$ -0-**

The accompanying notes are an integral part of this financial statement.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

NOTES TO THE FINANCIAL STATEMENT
FOR THE FISCAL YEAR ENDED JUNE 30, 2007

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accompanying Statement Of Revenues And Expenditures - General Fund of the Bureau of Elderly and Adult Services of the New Hampshire Department of Health and Human Services, Division of Community Based Care Services has been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) and as prescribed by the Governmental Accounting Standards Board (GASB), which is the primary standard-setting body for establishing governmental accounting and financial reporting principles.

A. Financial Reporting Entity

The Bureau of Elderly and Adult Services (Bureau) is an organizational unit of the New Hampshire Department of Health and Human Services, a department of the primary government of the State of New Hampshire. The accompanying financial statement reports certain financial activity of the Bureau.

The financial activity of the Bureau is accounted for and reported in the General Fund in the State of New Hampshire's Comprehensive Annual Financial Report (CAFR). Assets, liabilities, and fund balances are reported by fund for the State as a whole in the CAFR. The Bureau, as a part of a department of the primary government, accounts for only a small portion of the General Fund and those assets, liabilities, and fund balances as reported in the CAFR that are attributable to the Bureau cannot be determined. Accordingly, the accompanying financial statement is not intended to show the financial position or change in fund balance of the Bureau of Elderly and Adult Services in the General Fund.

B. Financial Statement Presentation

The State of New Hampshire and the Bureau use funds to report on their financial position and the results of their operations. Fund accounting is designed to demonstrate legal compliance and to aid financial management by segregating transactions related to certain government functions or activities. A fund is a separate accounting entity with a self-balancing set of accounts. The Bureau reports its financial activity in the fund described below:

General Fund: The General Fund, a governmental fund type, accounts for all financial transactions not specifically accounted for in any other fund. All revenues of governmental funds, other than certain designated revenues, are credited to the General Fund. Annual expenditures that are not allocated by law to other funds are charged to the General Fund.

C. Measurement Focus And Basis Of Accounting

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized as

soon as they are both measurable and available. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay the liabilities of the current period. For this purpose, except for federal grants, the State generally considers revenues to be available if they are collected within 60 days of the end of the current fiscal period. Expenditures generally are recorded when a liability is incurred, as under accrual accounting. However, expenditures related to debt service, compensated absences, and claims and judgments are recorded only when payment is due.

D. Budget Control And Reporting

General Budget Policies

The statutes of the State of New Hampshire require the Governor to submit a biennial budget to the Legislature for adoption. This budget, which includes a separate budget for each year of the biennium, consists of three parts: Part I is the Governor's program for meeting all expenditure needs and estimating revenues. There is no constitutional or statutory requirement that the Governor propose, or that the Legislature adopt, a budget that does not resort to borrowing. Part II is a detailed breakdown of the budget at the department level for appropriations to meet the expenditure needs of the government. Part III consists of draft appropriation bills for the appropriations made in the proposed budget.

The operating budget is prepared principally on a modified cash basis and adopted for the governmental and proprietary fund types with the exception of the Capital Projects Fund. The Capital Projects Fund budget represents individual projects that extend over several fiscal years. Since the Capital Projects Fund comprises appropriations for multi-year projects, it is not included in the budget and actual comparison schedule in the State of New Hampshire CAFR.

In addition to the enacted biennial operating budget, the Governor may submit to the Legislature supplemental budget requests to meet expenditures during the current biennium. Appropriation transfers can be made within a department without the approval of the Legislature; therefore, the legal level of budgetary control is at the department level.

Additional fiscal control procedures are maintained by both the Executive and Legislative Branches of government. The Executive Branch, represented by the Commissioner of the Department of Administrative Services, is directed to continually monitor the State’s financial operations, needs, and resources, and to maintain an integrated financial accounting system. The Legislative Branch, represented by the Joint Legislative Fiscal Committee, the Joint Legislative Capital Budget Overview Committee, and the Office of Legislative Budget Assistant, monitors compliance with the budget and the effectiveness of budgeted programs.

Unexpended balances of appropriations at year-end will lapse to undesignated fund balance and be available for future appropriations unless they have been encumbered or legally defined as non-lapsing, which means the balances are reported as reservation of fund balance. The balance of unexpended encumbrances is brought forward into the next fiscal year. Capital Projects Fund unencumbered appropriations lapse in two years unless extended or designated as non-lapsing by law.

