STATE OF NEW HAMPSHIRE
BUREAU OF ELDERLY AND ADULT SERVICES
MEDICAID LONG-TERM CARE PROGRAM

PERFORMANCE AUDIT REPORT
JULY 2009

To The Fiscal Committee Of The General Court:

We conducted an audit of New Hampshire's Medicaid long-term care program administered by the Bureau of Elderly and Adult Services to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee, in accordance with the standards applicable to performance audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require we plan and perform the audit to provide a reasonable basis for our findings and conclusions. Accordingly, we performed such procedures as we considered necessary in the circumstances.

The purpose of this audit was to evaluate the financial and medical eligibility determination process, management and coordination of service provision, and oversight of case management, providers, and costs associated with the long-term care program. The audit period focused on State fiscal year 2008.

This report is the result of our evaluation of the information noted above and is intended solely for the information of the Department of Health and Human Services and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant

July 2009

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ABBREVIATIONS

APTD	Aid To The Permanently And Totally Disabled
BEAS	Bureau Of Elderly And Adult Services
CFR	Code Of Federal Regulations
CMS	Centers For Medicare And Medicaid Services
DDU	Disabilities Determination Unit
DFA	Division Of Family Assistance
DHHS	Department Of Health And Human Services
DoIT	Department Of Information Technology
FSS	Family Services Specialist
GSIL	Granite State Independent Living
HB	House Bill
HCBC-ECI	Home And Community Based Care – Elderly And Chronically Ill
LBA	Office Of Legislative Budget Assistant
LTC	Long-Term Care
LPAOC	Legislative Performance Audit And Oversight Committee
MED	Medical Eligibility Determination Form
MMIS	Medicaid Management Information System

MQIP	Medicaid Quality Incentive Program
OMBP	Office Of Medicaid Business Policy
OQA	Other Qualified Agency
PCA	Personal Care Attendant
PCSP	Personal Care Service Provider
PE	Presumptive Eligibility
RSA	Revised Statute Annotated
SB	Senate Bill
SFY	State Fiscal Year

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SUMMARY

Purpose And Scope Of Audit

This audit was performed at the direction of the Fiscal Committee of the General Court consistent with the recommendation of the joint Legislative Performance Audit and Oversight Committee. It was conducted in accordance with generally accepted government auditing standards applicable to performance audits. The purpose was to assess the efficiency and effectiveness of the State's Medicaid long-term care (LTC) program administered by the Bureau of Elderly and Adult Services (BEAS), especially for eligibility determination and service provision. The audit period is State fiscal year (SFY) 2008.

Background

The Medicaid program is one of the key federal programs providing states funding for LTC services for the elderly and adults with disabilities. Enacted through the Social Security Act of 1965, Medicaid is an entitlement program, jointly financed by federal and state governments. The Department of Health and Human Services (DHHS) is the State agency responsible for administering the Medicaid program.

Trends in LTC have been shifting to a home and community-based, consumer-directed model. Federal and state governments have focused on "rebalancing" the LTC system away from an institutional setting. Medicaid LTC can be provided in an institutional setting or, through waivers granted by the federal government, in a home and community setting. New Hampshire participates in several waivers including the Home and Community Based Care for Elderly and Chronically Ill (HCBC-ECI), a Section 1915(c) waiver. Established through the Omnibus Budget Reconciliation Act of 1981, this waiver allows states to meet the needs of LTC recipients with case management and home health services, in lieu of institutional care. The BEAS recently renamed its HCBC-ECI program Choices for Independence; however, the program's Administrative Rules, He-E 800 still refer to the program as HCBC-ECI. Created to avoid an institutionalization bias and reduce costs associated with LTC, the waiver program requires the cost of home and community-based care not exceed the costs incurred had clients been institutionalized. New Hampshire has utilized the HCBC-ECI waiver since first approved in 1984.

Both the BEAS and the Division of Family Assistance (DFA) play significant roles in the State's Medicaid LTC program. The BEAS is responsible for determining medical eligibility, developing the support plan, and managing the overall program while the DFA determines an applicant's financial eligibility. Based on federal regulations, the DFA has 45 days to determine the financial eligibility for most Medicaid applicants; and although the BEAS has not been operating under this same requirement, the same deadline exists for determining medical eligibility.

Historically, New Hampshire's LTC program has favored nursing facility services. However, with the HCBC-ECI waiver and Chapter 388, Laws of 1998, encouraging the use of mid-level

services (e.g., assisted living, congregate housing, or residential care programs) and home-based services (e.g., home health aide, homemaker, or nursing services) for persons eligible for Medicaid nursing facility services, the trend has shifted. According to BEAS data, the number of Medicaid clients in nursing facilities has leveled off and community and home based care continues to increase. Table 1 shows the average monthly number of Medicaid clients in each level of care, their average costs, and the total annual costs of care in State fiscal year 2008 according to the Bureau (see Observation No. 11 regarding issues with program statistics used in Table 1).

Table 1

SFY 2008 Medicaid LTC Caseloads And Costs

Type of Care Provided	Average Monthly Caseload	Average Annual Per Client Cost	Total Costs During Year
Home Care[1]	2,495	$16,158	$40,315,871
Mid-Level Care	285	$18,260	$5,203,999
Nursing Home Care[2]	4,316	$59,580	$257,148,895

Note: [1] Includes case management costs that totaled $5.9 million.
[2] Includes $69.4 million in Medicaid Quality Incentive Program payments to nursing facilities.
Source: Unaudited DHHS information.

Data from the BEAS shows 4,521 LTC applications submitted during SFY 2008 from 3,852 individuals (514 applicants submitted multiple applications during the year).

Results In Brief

We found the Medicaid LTC program administered by the BEAS is a multifaceted system involving the BEAS, DFA, ServiceLink, community support networks, stakeholders, LTC service providers, case management agencies, applicants, and recipients. The LTC program includes intake, eligibility determination, developing support plans, service provision (both institutional and home and community based), and management and oversight of service provision.

Our audit presents 15 observations and recommendations to assist the Department and the Legislature in optimizing the efficiency and effectiveness of the BEAS long-term care system. Three observations would require legislative action. We found a complex eligibility process, involving the DFA and the BEAS, can extend for several months. While the DFA applies a 45-day time standard, the BEAS does not currently follow the same standard. We found the eligibility process can begin at the district office or a ServiceLink location and the medical and financial components may begin concurrently, may start separately, or one may be overlooked completely. We also found the look-back period used by the DFA for financial eligibility may not comply with federal or State requirements.

We found there is no consistent process for determining the appropriateness of provider rates and no regular assessment of the availability of services throughout the State. We found concern over the adequacy of provider rates and service availability as well as concern over the oversight and guidance pertaining to personal care services.

We found the program demands effective and continuous communication and information sharing; however, the BEAS has poor communication with those involved in the program and provides limited information with unclear reporting methodologies. Additionally, collaborations, partnerships, and feedback are not being utilized to maximize the efficiency and effectiveness of the LTC system. Finally, we found vulnerabilities and weaknesses exist in the BEAS management information system, Options.

This report recommends the DHHS follow federal timeliness guidelines for eligibility pertaining to both financial and medical eligibility and streamline the application process. We further recommend the DHHS follow statutory requirements to assess and report on provider rates. We recommend the Department provide guidance on personal care services and financial eligibility look-back periods. Additionally, we recommend the BEAS improve communication, information sharing, and reporting while better involving stakeholders.

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RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
1	23	No	Revise information collection process for determining HCBC-ECI medical and financial eligibility by evaluating the use of a single process for medical and financial applications, establishing a single start date for the application when both the medical and financial applications are submitted, ensure an application is not considered complete until both the medical and financial applications have been submitted, and inform clients of the timeliness standards. The timeliness of the full application process should be tracked for all applicants.	Concur
2	26	No	Improve medical and financial eligibility processes by establishing State time standards for the entire LTC Medicaid eligibility process, improving communication between those involved, establishing performance measures to report on timeliness, creating methods to accurately track timeliness, and comparing performance to State time standards regularly.	Concur
3	28	No	Improve Medicaid eligibility determination processes by creating the means to accurately track applications to ensure appropriate time standards are met, developing standard policies and procedures for all DFA staff, documenting reasons for delay in an applicant's Medicaid eligibility determination, and providing a Notice of Decision to all LTC applicants after a determination has been made.	Concur
4	30	No	Review implementation of the look-back requirements and use those required under federal regulation.	Concur
5	32	No	Better inform and train employees, stakeholders, and community partners about the presumptive eligibility process and report on the presumptive eligibility program and its success in reducing eligibility determination times.	Concur
6	36	No	Evaluate access to and availability of services and service providers across the State and identify how to meet the needs of all applicants in different regions of the State.	Concur

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
7	38	No	Comply with all statutory requirements for rate setting for LTC services including establishing methodologies, conducting regular assessments, considering stakeholder and public input, and reporting on this information. Ensure the LTC Rate Setting Committee is active and providing rate setting information to best structure, define, and set provider rates for continuous viability of the long-term care system.	Concur in Part
8	41	No	Define when and how personal care services should be used, provide guidance for determining if a family member's care should be compensated or considered an informal support; strengthen oversight of PCSPs including periodically auditing some HCBC-ECI clients' use of PCSP services, to ensure consistency, relevancy, and reasonableness in the service PCSPs are providing; and require relevant and ongoing training requirements to ensure PCSPs are qualified and continually educated on service issues. The BEAS should seek Legislative guidance on using PCSPs.	Concur
9	44	Yes	Require the BEAS provide information on all Medicaid expenditures required for maintaining an HCBC-ECI recipient in a home or community-based setting by including provider payment costs such as PCA. Establish policies for using both PCA and PCSP services while increasing oversight and control when both types of personal services are provided to Medicaid clients.	Concur
10	47	No	Improve methods and procedures for disseminating information to relevant parties. Consider utilizing a variety of communication tools.	Concur
11	50	Yes	Increase clarity and consistency in reporting LTC costs. Specifically, seek clarification from the Legislature on desired cost methodologies and report format, make LTC cost data readily available on the Bureau website for public inspection; and provide methodologies used to generate reports to all users of agency data and reporting.	Concur

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
12	53	Yes	Seek additional guidance from the Legislature on defining high cost cases. The BEAS should seek guidance on whether to include MQIP costs, use the average or total number of HCBC-ECI clients, evaluate the high costs for clients requiring skilled nursing to the average nursing facility cost or the average skilled nursing facility cost, and include case management costs to calculate the applicant's initial support plan. Update rules, polices and procedures to improve oversight of the high cost cases and ensure responsible management of program funds.	Concur
13	57	No	Develop and implement a method to verify the accuracy of data entered into Options.	Concur
14	58	No	Improve Options management controls by assessing and documenting risks system-wide, implementing security policies and procedures, ensuring access is terminated upon separation, requiring initial background checks, developing a disaster recovery plan, reviewing processes to ensure data integrity, and improving user training.	Concur
15	63	No	Review ServiceLink practices, revise policies and procedures for the LTC eligibility process for ServiceLinks where needed, and provide training and guidance to encourage consistency in the application process throughout the State. Review the ServiceLink model and the requirement for ServiceLink locations to obtain a 501(c)3 status.	Concur

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OVERVIEW

In June 2008, the Fiscal Committee approved a joint Legislative Performance Audit and Oversight Committee (LPAOC) recommendation to conduct a performance audit of the State's long-term care (LTC) Medicaid program as administered by the Department of Health and Human Services (DHHS) Bureau of Elderly and Adult Services (BEAS). We held our entrance conference with the DHHS in December 2008. The LPAOC approved the audit scope in March 2009.

SCOPE, OBJECTIVES, AND METHODOLOGY

This performance audit was conducted in accordance with generally accepted government auditing standards applicable to performance audits and accordingly employed such procedures we considered necessary in the circumstances.

Scope And Objectives

This audit was designed to answer the following question: **Is the Department of Health and Human Services efficiently and effectively managing and coordinating eligibility determinations and service provision for the State's Medicaid long-term care system for seniors and adults with disabilities?** To address these objectives, the audit efforts focused on the Department's financial and medical eligibility determination process, management and coordination of service provision, and oversight of case managers, providers, and costs. The audit period was State fiscal year (SFY) 2008.

Methodology

To determine if the DHHS efficiently and effectively managed the State's Medicaid program administered by the BEAS, we:

- reviewed pertinent State and federal laws and regulations, Department polices and procedures, Medicaid State Plan, and the Section 1915(c) waiver;
- reviewed audits on New Hampshire's Medicaid LTC system and similar reports from other states and the federal government;
- obtained the opinions and views of DHHS personnel, LTC service providers, and other stakeholders regarding the BEAS Medicaid LTC program;
- analyzed Medicaid expenditure data; and
- reviewed a sample of Medicaid LTC applications for:
    - timeliness,
    - compliance with rules and laws related to timeliness, and
    - management controls.

We utilized a survey, interviews, data analysis, and file reviews to complete our audit.

BACKGROUND

Federal Long-Term Care Support

The Medicaid program is one of the key federal programs providing states funding for LTC services for the elderly and adults with disabilities. Enacted through the Social Security Act of 1965, Medicaid is a substantial source of funding for LTC. Medicaid is an entitlement program, jointly financed by the federal and state governments. A single agency must administer Medicaid at the state level while the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services manages the program at the federal level. Nationwide, Medicaid finances the majority of LTC services and has more recently expanded to support more home and community-based services and choices for consumers. According to the U.S. Social Security Administration's 2008 Annual Statistical Supplement:

> Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2005... With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Medicaid LTC can be provided in an institutional setting or through waivers in a home and community setting. New Hampshire participates in several waivers including the Home and Community Based Care for Elderly and Chronically Ill (HCBC-ECI), a Section 1915(c) waiver. (The Bureau has renamed the HCBC-ECI program Choices for Independence.) Established through the Omnibus Budget Reconciliation Act of 1981, this waiver allows states to meet the needs of LTC recipients with case management and home health services, in lieu of institutional care. Certain aspects of Medicaid law are waived in order to provide home and community-based care for those otherwise eligible for institutional care. Created to avoid an institutionalization bias and reduce costs associated with LTC, the waiver program requires the cost of home and community-based care not exceed the costs incurred had clients been institutionalized. Additionally, RSA 151-E:11, II requires Commissioner approval for anyone whose cost would exceed 80 percent of the cost of institutionalization. Further, the average cost of home-based care shall not exceed 50 percent of the annual average cost of nursing facility care.

The most recent significant federal changes in the Medicaid LTC program were implemented through the federal Deficit Reduction Act of 2005 and focus on flexibility, consumer choice, and cost savings. While the Act will lead to an almost $140 billion reduction in federal entitlements for Medicaid, these overall reductions are being offset by provisions to increase spending in areas including LTC. Changes to LTC include stricter eligibility requirements, increased flexibility in program design, and increased consumer choice regarding services and management of those services.

The Older Americans Act was implemented in 1965 to promote the well-being of older adults while helping the elderly remain independent in their homes and communities by providing long term care through a variety of services. This act created the Administration on Aging and

initiated several grant programs to support state agencies as they address the social service needs of older people. The Older Americans Act, which was reauthorized in 2006 to extend through 2011, administers grants in support of HCBC-ECI, Aging and Disability Resource Centers (such as ServiceLink in New Hampshire), the National Family Caregiver Support Program, nutrition services, and the Long-Term Care Ombudsman Program. These grants are based on the number of people 60 years of age and older in the State. To participate, the governor must designate a state agency to develop and implement a statewide plan on aging. In New Hampshire, the BEAS is designated as the State agency.

The BEAS Medicaid Long-Term Care Program

Both the BEAS and the Division of Family Assistance (DFA) play significant roles in the BEAS Medicaid LTC program. The BEAS is responsible for determining medical eligibility, developing the recipient's plan of care, and managing the overall program. The BEAS 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 LTC system that:

- promotes and supports individual and family direction,
- provides supports that meet individual and family needs,
- provides high quality care and support, and
- promotes efficiency.

The BEAS is organized into six operational units. In addition, the Office of the Long-Term Care Ombudsman is administratively attached. The BEAS is a bureau within the Department's Division of Community Based Care Services.[1] The Bureau's six units are described briefly below.

1. *Adult Protective Services Unit and Field Operations* provides protection to incapacitated adults who are abused, neglected, or exploited and arranges for in-home support services to prevent abuse, neglect, or exploitation and to enable them to remain at home independently as long as possible.
2. *Business Systems* provides interconnected technical support to all BEAS business functions within the DHHS framework.
3. *Community Services Policy and Program Development* develops and implements the ServiceLink Resource Centers, the New Hampshire State Plan on Aging, the CMS Grants, and the programs and services funded by the Administration on Aging and the Social Services Block Grants.
4. *Finance* provides oversight and management of Medicaid and social service financial management functions including rate setting.
5. *Long-Term Care Services* manages the daily operations of the statewide HCBC-ECI program, including the medical eligibility process.
6. *Medicaid Administration* acts as a liaison between BEAS and the federal government and oversees LTC development.

[1] Prior to State fiscal year 2007, the Bureau of Elderly and Adult Services was a Division within the DHHS.

The Medicaid LTC program administered by BEAS is just one program the DFA supports. The DFA is responsible for determining the financial eligibility of applicants for financial, medical, food and nutrition, emergency, and child care assistance programs. According to federal regulations, the Department has 90 days to determine the financial and disability eligibility for disabled Medicaid applicants for LTC and 45 days to determine the financial eligibility of all other Medicaid LTC applicants (see Observations No. 2 and 3 for issues related to time standards).

Historically, New Hampshire's LTC program favored nursing facility services, but starting in 1984, it applied for and received a HCBC-ECI waiver from the U.S. DHHS. Subsequently, Chapter 388, Laws of 1998, encouraged the use of mid-level services (e.g., assisted living, congregate housing, or residential care programs) and home-based services (e.g., home health aide, homemaker, or nursing services) for persons eligible for Medicaid nursing facility services. As a result, the State amended its HCBC-ECI waiver to increase the types of services it could offer under the Medicaid program. According to DHHS data, the number of Medicaid clients in nursing facilities has leveled off and community and home-based care continues to increase.

Medicaid operates as a vendor payment program (i.e., service providers are paid directly by the State), in which participating providers must accept Medicaid payment rates as payment in full. During SFY 2008, LTC Medicaid expenditures were paid by the federal government, the State, and the counties (50 percent, 25 percent, 25 percent, respectively).[2]

Information Technology

Information technology systems are used to manage several aspects of the BEAS LTC Medicaid program, including intake, financial eligibility, medical eligibility, case management, and claims processing.

- Refer 7 is ServiceLink's call management and intake information system.
- Financial eligibility is determined within the DFA and managed using the New Heights system.
- The BEAS Options system manages medical application status, eligibility, and the plan of care.
- The Department's Medicaid Management Information System (MMIS) manages provider registration and Medicaid claims payment and is run by a contractor.

Initial inquiries to ServiceLink are entered into Refer 7. Once a medical application is filed, it is entered into Options. Financial eligibility is entered into New Heights. Once found medically eligible, the BEAS operations unit enters the medical eligibility in the New Heights system. Once both medical and financial eligibility are approved and entered in New Heights, the eligibility "crosses over" and feeds information into MMIS. All non-contracted, Medicaid LTC provider claims are processed and paid through MMIS. Non-Medicaid service providers contracted by BEAS are paid through a claims system within Options.

[2] As a result of Chapter 263:17, Laws of 2007, since the start of SFY 2009, the counties will pay 100 percent of the non-federal share of LTC expenditures up to a cap determined by the State Legislature on a biennial basis.

These information systems are not well integrated; Options does not interface with New Heights or MMIS, and Refer 7 is also a stand-alone system, not owned by the State. The Department reports the future MMIS system will better manage providers and their reimbursements, and interface with Options as well as New Heights. Additionally, the medical eligibility determination, a three-part medical eligibility form used by BEAS nursing staff to determine medical eligibility, is in the process of being automated.