Contracts and purchasing commitments are recorded as encumbrances when the contract or purchase order is executed. Upon receipt of goods or services, the encumbrance is liquidated and

the expenditure and liability are recorded. The Bureau of Elderly and Adult Services' unliquidated encumbrance balance in the General Fund at June 30, 2007 was $6,687,688.

A Budget To Actual Schedule - General Fund is included as supplementary information.

NOTE 2 – CHAPTER 129 OF THE LAWS OF 2007

The Bureau's reported expenditures for the fiscal year ended June 30, 2007 included $8.9 million of nursing services and $2.3 million of Proshare expenditures related to the enactment of Chapter 129 of the Laws of 2007 (House Bill 721). The recovery of federal and county participation in these expenditures is not reflected in the revenues reported for the year ended June 30, 2007, as the revenues were not collected within the State's available-period criteria used for recognizing revenue on the modified accrual basis of accounting. At June 30, 2007 the Bureau had deferred the recognition of $9.4 million of revenue related to these expenditures.

NOTE 3 - EMPLOYEE BENEFIT PLANS

New Hampshire Retirement System

The Bureau of Elderly and Adult Services, as an organization of the State government, participates in the New Hampshire Retirement System (Plan). The Plan is a contributory defined-benefit plan and covers the majority of full-time employees of the Bureau of Elderly and Adult Services. The Plan qualifies as a tax-exempt organization under Sections 401 (a) and 501 (a) of the Internal Revenue Code. RSA 100-A established the Plan and the contribution requirements. The Plan, which is a cost-sharing, multiple-employer Public Employees Retirement System (PERS), is divided into two membership groups. Group I consists of State and local employees and teachers. Group II consists of firefighters and police officers. All assets are in a single trust and are available to pay retirement benefits to all members.

Group I members at age 60 qualify for a normal service retirement allowance based on years of creditable service and average final compensation (AFC). The yearly pension amount is 1/60 (1.67%) of AFC multiplied by years of creditable service. AFC is defined as the average of the three highest salary years. At age 65, the yearly pension amount is recalculated at 1/66 (1.5%) of AFC multiplied by years of creditable service. Members in service with ten or more years of creditable service who are between ages 50 and 60 or members in service with at least 20 or more years of service, whose combination of age and service is 70 or more, are entitled to a retirement allowance with appropriate graduated reduction based on years of creditable service.

Group II members who are age 60, or members who are at least age 45 with at least 20 years of creditable service can receive a retirement allowance at a rate of 2.5% of AFC for each year of creditable service, not to exceed 40 years.

All covered Bureau of Elderly and Adult Services employees are members of Group I.

Members of both groups may qualify for vested deferred allowances, disability allowances, and death benefit allowances subject to meeting various eligibility requirements. Benefits are based on AFC or earnable compensation, service, or both.

The Plan is financed by contributions from the members, the State and local employers, and investment earnings. During the fiscal year ended June 30, 2007, Group I members were required to contribute 5% and group II members were required to contribute 9.3% of gross earnings. The State funds 100% of the employer cost for all of the Bureau of Elderly and Adult Services' employees enrolled in the Plan. The annual contribution required to cover any normal cost beyond the employee contribution is determined every two years based on the Plan's actuary.

The Bureau of Elderly and Adult Services' payments for normal contributions for the fiscal year ended June 30, 2007 amounted to 6.81% of the covered payroll for its group I employees. The Bureau's normal contributions for the fiscal year ended June 30, 2007 were $337,000.

A special account was established by RSA 100-A:16, II (h) for additional benefits. The account is credited with all the earnings of the account assets in the account plus the earnings of the remaining assets of the plan in excess of the assumed rate of return plus ½ of 1%.

The New Hampshire Retirement System issues a publicly available financial report that may be obtained by writing to them at 54 Regional Drive, Concord, NH 03301 or from their web site at http://www.nhrs.org.

Health Insurance For Retired Employees

In addition to providing pension benefits, RSA 21-I:30 specifies that the State provide certain health care benefits for retired employees and their spouses within the limits of the funds appropriated at each legislative session. These benefits include group hospitalization, hospital medical care, and surgical care. Substantially all of the State's employees who were hired on or before June 30, 2003 may become eligible for these benefits if they reach normal retirement age while working for the State and receive their pensions on a periodic basis rather than a lump sum. During fiscal year 2004, legislation was passed that requires State Group I employees hired after July 1, 2003 to have 20 years of State service in order to qualify for health insurance benefits. These and similar benefits for active employees are authorized by RSA 21-I:30 and provided through the Employee Benefit Risk Management Fund, which is the State's self-insurance fund implemented in October 2003 for active State employees and retirees. The State recognizes the cost of providing these benefits on a pay-as-you-go basis by paying actuarially determined contributions into the fund. The New Hampshire Retirement System's medical premium subsidy program for Group I and Group II employees also contributes to the fund.

The cost of the health benefits for the Bureau of Elderly and Adult Service's retired employees and spouses is a budgeted amount paid from an appropriation made to the administrative organization of the New Hampshire Retirement System. Accordingly, the cost of health benefits for retired Bureau of Elderly and Adult Services employees and spouses is not included in the Bureau of Elderly and Adult Service's financial statements.

NOTE 4 - LITIGATION

The following current litigation involves programs and activities of the New Hampshire Department of Health and Human Services, Bureau of Elderly and Adult Services.

New Hampshire Association of Counties, et al. v. Commissioner of Department of Health and Human Services ("NHAC I")

Some of the State's ten Counties (the Plaintiff Counties) challenged the Department of Health and Human Services' (DHHS) decision holding them responsible for paying a share of the cost of Medicaid payments for clients receiving Old Age Assistance (OAA) or Aid to the Permanently and Totally Disabled (APTD). Under RSA 167:18-b, the counties are liable for one-half of the State's expenditures for OAA and APTD recipients who are "in nursing homes." DHHS believed that RSA 167:18-b also allowed it to bill the Plaintiff Counties for nursing services that are provided to recipients who are in institutions, such as rehabilitation hospitals, that are not licensed as "nursing homes" but are certified under Medicaid as nursing facilities authorized to provide nursing level care. DHHS has been billing the Plaintiff Counties for these services since at least 2002.

The second issue raised by the Plaintiff Counties in their suit is whether DHHS exceeded the statutory cap on the total amount that the Counties can be billed under RSA 167:18-b in fiscal year 2004. RSA 167:18-b establishes a $60 million cap on the total liability for the Counties under this section of the statute. The legal dispute in this case involves whether that figure should be interpreted as a gross amount or a net amount. In 2004, the total amount of the bills sent to the Plaintiff Counties for their share of payments under RSA 167:18-b was approximately $62.1 million. However, DHHS gave the Plaintiff Counties approximately $2.1 million in statutory credits, thereby bringing the total owed to $60 million. The Plaintiff Counties refused to pay the total amount, claiming that the statute limits the total amount that can be "billed" to the Counties at $60 million, and therefore the credits should have been subtracted from the $60 million, thereby limiting their liability to $57.9 million.

The parties filed cross-motions for summary judgment and on October 27, 2006, the Merrimack County Superior Court granted summary judgment in favor of the Plaintiff Counties on both issues. DHHS filed a notice of appeal in November 2006.

On August 17, 2007 the Supreme Court issued an order in which it vacated the majority of the lower court’s decision, affirmed it in part and remanded it back to the lower court for additional factual findings.

Most significantly, the Supreme Court held that the term "nursing home" in RSA 167-18-b means any institution certified by the federal Medicaid program to provide nursing facility services. The result is that the vast majority of the bills which were submitted to the Plaintiff Counties were appropriate and legal, and therefore the Plaintiff Counties will not be entitled to any reimbursement from the State of those amounts paid. In addition, the State will be able to demand payment for certain bills which the Plaintiff Counties refuse to pay.

The Supreme Court also ruled that the cap provisions should be understood as limiting the Counties overall liability at $58 million. The Supreme Court held that since there was insufficient evidence in the record as to how much the Plaintiff Counties have reimbursed the State during the relevant period, the matter would need to be sent back to the trial court for further proceedings. The matter was remanded to the Merrimack County Superior Court, and cross motions for summary judgment were filed in November 2007. To date the parties have not received a response from the Court and further hearings have been scheduled.

It is not possible to calculate the likely fiscal impact to the State at this time. The most recent Supreme Court ruling means that the State will most likely not suffer any financial impact going forward (i.e. the State will not be required to expend any money to reimburse the Counties for moneys previously collected) from the Plaintiff Counties. The question that remains unanswered is the extent to which the State will be allowed to recover approximately $5 million which was withheld by the Plaintiff Counties in prior fiscal years.

New Hampshire Association of Counties, et al. v. Commissioner of Department of Health and Human Services ("NHACII")

The Plaintiff Counties have filed a second lawsuit in Merrimack County Superior Court challenging the manner in which the State assesses the Counties a portion of the cost for long-term care. In this lawsuit, the Plaintiff Counties claim that the most recent budget law (Chapter 262 of the Laws of 2007) violates Article 28-a of the New Hampshire Constitution in that it constitutes an "unfunded mandate."