In the current environment, not only do these systems not communicate with each other, but also each entity responsible for components of the Medicaid LTC process do not have access to all systems. For example, ServiceLink, the initial point of entry for the State's LTC system, enters information into Refer 7 and Options but does not have access to New Heights. Fragmentation in both systems and access makes it difficult for these entities to easily determine the status of any individual applicant in the eligibility determination process.

ServiceLink

In 1997, the DHHS released a report entitled "Shaping Tomorrow's Choices" with a focus on shifting LTC from nursing facility to home and community-based care. Public feedback on this initiative identified fragmentation and lack of coordination in the LTC system as a barrier to successful transition. This, in part, led to language in Chapter 388, Laws of 1998, requiring the creation of a system of community-based "focal points" to provide information and referral services to elderly and chronically ill adults. The initial program required representation in each county. In 2003, the system was given additional support when the BEAS and the University of New Hampshire won an Aging and Disability Resource Grant to assist with technology. Piloted in two counties in 2004, and an additional three counties in 2006, statewide implementation of the expanded model, known as ServiceLink, was completed in January 2007. There are currently 10 ServiceLink contracts representing 13 offices and 40 satellite locations across the State.

ServiceLink has many responsibilities including NH Family Caregiver Support, State Health Insurance Assistance Program, Senior Medicare Patrol Project, and Medicaid LTC Services. As part of the Medicaid LTC program, ServiceLink personnel answer inquiries, educate consumers about community supports and the LTC program, pre-screen for financial eligibility, and collect information about activities of daily living. ServiceLink and district offices are responsible for intake into the LTC system. ServiceLink personnel complete the medical application, set appointments with a DFA Family Services Specialist to determine financial eligibility, and make an appointment with a BEAS nurse for a medical determination. Additionally, ServiceLink personnel may make home visits and assist clients in collecting the necessary paperwork for financial eligibility.

Logic Model

Measuring the performance of a government program is difficult because many factors contribute to outcomes. Determining the absolute extent to which a government entity contributes to a particular outcome is not usually possible. Instead, the aim of performance measurement is to acquire insight and provide some evidence the Medicaid LTC Program is

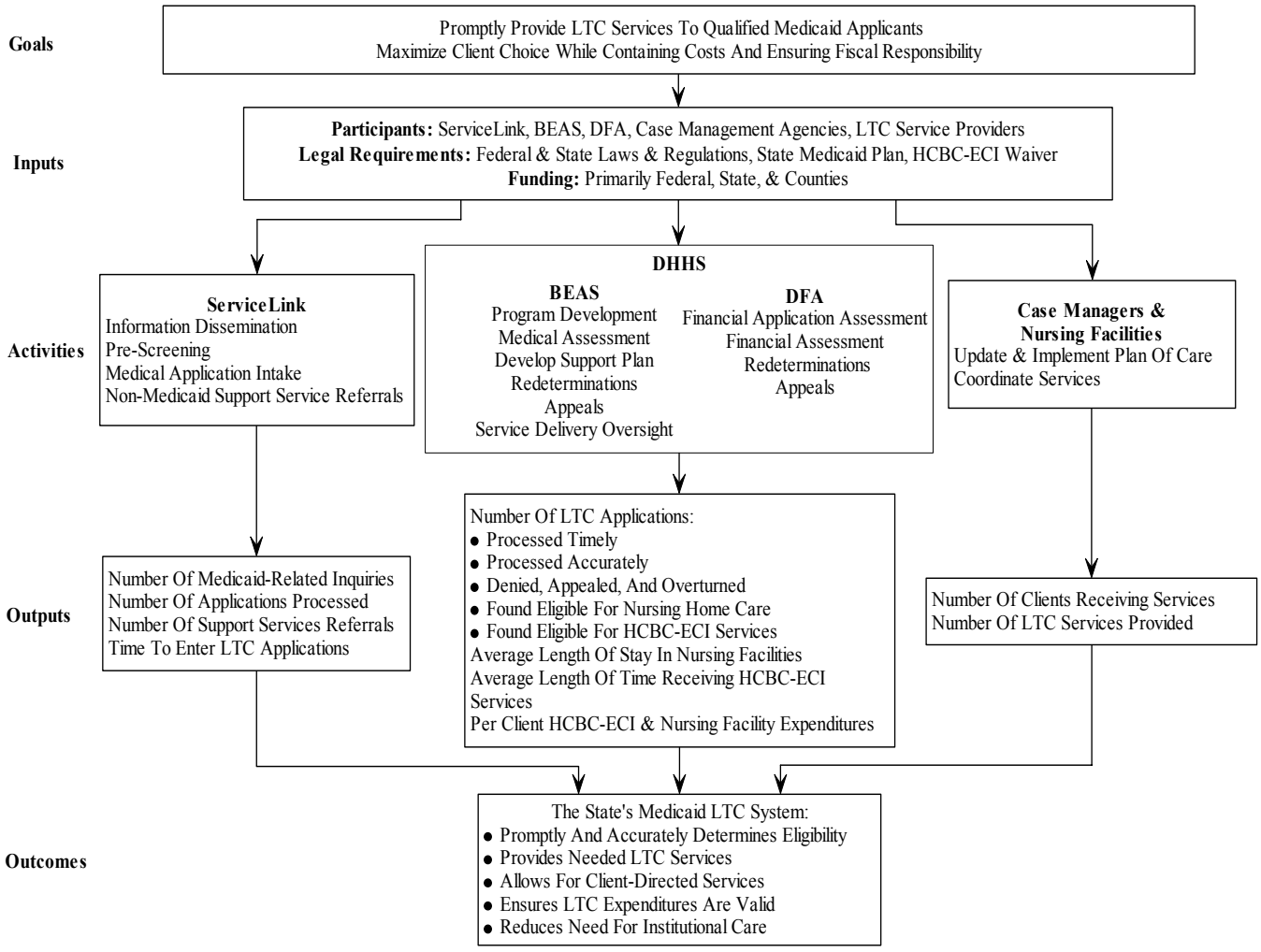
actually having an impact. A key tool for determining attribution is a logic model, which illustrates intended relationships.

Logic models are presented as flow charts describing programs in a way that facilitates developing relevant measures by portraying intended causal relationships between activities, outputs, and outcomes. The flow chart illustrates how a program intends to solve identified problems. Individual program activities, outputs, and outcomes are arranged in rows. Relationships between the various activities, outputs, and outcomes are arranged vertically on the page according to the sequential flow of program logic. The arrows linking the program elements signify the intended flow of the program.

New Hampshire sought the HCBC-ECI waiver in order to provide greater choice of LTC services to recipients with the additional benefit of reducing costly nursing home placements. Figure 1 focuses on the two components of the Medicaid program: 1) how the DFA and the BEAS determine Medicaid eligibility, and 2) how LTC services are provided to Medicaid recipients. We created this logic model to aid in understanding the management of these functions; it is not intended to describe all activities carried out by the BEAS and the DFA-related LTC services.

Figure 1

LTC Eligibility Determination Process And Service Provision Logic Model



Source: LBA analysis of interviews and BEAS documentation.

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ELIGIBILITY DETERMINATION PROCESS

We reviewed a sample of 157 applicants for the Medicaid long-term care (LTC) program to determine how successful the Department of Health and Human Services (DHHS) is in meeting federal time standards and to identify difficulties, if any, in the LTC eligibility process. Home and Community Based Care-Elderly and Chronically Ill (HCBC-ECI) and nursing facility applicants can be negatively affected by untimely Medicaid LTC determinations. The greater risk is for those waiting for HCBC-ECI services, as they typically do not receive services until the application is approved. Nursing facilities can provide services to Medicaid LTC applicants and be reimbursed retroactively; HCBC-ECI service providers cannot. We found the DHHS does not fully practice or completely comply with federal mandates regarding time standards for the entire eligibility process and the financial eligibility look-back period. Further, the Department has not adequately explained Medicaid LTC presumptive eligibility.

Figure 2 presents the overall Medicaid eligibility determination process for the LTC program administered by the Bureau of Elderly and Adult Services (BEAS). This process requires determination of both medical eligibility by the BEAS and financial eligibility by the Division of Family Assistance (DFA). Figure 2 shows procedures for medical and financial eligibility are somewhat independent of one another and designed to run concurrently. In addition, the figure identifies the different entities and information systems involved in the eligibility determination process.

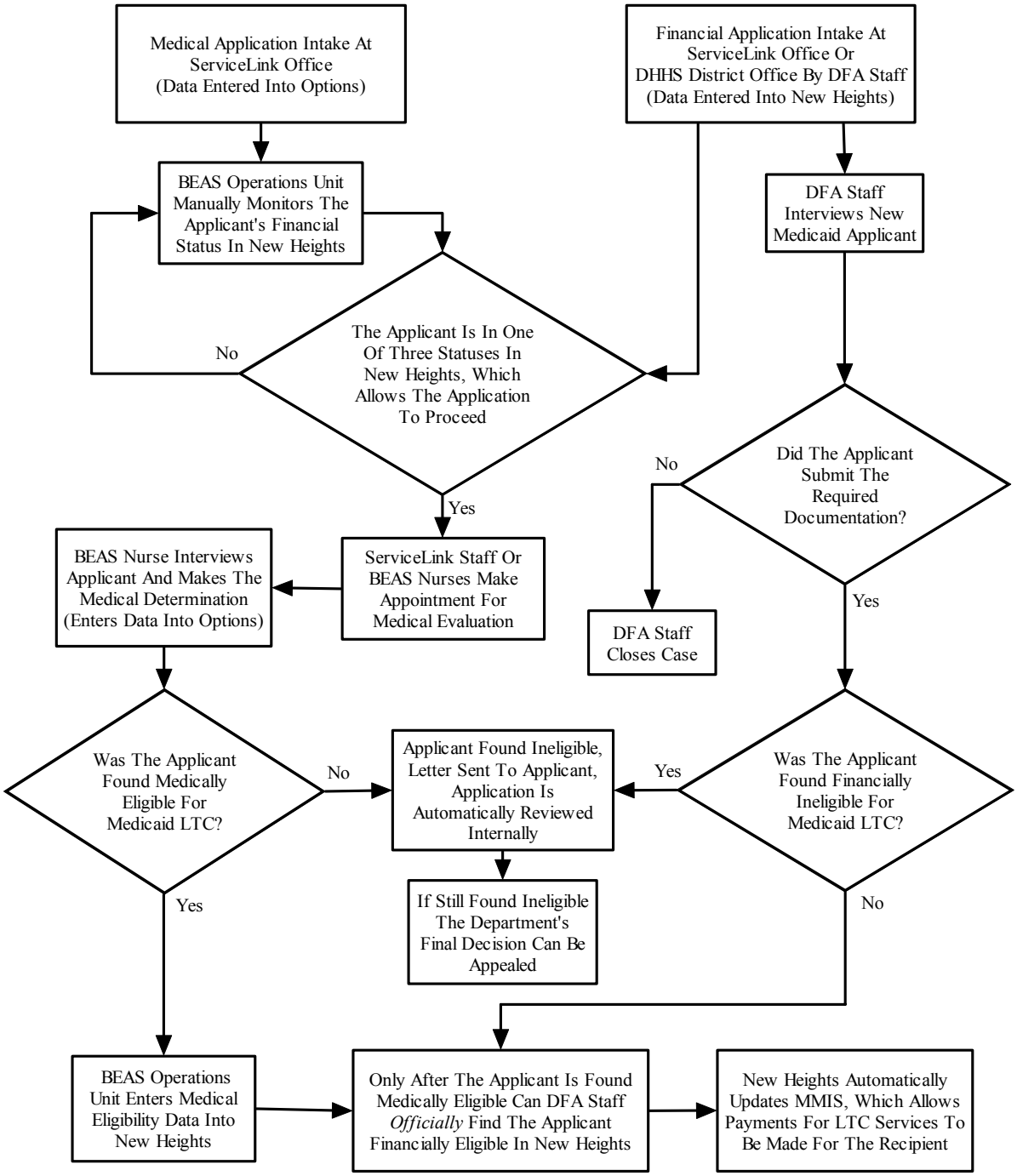
Time Standards

Sections 1902(a)(8) and 1902(a)(19) of the Social Security Act and the federal Medicaid regulation 42 CFR 435.911 require states to establish time standards for determining financial eligibility of Medicaid applicants. The time standards are not to exceed 90 days for applications on the basis of disability and 45 days for all other applicants. A state must determine Medicaid eligibility within its established time frames except in unusual circumstances outside of the state's control. The DHHS has established the maximum allowable time standards (i.e., 90 days for disability determinations and 45 days for all others) for determining applicants' financial eligibility. Because the DFA does not find applicants financially eligible until the BEAS determines them to be medically eligible, the Department has subjected its medical eligibility to the federal time standards.

Figure 2

BEAS Administered LTC Eligibility Process

Financial And Medical Applications Can Be Submitted Independent Of One Another



Source: LBA analysis of interviews and BEAS and DFA documentation.

File Review

The BEAS provided Options data consisting of 4,521 applications from 3,852 applicants received by the Department in SFY 2008. We selected a random sample of 157 applicants and reviewed their medical and financial case files and New Heights and Options records. We evaluated the Department's processing of applications for timeliness, data accuracy, and compliance with law, administrative rule, policy, and procedure.

We measured timeliness by following the application through fundamental steps in both the financial and medical LTC Medicaid eligibility process when possible. In the sample, 118 applicants were found eligible for LTC Medicaid, six were denied financially, seven were denied medically, and 26 withdrew from the process. Table 2 presents our sample of new and existing Medicaid applicants, whether an eligibility determination was made by the DHHS, or if the application was incomplete. Table 2 also separates applicants seeking Aid to the Permanently and Totally Disabled (APTD), which fall under the 90-day time standard, from all other applicants (non-APTD) under the 45-day time standard. Table 3 separates the numbers of sample applicants applying for HCBC-ECI from nursing facility services.

Table 2

Application Categories

	New Medicaid Applicants	Existing Medicaid Applicants	Total
Determination Made By DHHS			
APTD	11	32	43
Non-APTD	54	34	88
Sub Total	65	66	131
Incomplete LTC Medicaid Application			
APTD	2	4	6
Non-APTD	7	13	20
Sub Total	9	17	26
Totals	74	83	157

Source: LBA analysis.

Table 3

HCBC-ECI And Nursing Facility Applicants

	New Medicaid Applicants	Existing Medicaid Clients	Total
HCBC-ECI	22	48	70
Nursing Facility	52	35	87
Total	74	83	157

Source: LBA analysis.

According to DHHS staff, applicant situations differ and the amount of data collected for each varies; therefore, we examined different subsets of the sample for the various segments of the Medicaid LTC eligibility process. For example, we could only track new applicants through the entire Medicaid LTC eligibility process; existing Medicaid recipients could not be completely tracked because a new financial application is not required and consequently does not have a financial start date. For our review of the DHHS's compliance with federal time standards, we identified the subset of applications with the most complete set of dates. Table 4 presents new and existing Medicaid applicants and their status.

Table 4

Applicant Status

	New Medicaid Applicants	Existing Medicaid Applicants	Total
APTD	13	36	49
Non-APTD	61	47	108
Total	74	83	157

Source: LBA analysis.

Applicants with the most complete data set are the 61 new applicants in Table 4 who applied for both medical and financial eligibility and are non-APTD. The Department was able to make a determination of eligibility for 54 of these 61 applicants. Our analysis of these 54 applicants[3] found 48 (89 percent) were determined eligible for LTC services (either HCBC-ECI or nursing facility) and 6 (11 percent) were found ineligible.

[3] New Medicaid applicants, not applying for APTD, with a DHHS eligibility determination.

Time Comparison

The amount of time it takes some applicants to navigate the Medicaid LTC eligibility process may be greater than the official processing time. We selected the subset of 48 new applicants (not applying on the basis of disability) approved for Medicaid LTC from our sample of 157 and analyzed elapsed time from the date the first application (financial or medical) was submitted to either ServiceLink or a district office until financial determination was made. We chose this sub-sample of 48 because the applicants were new to the Medicaid system; therefore, the applicants had to complete both medical and financial applications and be processed for eligibility by both the BEAS and the DFA.

Our analysis found it takes on average 71 days (median 61) to complete the Medicaid LTC eligibility process when calculated from the receipt of the first application until financial determination. Using the same 48 applications, the DHHS time standard tracked by DFA resulted in an average of 55 days (median 47) to complete the financial eligibility process. Both analyses resulted in the average time from application received until determination taking longer than the 45 days mandated by federal regulation. Although these statistics reflect negatively on the DHHS, the Department is not always responsible for delays in the eligibility process. Several things may delay the Medicaid LTC eligibility process beyond the Department's control. Some of these include waiting for the applicant or the applicant's representative with power of attorney to produce needed paperwork, a power of attorney signature, the applicant to schedule an interview, or medical records necessary for determining eligibility.

Timeliness Of Medical Determinations

While the BEAS has not operated within the federal time standards, its management information system, Options, collects the dates of several steps within the medical eligibility process. To review the timeliness of the medical determination process, we selected a subset of 105 applicants from our sample of 157. These were new applicants or existing Medicaid recipients, not newly applying for APTD, and approved for Medicaid LTC. Table 5 presents the median and mean number of days for key steps in the process. Table 6 shows the time BEAS took to approve 105 applicants for medical eligibility.

Presumptive Eligibility

In January 2008, RSA 151-E:18 went into effect requiring the DHHS Commissioner to establish a presumptive eligibility program to prevent unnecessary and costly institutionalization of Medicaid LTC-eligible applicants. The goal of this program is to allow Medicaid LTC-eligible applicants the option to choose home and community-based care in place of costlier institutional care. In May 2008, the Department implemented presumptive eligibility rules; however, only one applicant successfully used this new procedure in 2008, which was intended to speed up the determination process of likely Medicaid recipients.

Table 5

Number Of Days For Medical Eligibility

Description Of Time Lapse	Mean Day Count	Median Day Count	Description Of Day Count
Time for ServiceLink to enter application.	4	1	Application Received to Intake Date
Time to receive all application information and establish financial status.	8	4	Application Received to Application Accepted Date
Time to set and complete a face-to-face nurse's visit.	27	19	Application Accepted Date to Nurse Visit
Time for nurse and BEAS operations to collect paperwork and enter relevant information.	13	8	Nurse Visit to New Heights Entry
Complete Medical Determination Process	48	36	Application Received to New Heights Entry

Note: This analysis includes the 105 applications from our sample determined to be eligible and not applying for APTD.
Source: LBA analysis.

Table 6

Timeliness Of Medical Eligibility Approvals

Time Period	Number Of Applications	Cumulative Percent
Less than 16 days	8	8
16 – 30 days	35	41
31 – 45 days	28	68
46 – 60 days	12	79
61 – 75 days	7	86
76 – 90 days	1	87
Over 90 days	14	100
Total	105	
	Days	
Mean	48	
Low	6	
High	187	

Note: This analysis includes the 105 applications from our sample determined to be eligible and not applying for APTD.
Source: LBA analysis.

Observation No. 1

Revise The Application Intake Process For Medicaid LTC Applicants

The LTC eligibility determination process allows medical and financial applications to be submitted separately to the BEAS and the DFA, respectively. This may result in uncertainty regarding responsibility for delays. The DFA and the BEAS require separate applications to initiate their respective reviews; this bifurcated process does not guarantee the applicant files all required materials for both applications. Additionally, existing Medicaid clients applying for LTC services are not required to submit a new financial application, making it difficult for the Department to track the timeliness of financial eligibility determinations.

The DFA only has standards for measuring the time taken to process *new* Medicaid applications; no standards exist for *current* Medicaid recipients applying for LTC services. Federal regulation 42 CFR 435.911 requires states to establish eligibility determination time standards for new Medicaid applicants. According to a Centers for Medicare and Medicaid Services official, states

should also consider applying these time standards to existing Medicaid recipients applying for LTC services. Without establishing a time standard and a method to monitor the progression of existing Medicaid applicants through the LTC eligibility process, the Department cannot adequately measure and manage this function to ensure it is meeting the needs of all LTC applicants in a timely manner.