Chapter 262 sets out the multi-year approach to this problem. In the first year, it continues the existing relationship with the Counties with regard to the sharing of the costs of long-term care. In the subsequent years, the new law changes the relationship between the Counties and the State, shifting certain costs onto the Counties, but taking other responsibilities away from the Counties.

The Plaintiff Counties have filed a petition seeking a declaratory judgment and injunctive relief. They are seeking to be excused from having to contribute to the cost of long-term care for patients on Medicaid. The Counties currently pay approximately $70 million per year towards long-term care under Medicaid. The parties filed cross-motions for summary judgment on November 7, 2007 and a hearing was held on February 13, 2008.

It is difficult to assess the likely financial impact to the State from this litigation. If the Plaintiff Counties were to prevail, it would result in a decrease in anticipated revenue for long-term care. This would result in the need to decrease the appropriation for long-term care, by reducing services, or increase revenue from some other source.

Bel Air Associates v. Department of Health and Human Services

The New Hampshire Supreme Court decided Bel Air Associates v. Department of Health and Human Services in September 2006 involving certain restrictions on the rates paid by the Department of Health and Human Services (DHHS) to nursing home providers. The Supreme Court held that DHHS' capital costs cap and its budget neutrality factor should have been created by administrative rule. The Supreme Court further held that because they were not created as rules, they could not be applied against Bel Air Associates. The Supreme Court did not order any damages against DHHS as it did not allow a late attempt by Bel Air Associates to add a breach of contract claim in Merrimack County Superior Court in late November alleging approximately $600,000 in damages. The parties filed cross-motions for summary judgment in June 2007 and the Court granted the State's motion for summary judgment in late December 2007. Bel Air Associates appealed the decision to the New Hampshire Supreme Court, and the parties will be filing briefs this Spring. In December 2006, DHHS also issued an emergency rule authorizing the capital costs cap and the budget neutrality factor. Those rules were made permanent in May 2007. Various nursing homes threatened to file injunctions preventing enforcement of the

emergency rule, but other than Bel Air, none have filed. At this time, it is not possible to predict the outcome of these matters or the amount, if any, that DHHS will be required to pay.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES
REQUIRED SUPPLEMENTARY INFORMATION

BUDGET TO ACTUAL SCHEDULE - GENERAL FUND
FOR THE FISCAL YEAR ENDED JUNE 30, 2007

	Original Budget	Actual	Favorable (Unfavorable) Variance
Revenues			
Federal	$ 192,882,327	$ 188,254,202	$ (4,628,125)
County And Other	74,360,751	70,925,572	(3,435,179)
Nursing Facility Quality Assessment	24,807,154	33,942,021	9,134,867
Total Revenues	**292,050,232**	**293,121,795**	**1,071,563**
Expenditures			
Nursing Services	192,870,528	195,273,745	(2,403,217)
Medicaid Quality Incentive	49,614,308	67,453,660	(17,839,352)
Home Nursing Services	32,160,742	34,146,415	(1,985,673)
Provider Payments	30,792,106	25,161,146	5,630,960
Proshare	21,052,401	13,811,954	7,240,447
Social Services Block Grant	10,107,510	10,111,262	(3,752)
Medicare Part D	-0-	9,666,636	(9,666,636)
Administration On Aging Grants	9,572,359	9,189,039	383,320
Personnel	7,748,139	7,725,071	23,068
Nursing Services Mid-Level Care	4,736,465	3,646,460	1,090,005
Other Nursing Homes	3,736,432	3,362,953	373,479
Outpatient Hospital	1,904,569	2,673,374	(768,805)
Other	2,198,975	1,927,988	270,987
Other Nursing Services	1,265,467	1,329,910	(64,443)
Congregate Housing	711,246	734,234	(22,988)
Medicaid Service Grants	4,231,917	472,880	3,759,037
Total Expenditures	**372,703,164**	**386,686,727**	**(13,983,563)**
Excess (Deficiency) Of Revenues Over (Under) Expenditures	**(80,652,932)**	**(93,564,932)**	**(12,912,000)**
Other Financing Sources (Uses)			
Net General Fund	80,652,932	93,564,932	(12,912,000)
Total Other Financing Sources (Uses)	**80,652,932**	**93,564,932**	**(12,912,000)**
Excess (Deficiency) Of Revenues And Other Financing Sources Over (Under) Expenditures And Other Financing Uses	**$ -0-**	**$ -0-**	**$ -0-**

The accompanying note is an integral part of this schedule.