According to a DFA official, when an established Medicaid recipient applies for LTC services a second, more extensive, review of the applicant's financial background is supposed to be conducted. However, there is no clear way to track the second review and there are instances when no second review takes place. This may occur under the three following conditions:

- the applicant has already been approved for some form of Medicaid, but not specifically LTC Medicaid,
- the DFA does not receive a *new* application for LTC services or notification by ServiceLink the client is applying for LTC services, and
- the applicant has been determined medically eligible by the BEAS.

When these criteria are met, the applicant will erroneously be determined eligible for LTC by the DFA's management information system. After the applicant's information "crosses over" to a payment system,[4] the DHHS typically becomes aware of the situation because providers will bill the State's Medicaid program, and payment will not be processed because billing codes differ.

A DFA district office supervisor reported the medical eligibility process will complete, without notification of a need for financial eligibility determination, once or twice a month. The supervisor reported additional disconnects within the LTC eligibility system include DFA Family Service Specialists (FSS) not being notified when a client applies for Medicaid LTC, or been admitted to a nursing home.

Assistance from the DHHS or a ServiceLink is not necessary to complete either the financial application (Form 800) or the two-page medical application; and a single process for both the medical and financial applications could be utilized. Some ServiceLink locations have clients complete the Form 800 and mail it to the district office; while district offices will assist ServiceLink with the medical application by collecting this form and mailing or faxing it to ServiceLink. According to a DFA official and staff at two ServiceLink locations, a single application would be easier for clients; better understanding of the process may result if it began simultaneously. According to ServiceLink staff a single application would also simplify the process.

Neither ServiceLink nor the DHHS has an applicant tracking system measuring the time it takes for potential applicants to arrange an initial meeting at either a ServiceLink or a district office. If an individual is ready to apply for Medicaid LTC services, the DHHS should monitor how long it takes potential applicants to file the appropriate applications in order to officially start the 45-

[4] Crossover occurs when information from DFA's New Heights computer system is automatically entered into the Medicaid Management Information System, at which point the applicant is approved to begin receiving services.

or 90-day time period. The federal time standard begins with the signed financial application, not when the individual starts the process by calling or walking into the office. If it takes multiple weeks to schedule an appointment, this delay could be interpreted as the DHHS not meeting the spirit of the time standard.

Recommendations:

We recommend the DHHS revise its information collection process for determining HCBC-ECI medical and financial eligibility by:

- **evaluating use of a single application process for both the medical and financial applications,**
- **using the same starting date for medical and financial eligibility determination processes,**
- **ensuring application reviews start only after all the initial financial and medical information has been properly submitted to either a district office or a ServiceLink location,**
- **informing applicants time standards begin upon submission of signed applications accompanied by all required materials for both financial and medical reviews, and**
- **ensuring existing Medicaid applicants are tracked through the LTC determination process as well as how long it takes LTC applicants to schedule an initial meeting to start the application process.**

Auditee Response:

We concur.

The Department of Health and Human Services (DHHS), as a part of an effort to reexamine eligibility practices department wide, is in the process of reviewing the LTC eligibility application process. The Department expects to identify where intersects exist within the financial and medical eligibility and modify those intersects to impact on the amount of time it takes for applications to be processed. The Division of Family Assistance (DFA) has already begun to streamline the financial eligibility via the Front Door ACCESS project. The Front Door ACCESS project enabled District Offices to pre-schedule appointments, thus minimizing delay and wait time for persons applying for services. Under serious consideration as a part of the Commissioner's restructuring plan, is the creation of a centralized LTC Unit where a single application is submitted in any one of a number of ways, i.e. in person, the web, from residential care facilities, from LTC units and or ServiceLink Offices. Both the financial and medical eligibility staff would be centrally located, available as consultants to one another and applicants applying for LTC services. Applicants could be interviewed from a central location, the district office or ServiceLink during scheduled appointment times. Centralization would streamline a complex process significantly and reduce the difficulty applicants and families face. It would allow DFA to work collaboratively with the Bureau of Elderly and Adult Services (BEAS) to ensure that the medical and financial determinations run concurrently as one process resulting in a significant reduction to the existing time frame.

A concern that presents significant logistical issues for the Department, is the fact that the New Heights and Options information systems are not integrated systems and as such do not communicate with each other making it difficult to determine a current status of either the financial or medical eligibilities. DFA will approach the New Heights Team to eliminate the cross over for individuals who have been approved medically but a new financial determination has not been entered into the Medicaid Management Information System (MMIS). Through a system change the medical determination will be entered in New Heights and appear on the dashboard of the Family Service Specialist (FSS). The FSS will be advised of the medical determination and schedule the client for a financial determination. The Department expects to accomplish a reduction in process time frames by implementing quality improvement strategies utilizing LEAN process improvement techniques. LEAN process improvement techniques are process improvement strategies used in leading companies nationally to streamline and improve business processes. LEAN process improvement is based on the idea of optimizing time, human resources, assets and productivity to improve organizational performance.

Observation No. 2

Establish State Time Standards For Entire LTC Determination Process

The DHHS is not meeting federally established time standards for Medicaid LTC eligibility determinations, nor is it likely to meet these standards with its bifurcated process. Sections 1902(a)(8) and 1902(a)(19) of the Social Security Act and the federal Medicaid regulation 42 CFR 435.911 require states establish time standards for determining financial eligibility of Medicaid applicants. The time standards are not to exceed 90 days for applications on the basis of disability and 45 days for all other applicants. A state must determine Medicaid eligibility within its established time frames except in unusual circumstances outside the state's control. The DHHS should be processing LTC Medicaid applications within these federal time standards.

At least two DHHS units determine LTC Medicaid eligibility, the DFA for financial eligibility, and the BEAS for medical eligibility. We found the DFA monitors the time it takes to process all Medicaid financial applications against the 45 calendar day federal standard using New Heights, the Division's management information system. In addition, DFA applicants are informed eligibility should be determined within the appropriate time frame if all information is submitted timely. Although only the financial half of the process has been working under a time standard, both the financial and medical determinations are needed to find a Medicaid applicant eligible for LTC.

We reviewed a sample of 157 LTC Medicaid applications and identified 116 the BEAS found medically eligible.[5] Of these, we determined 21 (18 percent) were over the 45-day time standard solely for medical determination. Medical determination was calculated from the date the two-page medical application was received by a ServiceLink location, until the BEAS entered the medical determination into the New Heights system. When the BEAS takes longer than 45 days to make a determination of medical eligibility, it guarantees the DFA will also not meet the

[5] This number does not include 13 LTC applications applying through the APTD program and its 90-day time standard.

federally required 45-day standard. Moreover, we reviewed 38 late DFA financial determinations and identified 11 financial applications were waiting on the BEAS to make a medical determination, causing the DFA to exceed the 45 days. In the 27 other cases it was not clear if the DFA was waiting for the BEAS or if the DFA was also late in making a determination.

When making an eligibility determination for LTC Medicaid applications on the basis of disability,[6] federal regulation implies the 90 days should include the time it takes the Disability Determination Unit (DDU), as well as the DFA and the BEAS, to make their determinations. Similar to the 45-day requirement, the 90 days is for the whole process. The DDU has its own process for determining eligibility for Medicaid applications on the basis of disability. In the DDU's interpretation, the 90 days only covers the time the Unit has to make its disability determination and does not include the time it takes for the DFA and the BEAS to make their eligibility determinations. However, a DDU official stated the Unit expedites APTD applications seeking LTC services, which was evident, to some extent, from our file review. Our analysis of 12 new LTC APTD applications found the DDU made their determination within a week for five cases (42 percent), five more were processed within 64 days (42 percent), and the remaining two were over the 90-day time standard.

By not working under established time standards for the entire process when determining eligibility, the process is protracted, inhibiting eligible Medicaid applicants from receiving needed LTC services in a timely manner. According to the federal regulation, it is the State's duty to provide all individuals wishing to apply for medical assistance the opportunity to do so and deliver punctual assistance to eligible individuals.

Recommendations:

We recommend the DHHS improve its medical and financial eligibility processes by:

- **establishing State time standards for the entire LTC Medicaid eligibility process;**
- **determining the required interactions and communication needed between the DFA, the BEAS, and other entities involved in the process;**
- **establishing goals and performance measurements for key steps in the process;**
- **creating methods to accurately track applications to ensure time standards are met, and;**
- **reviewing DFA and BEAS time standard performance on an ongoing basis.**

Auditee Response:

We concur.

BEAS is responsible for determining medical eligibility for LTC services provided in a nursing facility or for services offered as an alternative to nursing facility placement as described in 42CFR 441.302 (c) (1) and section 1919 (a) of the Social Security Act and DFA is responsible for determining financial eligibility. BEAS has interpreted that Centers for Medicaid and

[6] Applicants are applying for the APTD Medicaid program.

Medicare Services (CMS) does not recommend specific time frames for determining medical eligibility for nursing facility care or waiver services.

BEAS has to date determined the time frame calculation to begin when an applicant has an active, pending or open financial status as specified in the New Heights system, not when the application is input at Service Link Resource Centers. Those individuals waiting to become financially eligible for Medicaid are not distinguished from all applicants for medical eligibility. The Department is in the process of measuring both the medical and financial processes utilizing LEAN process improvement techniques and expects to accomplish a significant reduction in process time frames.

DHHS will establish time standards that are reflective of internal process improvements and consistent with CMS established rules that apply to financial and medical determination processes.

Observation No. 3

Revise Current Practice To Comply With Federal Rules Regarding Medicaid Eligibility Determination

The DFA does not fully meet federal regulations for time standards, documenting reasons for delay in an applicant's case record, or providing notice of the agency's decision to all applicants for Medicaid LTC eligibility determinations.

- 42 CFR 435.911(b) requires the time standards cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

- 42 CFR 435.911(d) requires the agency document the reasons for delay in the applicant's case record.

- 42 CFR 435.912 requires the agency send each applicant a written notice of the agency's decision on the application, and if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of the applicant's right to request a hearing.

The DFA attempts to monitor the financial Medicaid determination process from when the application is received until a financial determination is made. However, federal regulation requires the eligibility process conclude when the notice of decision is sent to the applicant, not on the financial determination date. According to a DFA official, there is no actual procedure in place for the DFA to track applicants through the financial determination process. Moreover, if the DFA does not meet the time standard deadlines, there are no Department, State, or federal penalties in place.