Notes To The Budget To Actual Schedule - General Fund
For The Fiscal Year Ended June 30, 2007

Note 1 - General Budget Policies

The statutes of the State of New Hampshire require the Governor to submit a biennial budget to the Legislature for adoption. This budget, which includes annual budgets for each year of the biennium, consists of three parts: Part I is the Governor's program for meeting all expenditure needs as well as estimating revenues to be received. There is no constitutional or statutory requirement that the Governor propose, or the Legislature adopt, a budget that does not resort to borrowing. Part II is a detailed breakdown of the budget at the department level for appropriations to meet the expenditure needs of the government. Part III consists of draft appropriation bills for the appropriations made in the proposed budget.

The operating budget is prepared principally on a modified cash basis and adopted for the governmental and proprietary fund types with the exception of the Capital Projects Fund.

The New Hampshire biennial budget is composed of the initial operating budget, supplemented by additional appropriations. These additional appropriations and estimated revenues from various sources are authorized by Governor and Council action, annual session laws, and existing statutes which require appropriations under certain circumstances.

The budget, as reported in the Budget To Actual Schedule, reports the initial operating budget for fiscal year 2007 as passed by the Legislature in Chapter 176, Laws of 2005.

Budgetary control is at the department level. All departments are authorized to transfer appropriations within their departments with the prior approval of the Joint Legislative Fiscal Committee and the Governor and Council. Additional fiscal control procedures are maintained by both the Executive and Legislative Branches of government. The Executive Branch, represented by the Commissioner of the Department of Administrative Services, is directed to continually monitor the State’s financial system. The Legislative Branch, represented by the Joint Legislative Fiscal Committee, the Joint Legislative Capital Budget Overview Committee, and the Office of Legislative Budget Assistant, monitors compliance with the budget and the effectiveness of budgeted programs.

Unexpended balances of appropriations at year-end will lapse to undesignated fund balance and be available for future appropriations unless they have been encumbered or are legally defined as non-lapsing accounts.

Variances - Favorable/(Unfavorable)

The variance column on the Budget To Actual Schedule highlights differences between the original operating budget for fiscal year 2007 and the actual revenues and expenditures for the same period. Actual revenues exceeding budget or actual expenditures being less than budget generate a favorable variance. Actual revenues being less than budget or actual expenditures exceeding budget cause an unfavorable variance.

The unfavorable expenditure variances shown in the Budget To Actual Schedule represent the difference between the actual expenditures incurred during fiscal year 2007 and the original

budget in place at the beginning of fiscal year 2007. These unfavorable expenditure variances do not represent expenditures incurred in excess of appropriations because the original budget amounts do not include supplemental appropriations. The State and the Bureau use supplemental appropriations to add appropriations to original budget amounts to reflect changes in levels of operations not provided for in the original budget. During fiscal year 2007, the Bureau's original expenditure budget amounts were supplemented by $31 million of additional appropriations.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF ELDERLY AND ADULT SERVICES

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CASH BASIS)
FOR THE FISCAL YEAR ENDED JUNE 30, 2007

Federal Catalog Number	Federal Grantor *Federal Program Title*	Expenditures	Pass Thru Percent
	Department Of Health And Human Services		
93.041	*Special Programs For The Aging - Title VII Chapter 3, Programs For Prevention Of Elder Abuse, Neglect, And Exploitation*	$ 28,574	0%
93.042	*Special Programs For The Aging - Title VII Chapter 2, Long-Term Care Ombudsman Services For Older Individuals*	103,759	0%
93.043	*Special Programs For The Aging - Title III Part D - Disease Prevention And Health Promotion Services*	129,832	0%
93.044	*Special Programs For The Aging - Title III Part B - Grants For Supportive Services And Senior Centers*	2,322,796	0%
93.045	*Special Programs For The Aging - Title III Part C - Nutrition Services*	3,388,402	0%
93.048	*Special Programs For The Aging - Title IV And Title II - Discretionary Projects*	157,718	0%
93.052	*National Family Caregiver Support, Title III, Part E*	598,890	0%
93.053	*Nutrition Services Incentive Program*	872,262	100%
93.667	*Social Services Block Grant*	8,561,885	0%
93.778	*Medical Assistance Program*	170,882,817	0%
93.779	*Centers For Medicare And Medicaid Services (CMS) Research, Demonstrations And Evaluations*	355,603	0%
		$ 187,402,538	