Federal regulation requires the agency document in the applicant's case record reasons for delay in Medicaid eligibility determination. Our review of 157 Medicaid applicant files, including the

DFA's New Heights computer system records, found inconsistent documentation regarding case proceedings. Our file review and conversations with DFA staff found no formal policy or procedure guiding staff on properly documenting reasons for delays in processing the financial eligibility determination to comply with 42 CFR 435.911(d). Documentation, if any, was hand written in different places within the paper file or kept in the comments section of New Heights. Requiring DFA staff to formally document any delay in an applicant's financial eligibility determination could provide an explanation or demonstrate why a case may be outside of the allowable time standard. This would be especially helpful to the DFA to clearly and consistently document when the time standard is not met due to circumstances outside the DFA's control.

Specific to LTC Medicaid financial determinations, the DFA only sends a Notice of Decision to HCBC-ECI applicants. Federal regulation requires notification of decision be delivered to all applicants. According to a DFA official, applicants in a nursing facility applying for LTC Medicaid eligibility for the nursing home do not receive a decision of financial determination from the DFA. The nursing facility is notified by the Department's payment system, called the Medicaid Management Information System, payment claims may now be processed.

The DFA would benefit from standard operating procedures and a review system, to improve compliance with federal regulations.

Recommendations:

We recommend the DFA improve its Medicaid eligibility determination processes by:

- **creating the means of accurately tracking applications to ensure appropriate time standards are met;**
- **developing standard policies and procedures for all DFA staff, documenting reasons for delay in an applicant's Medicaid eligibility determination; and**
- **providing a Notice of Decision to all LTC applicants after a determination has been made.**

Auditee Response:

We concur.

New applications for financial Medicaid eligibility determination are tracked for timeliness in New Heights without difficulty. The applications that currently present difficulty monitoring in New Heights are from persons who are already Medicaid enrollees and who apply for services under LTC nursing facility or HCBC-ECI. Those applications are not reflected as a new Medicaid application and therefore the date the applicant applied for financial eligibility for LTC is not entered into New Heights.

The applicant's original Medicaid application date remains constant in New Heights and is not changed as a result of the program an individual may apply for. As a result, if an individual is currently open for Medicaid and applied for services under LTC nursing facility or HCBC-ECI a new Medicaid application date is not entered into New Heights.

DFA does not issue a notice of decision to Medicaid applicants until the financial determination is completed and the MED is completed for services through the LTC or HCBC-ECI program because of the difference in income limits. The income limit for Medicaid is $591 for a household size of one (1), but for services through LTC and HCBC-ECI waiver the income limit is $2,011 or in the case of LTC it is compared to the rate the state reimburses the nursing facility. Issuing a notice of decision for Medicaid when the services have not yet been approved would create confusion on the part of the applicant. In most cases, the applicant would be determined eligible for Medicaid In and Out and have a spend down or deductible, which would be confusing to the recipient.

The Standard Operating Procedure will be updated to ensure that the FSS document the following in case comments:

- *The date the financial eligibility determination begins.*
- *After the interview, the FSS will contact the nursing facility to ensure the MED has been completed and forwarded to BEAS.*
- *Once the financial review is completed, if the medical decision has not been entered into New Heights, another contact will be made with the nursing facility.*
- *At the interview for HCBC-ECI, the FSS will complete the MED and have the client or authorized representative sign the form. The MED will be faxed to ServiceLink at the end of the interview.*
- *Once the financial review is completed, a contact will be initiated by the FSS to ServiceLink if the medical decision has not been entered into New Heights.*
- *All delays will be noted clearly in case comments.*
- *Bi-monthly randomized sampling of records will be conducted to assure the process is in compliance with specific time frames.*

Observation No. 4

Comply With Federal Law Regarding Look-Back Period For Financial Eligibility Determinations

According to interviews with two DFA officials, Family Services Specialists (FSS) obtain financial information from LTC applicants looking back one year prior to the date of the Medicaid application. The FSS may choose to collect additional years if any anomalies or anything curious is identified during the eligibility determination process. Department policy during SFY 2008 required a 36-month look-back period for all assets except for trusts, which required 60 months. DFA employees reported utilizing either intuitive suspicions from scripted interview techniques or suspicious activity within the financial statements to determine whether the full look-back period was needed.

When a client applying for LTC is already a Medicaid recipient, the DFA might not request any additional paperwork or require an interview, even though LTC Medicaid has different eligibility requirements. A DFA official noted applicants on food stamps or cash assistance require no other financial review. If applicants are just receiving Medicaid, then all finances need to be re-verified

including bank statements, trusts, transfers and any other required materials. Additionally, this official acknowledged these cases are handled inconsistently by district offices.

Changes in federal law increase the look-back period from 36 to 60 months. According to the DFA Adult Assistance Manual and the DHHS Supervisory Release 08-17, all transfers of assets occurring on or after February 8, 2006 are subject to a 60-month look-back period. This is based on changes required by the Deficit Reduction Act of 2005. The phase-in required a three-year look back from February 8, 2006 until February 8, 2009 and the addition of one month of required look-back for each month thereafter until the full five-year look-back requirement is attained in February 2011.

BEAS and DFA employees, ServiceLink personnel, and stakeholders reported the financial eligibility process was overwhelming for applicants under current requirements and look-back periods. Additionally, one stakeholder reported extensive paperwork required for the financial eligibility process, such as obtaining past bank statements, may be costly for the applicant.

We did not conduct a detailed review of the DFA financial eligibility determination procedures. However, interviews with DFA personnel identified a regular practice of obtaining only one year of financial information. This does not comply with previous federal requirements for a three-year look back for asset transfers, nor does it comply with the current phase-in approach requiring 60 months by February 2011. Without utilizing federally required look-backs to examine financial history, the State Medicaid system may be offering Medicaid services to applicants who would not otherwise be eligible.

Recommendation:

We recommend the DFA review its implementation of the look-back requirements and use those required under federal regulation.

Auditee Response:

We concur.

As stated, the Standard Operating Procedure within DFA is to require 12 months of financial verification unless a transfer of assets occurred on or after February 8, 2006 or a trust was created in the preceding 60 months. The Division reserves the right to request additional financial verification up until the client is opened for Medicaid under LTC or HCBC-ECI.

The FSS is required to check for a transfer of assets in the form of real property via, NH Deeds.com and through Accurint (a nationwide search engine) for property owned or transferred by an applicant. A property transfer would result in additional financial verification being requested.

Recent changes in federal regulations, 42 USC1396 w, requires that states submit a plan to access verification of information held by financial institutions. This regulation will require that

applicants for or recipients of medical assistance under the state plan authorize access to financial information. The Division is working on this change and plans to have a policy in place in 2010/11. This is will enhance our ability to comply with the federal regulation around the look back period.

Observation No. 5

Improve Presumptive Eligibility Process

Effective January 1, 2008 the BEAS adopted the presumptive eligibility (PE) determination program, required by RSA 151-E:18, for applicants expected to be eligible for HCBC-ECI services. According to Division of Family Assistance (DFA) personnel, the PE program encourages faster determinations for those likely eligible for home and community-based waiver services. BEAS and DFA employees reported only one application for presumptive eligibility during 2008.

PE applicants will have access to HCBC-ECI services sooner than those not eligible for PE. Administrative Rule He-W 619.01(b) defines PE as a "period of medical coverage, excluding home or environmental modification coverage, extended to qualifying individuals pending the final processing of a Title XIX Medicaid application."

According to RSA 151-E:18, III and Administrative Rule He-W 619.04 (c) and (d), the presumptive eligibility determination period can last no more than 25 business days, compared to 45 calendar days for non-presumptive eligibility cases. To apply for PE determination, the applicant must first meet with a DFA-trained worker employed by a "community partner," such as a hospital, nursing facility, or a ServiceLink office. According to a DFA official, there are currently 16 trained community partners, but they do not cover the entire State geographically.

Paperwork from the first meeting with the community partner is sent to the local ServiceLink office. "Day 1" of the PE period begins with ServiceLink accepting the PE application. The DFA and the BEAS are informed of the application by email. ServiceLink has ten days to collect documentation from the applicant verifying financial information provided to the community partner. ServiceLink also faxes the paperwork to a DFA Family Service Specialist, who makes the final financial determination. The BEAS central office assigns a nurse to complete a face-to-face clinical assessment; this must occur within 20 business days of the initial meeting. The review for financial eligibility may occur before or after the clinical assessment, but no more than five business days after. According to BEAS personnel, services may only be provided after the face-to-face clinical assessment and a review of a completed Medicaid application.

Administrative Rule He-W 619.02 requires certain additional criteria from the process described above, including whether an applicant for PE determination:

- is likely to be at risk of institutionalization without HCBC-ECI services;
- is likely to be Medicaid eligible;
- has not previously applied for or received PE coverage in the previous 12 months;

- acknowledges if the application is denied for any reason, the applicant shall be responsible for the cost of services rendered after a determination of ineligibility, and during the PE period if the DHHS finds the application was filed with fraudulent intent.

Additionally, according to federal law, applicants are not eligible if they have transferred assets in the past 60 months, created a trust within the past 60 months, or purchased an annuity.

We found several potential reasons for the underutilization of the PE program.

- According to a DFA official, presumptive eligibility is not explained to applicants who walk into a DHHS district office to apply for Medicaid. This contradicts RSA 151-E:18, II, which states PE shall be made available at DHHS district offices.
- Four of the 18 (22 percent) stakeholders and front-line employees we interviewed who are familiar with the State's LTC Medicaid system had not heard of presumptive eligibility until we brought it to their attention.
- Certain BEAS personnel and stakeholders inaccurately understand certain financial provisions in the PE law. RSA 151-E:18, VI requires the applicant reimburse the DHHS for funds expended on the applicants behalf if the Department finds the application was "filed with fraudulent intent." All PE applicants sign a form acknowledging this. However, personnel at three ServiceLink offices we interviewed held the inaccurate impression clients must reimburse the State if found ineligible, even if no fraud is involved.
- Certain community partners, stakeholders, and providers do not want to deal with the PE process. There is no extra money for community partners to expedite the necessary work for PE.
- Employees of two of the five ServiceLink offices we interviewed said they either had limited knowledge of PE or were not comfortable doing the pre-screening for financial eligibility.
- The 25 business days allowed in statute under the PE program is the equivalent of as many as 35 calendar days, which is just 10 days less than the 45 calendar days provided under the normal eligibility process.

In our sample of 157 LTC Medicaid applications, the DHHS made a final determination in 131 cases. Of the 131 applicants, 118 (90 percent) were determined eligible for LTC services. With a relatively high acceptance rate, it is likely other Medicaid applicants for long-term care could benefit from PE, through receiving HCBC-ECI services sooner.

Recommendations:

We recommend the DHHS better inform and train its employees, stakeholders, and community partners about the presumptive eligibility process. In addition, the Department should report on PE program use and its success in reducing eligibility determination times.

Auditee Response:

We concur.

The history of the development of RSA 151-E: 18 is noted in this response and is offered to enhance one's understanding of the timeframe involved when preparing for presumptive eligibility (PE). Both HB 723 and HB 893-FN were introduced to the House on 1/31/07. HB 723 was initially introduced as an act extending the moratorium on nursing home beds. There was no fiscal impact associated with the bill as the moratorium has been in place since the mid-nineties. It passed the House without an amendment and crossed over to the Senate. HB 893-FN related to LTC and introduced PE. The Department provided information on how the bill would impact the budget and operations. The House Finance committee voted to retain the bill on April 4, 2007. HB 723 went to the Senate Health and Human Services committee in May of 2007 and the bill was amended to include all of HB 893-FN. HB 723 passed containing all of the changes contain in HB 893-FN without analysis from the Department. RSA 151-E:18 became effective on January 1, 2008.

DFA immediately began drafting administrative rules, (He-W 619), in response to RSA 151-E:18 that met the approval of Joint Legislative Committee on Administrative Rules and became effective on May 10, 2008. Policies were drafted, training materials created, and trainings scheduled internally and externally as follows:

July 2, 2008:	*Qualified providers in two counties (Monadnock and Merrimack) to ensure that appropriate and sound practices were in place prior to statewide rollout of the process.*
June 2008:	*State Office staff responsible for processing applications refresher.*
December 4, 2008:	*Statewide DFA staff trained.*
December 5, 2008:	*Statewide rollout of PE process; training for all Service Link Resource Center staff.*
March 2009:	*Tracking system developed by BEAS to provide information on the process, its effectiveness, feedback from providers and the numbers of applicants.*
May 5, 2009:	*Adult Protective Services supervisors trained.*

As eligibility standards for LTC services are higher than general Medicaid and have not been waived by CMS the Department is committed to including a review of the PE process as it reviews other eligibility processes linked to LTC in an effort to streamline wherever possible. Included in the review of the PE process will be providers who work with stakeholders that have had experience with the PE process.

Additionally the Department concurs further training will improve utilization of the PE process. All trainings will include competency testing to ensure those being trained demonstrate comprehension. Upon completion of the Departments review of the PE process, a quality indicator will be developed by DFA and BEAS jointly to institutionalize on-going monitoring and continuous improvement.

LONG-TERM CARE SERVICE PROVIDERS

While statutes and Administrative Rules exist in the State for determining and setting Medicaid rates, these rates have been inconsistently set for the long-term care (LTC) system administered by the BEAS. As such, it is unclear if provider rates are sufficient to maintain an adequate provider pool to meet the needs of LTC recipients in all LTC settings. Additionally, further guidance is required pertaining to the appropriate use and functionality of personal care services.

Survey Of Case Managers

A successful LTC system depends on the availability and provision of services. The LTC system administered by the BEAS relies on a variety of services including nursing facilities, home health, and mid-level care. We conducted a survey of case managers to assess the availability of home health and mid-level care services available throughout the State. We sent 77 surveys to case managers at five case management agencies and received 46 responses for a 60 percent response rate. The survey identified some variation in provider availability in different regions of the State. There are shortages of residential and respite care statewide. Additional information included:

- Many LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI recipient, particularly for home health aides and homemaker services, according to 66 percent and 49 percent of respondents, respectively.
- Respondents indicated many providers, with the exception of those providing home delivered meals, have refused to accept HCBC-ECI recipients, particularly for adult day care (43 percent of respondents) and home health aid services (41 percent of respondents).
- Respondents reported agencies believe reimbursement rates are too low and some agencies are limiting HCBC-ECI clients due to low reimbursement rates.
- Lack of transportation was cited as a major issue. Securing transportation for clients is difficult and some clients must cancel medical appointments due to lack of available transportation.
- Respondents identified often using personal care service providers (PCSP) because PCSPs provide personal care, as well as transportation, and are a cost savings to the State. In addition, clients often prefer their caregiver to be someone with whom they are acquainted. Respondents also identified a need for more guidelines pertaining to PCSPs.
- Respondents identified difficulties for clients to find funds for dental work and dentures.

Appendix B provides the full results from this survey, reporting by county as well as a statewide summary.

Observation No. 6

Evaluate Statewide Availability Of LTC Providers

Interviews with BEAS personnel, case management agencies, and other stakeholders noted the availability of LTC services vary by geographic region. Four of the five case management agencies in the State reported services or providers were lacking in the North Country. Additionally, three of five case management agencies reported providers require minimum blocks of time or refuse to serve Medicaid clients. Three of five BEAS nurses reported lack of support services such as transportation, services varied in different communities, and insufficient numbers of service providers. Both case management agencies and BEAS nurses reported using personal care service providers to fill needed service or provider voids.

We surveyed case managers from the five case management agencies to assess the variation in services and provider availability throughout the State. The survey gathered information by the State's 10 counties and we analyzed the statewide and regional results[7] (see Appendix B for the raw survey results). The survey results supported interview information. When the results are separated by region, the availability of services varies across the State. Ninety-five percent of survey respondents identified adult day care as readily available or available in the South and Seacoast regions; while only 44 percent reported the same availability in the North Country. Eighty-nine percent of respondents identified homemakers services as readily available or available in the South and Seacoast region, but only 68 and 64 percent for the North Country and the West respectively. Statewide, residential care was reported not readily available by 47 percent of respondents, and respite care was identified as not available at all by 52 percent.

Many LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client, particularly for home health aides and homemaker services, according to 66 percent and 49 percent of total respondents, respectively. This was identified as an issue across the State with the South and Seacoast region most often identifying this practice. Providers refusing to take HCBC-ECI clients due to low reimbursement rates was also identified as a statewide issue with the most significant results noted in the North Country, and the South and Seacoast region. Respondents indicated many providers have refused to accept HCBC-ECI clients, with particular effect on adult day care (43 percent of respondents) and home health aide services (41 percent of respondents).

Survey respondents also identified issues such as:

- difficulties staffing on weekends and evenings statewide,
- lack of transportation, and
- multiple providers necessary to meet a single client's needs affecting continuity of care.

[7] Based on similarities in geographic regions and interview feedback, we grouped the counties under the following names: North Country (Belknap, Carroll, Coos, Grafton), South and Seacoast region (Strafford, Hillsborough, Merrimack, Rockingham) and the West (Cheshire, Sullivan).

According to RSA 151-E:16, cost estimates and provider reimbursement rates for the State's LTC system should ensure "a provider workforce that is sufficient to fully meet the needs of eligible consumers" in all settings including home and community-based, mid-level, and nursing facility care. States can waive statewide, comparability, and income and resource requirements but must identify this in the 1915(c) waiver application. The BEAS did not waive the statewide requirement for the program. However, the BEAS *Consent to Level of Care Determination/Support Plan*, requiring sign off from all HCBC-ECI applicants, specifies the support plan is based on provider availability and notes the "program does not guarantee availability of service providers."

From interviews, it appears disparate provider and service availability across the State stems from several potential causes. First, the State has no methodology establishing provider rates and has not ensured the current Medicaid provider rates will attract the level of providers necessary to sustain the system (see Observation No. 7). Additionally, the rural nature of the northern part of the State and the wide disparity of income levels from the North to the South creates complexities for ensuring the needed provider pool. The rural nature of the North Country, no compensation for mileage or drive time, and a smaller population limit incentives for providers to expand to this region. Separately, the relative affluence of the South and Seacoast, as well as the West, regions of the State may encourage providers to refuse Medicaid clients where the rates may be low compared to higher compensation expectations.

Limited numbers of providers reduce the services available to clients. This may mean the option to remain at home rather than being institutionalized is not available.

Recommendations:

We recommend the BEAS evaluate access to and availability of services and service providers across the State and identify how to meet the needs of all applicants in different regions of the State.

Auditee Response:

We concur.

BEAS has taken several steps to gather information about service and provider availability during the 2008 calendar year:

- *Listening sessions throughout the state were advertised for the public and for providers;*
- *Participant Experience Surveys were conducted with 288 participants to determine their level of satisfaction with the eligibility process and community based care; the sample was a statistically valid sample drawn from the state-wide record of participants;*
- *A LTC workforce development workgroup was formed with providers to discuss the issues they are having attracting and retaining adequate direct care staff; and*

- *Involvement with the Governor's Commission to Study Incentives for Providers of Home and Community-Based Care Services SB 496, Chapter 226, Laws of 2008.*

At the Department level, the Commissioner has formed a Stakeholder Council, which includes a sub-committee on LTC, where the Department, providers, and advocates meet to discuss initiatives, provide advice and recommend solutions to issues linked to LTC such as rates and transportation. Further, BEAS has invited several providers of different types of community services to work with the Bureau as a focused group to identify specific challenges in service delivery and to work together toward solutions. This focused group will work through the remainder of calendar 2009. Several creative initiatives have been discussed, such as rate setting, the development of a statewide transportation plan to improve participant access, performance based contracting, group purchasing of benefits/supplies and annual provider recognition based on meeting specifically identified quality indicators.

Observation No. 7

Follow Statutory Requirements To Develop HCBC-ECI Provider Rates

The DHHS is not complying with rate setting laws to ensure the HCBC-ECI provider rates are appropriate to meet the needs of all waiver recipients while being fiscally responsible. We identified four New Hampshire laws addressing rate setting and rate setting methodologies.

- RSA 126-A:18-a requires the DHHS Commissioner to adopt rules establishing a methodology for determining Medicaid reimbursement rates for home health services, annually establish rates reflecting the average cost to deliver services, and annually report the home health service rates to the Speaker, the Senate President, and the chairs of the House and Senate Finance Committees.
- RSA 126-A:18-b requires the DHHS to review Medicaid reimbursement rates every two years benchmarking them to Medicare rates, Medicaid rates in other New England states, private pay rates, and actual provider costs. Additionally, public testimony and applicable State and federal regulations should be considered. This law also requires biennial reporting on rate setting methodology and justification of the rates.
- RSA 151-E:6-a establishes a LTC Rate Advisory Committee, appointed by the Commissioner, composed of relevant stakeholders which is required to review the rate-setting structure for reimbursement of long-term care providers and submit a biennial report and recommendations for legislation beginning in 2002. This committee is also tasked with evaluating rate payments and making recommendations on rates to the Department.
- RSA 151-E:16, I, requires the Department to estimate and report on the cost to adequately fund the LTC program including services in home and community-based, mid-level, and nursing facility settings. Additionally, the estimates are required to be based on reimbursement rates ensuring a provider population to fully meet the recipients' needs.

Administrative Rule He-W 553.08, for Home Health Services, provides a specific methodology for skilled nursing and home health aide services only; no other home health services are included.

The Bureau of Elderly and Adult Services has established HCBC-ECI provider rates for services authorized by the waiver including homemaker, home health aide, personal care, nursing, home delivered meals, respite care, residential care, adult day care, and others. Many of these rates have been updated in both State fiscal years (SFY) 2008 and 2009, although the BEAS identifies the rate changes are based on inflationary pressure in the medical sector or allocations in the budget and not a prescribed rate setting methodology.

The Department's Office of Medicaid Business Policy (OMBP) prepared the Medicaid Provider Reimbursement Rate Benchmarks for Key Services, dated October 2008 and required by RSA 126-A:18-b; however, the OMBP limited the services for which benchmarks were prepared due to "resource constraints." The OMBP did not ask other Bureaus to provide benchmarking information, nor did BEAS offer to provide information for the benchmarking report. Finally, the BEAS is not aware of a currently active LTC Rate Setting Advisory Committee required by RSA 151-E:6-a and has no evidence of any additional Committee reports since 2002.

Without regular and thorough analysis as required by statute, it is unclear if rates are sufficient to maintain an appropriate provider pool in all LTC settings (see Observation No. 6). Services provided under the HCBC-ECI waiver have not been benchmarked or analyzed as required by the law for the last two rate changes. With no benchmarking and no active Rate Advisory Committee, it is unclear if sufficient rates for LTC are established or if they meet the requirement of RSA 151-E:16 and federal guidelines. Provider rates may also affect the ability to recruit, train, and maintain a high quality provider pool. We reviewed basic provider rates for home health waiver services in New Hampshire, Massachusetts, Maine, and Rhode Island. Each state's waiver, description of services, and availability of services varies, so comparisons to New Hampshire's rates are inexact. Despite this, we found New Hampshire had neither the highest nor the lowest providers rates in the region. Such comparisons, while informative, still do not address whether the current rates ensure an adequate workforce in the State.

Recommendations:

We recommend the DHHS comply with all the statutory requirements for rate setting for LTC services including:

- **establishing methodologies,**
- **conducting regular assessments,**
- **considering stakeholder and public input, and**
- **reporting on this information.**

We also recommend the Commissioner ensure the LTC Rate Setting Committee is active and providing rate setting information to best structure, define, and set provider rates for continuous viability of the LTC system.

Auditee response:

We concur in part.

RSA 126-A:18-a

The Department is obligated by RSA 126-A:18-a to adopt rules establishing a methodology for determining Medicaid reimbursement rates for home health services, and does so in accordance with the following rule:

PART He-W 553 HOME HEALTH SERVICES
Section He-W 553.01 Definitions
Section He-W 553.02 Recipient Eligibility
Section He-W 553.03 Provider Participation
Section He-W 553.04 Required Documentation
Section He-W 553.05 Covered Services
Section He-W 553.06 Non-Covered Services
Section He-W 553.07 Payment for Services
Section He-W 553.08 Rate Setting Methodology
Section He-W 553.09 Third Party Liability
Section He-W 553.10 Utilization Review and Control

The DHHS has assigned rate-setting responsibilities to the Office of Medicaid Business & Policy (OMBP). This Office is charged with establishing Medicaid reimbursement rates annually to reflect the average cost to deliver services and annually reporting said rates to the Speaker, the Senate President and the chairs of the House and Senate Finance Committees.

RSA 126-A:18-b

OMBP, in accordance with Chapter 205, Laws of 2007 (HB 43), completes a review of Medicaid reimbursement rates, and benchmarks them to Medicare rates, every two years in compliance with RSA 126-A:18-b. The last Biennial Report, dated October 1, 2008, is available on the DHHS website, http://www.dhhs.state.nh.us/DHHS/OMBP/LIBRARY/Financial+Report/rate_ benchmarks.htm.

RSA 151-E: 16-a

Establishes a LTC Rate Advisory Committee appointed by the Commissioner. This committee has been inactive since 2002 and consists of twenty-four (24) members representing various interests.

RSA 151:E-16, I

In accordance with RSA 151:E-16, I, BEAS estimates and reports on the cost to adequately fund the LTC program including services in a home and community-based, mid-level, and nursing facility setting through the biennial budget process. BEAS submits a "Maintenance Budget" which identifies maintenance costs to adequately fund the LTC program which are then

considered by the Governor's Office, the House of Representatives and the Senate in public forums, resulting in a budget appropriation; i.e. HB1 and HB2.

Services under the Home and Community Based Care (HCBC-ECI) waiver program are identical to services provided under the State Plan (Provider Payments) program in BEAS (institutional care) and OMBP (non-institutional care). DHHS has a policy within the department to maintain consistent rates for identical services regardless of the program or bureaus or divisions who provide the services. Since OMBP's budget is considerably larger than BEAS, often times BEAS follows OMBP's lead in establishing rates.

BEAS began conducting consumer and provider listening sessions throughout the state gathering public and stakeholder input. These listening sessions were conducted in the spring, summer and early fall as the agency budget was being developed.

The Department currently complies with statutory requirements for rate setting for LTC services (including RSA 126-A:18-a, RSA 126-A:18-b and RSA 151-E:16, I) regarding established methodologies, conducting regular assessments, considering stakeholder and public input, and reporting on this information.

RSA 151-E:6-a establishes a LTC Rate Advisory Committee, but with its tenuous position relative to HB 245 LTC Rate, the Department will delay implementation until legislative action is concluded. If legislation maintains RSA 151:E-16, I, the Department will act according to the terms and conditions of the statute and establish a LTC Rate Advisory Committee.

Observation No. 8

Develop Clear Guidelines And Controls For Using Personal Care Service Providers

According to Administrative Rule He-E 801.02(ae), personal care services are "non-medical, hands-on services that assist eligible individuals to maintain themselves in a community setting." The HCBC-ECI waiver program has increasingly used personal care service providers (PCSP) to help clients remain at home. PCSPs can be either agency- or client-directed. Agency-directed PCSPs are hired, managed, trained, and advised by a home health agency. Client-directed PCSPs are selected, managed, trained, and advised by the consumer. However, in client-directed cases an "other qualified agency" (OQA) is usually the employer of record for the PCSP. Employees of home health agencies or family members, friends, or neighbors employed by an OQA or home health agency may provide personal care services.

In SFY 2008, 1,636 clients received personal care services at a total cost of $14.9 million. This represents a 41 percent increase over BEAS reported costs for SFY 2007, of just under $10.6 million. During SFY 2008, the average weekly hours of waiver program personal care services was just under 10 hours, ranging from less than one hour to over 58 hours per recipient. Average annual, per recipient cost was just over $9,000.[8] The Medicaid provider reimbursement rate for

[8] This value is underestimated as the total cost per recipient was divided by the hourly rate and then 52 weeks; however, not all recipients were eligible for the service for the full 52 weeks. Additionally, cost per recipient

personal care services was $4.47 per quarter-hour, or $17.88 per hour with the actual personal care employee starting at about $10 per hour.

Our survey of case managers, and interviews with BEAS personnel, case management agencies, and other stakeholders identified many benefits of using PCSPs. These benefits include providing a range of client-needed services in the home, transportation to appointments and other community-based activities, and being less costly than nurses or home health aides.

Both survey respondents and interviewees reported concerns with use of PCSPs, including:

- "plan creep" or expanding costs of the plan of care;
- lack of training and qualifications of PCSPs;
- inadequate policies, guidance, or rules;
- lack of BEAS oversight; and
- the potential for fraud.

The two largest providers of PCSP services reported in interviews about half to one-third of their PCSPs were family or friends of the client. Potential risks with using family and friends as PCSPs were identified as: quality of services received; appropriateness of identified services; monitoring, as clients "will not speak out against a family member;" determining whether using PCSPs was an income support program for families; and if providers or the BEAS were "marketing" the service as an option to family members.

The BEAS does not: train PCSPs; guide client-directed friends and family through the process; or identify, regulate, or define whether to compensate a potential PCSP or include the services among the in-kind, informal supports in the plan of care. Nor does the BEAS identify when to provide additional professional in-home support services, in lieu of paying a PCSP to provide the support. This lack of definition, guidance, and training may contribute to uncertainty regarding the appropriateness of personal care services, or when they should be provided. Although case management agencies are tasked with oversight of PCSPs, there is no definition or clarification in statute or Administrative Rule other than a requirement for general oversight.

The risks of using PCSPs are not unique to New Hampshire. A 2009 audit of personal care services in Minnesota's Medicaid program found personal care services remain "unacceptably vulnerable to fraud and abuse" and the state "has not implemented sufficient controls and guidance" ensuring assessments of the need for services are reasonably consistent around the state.[9] The audit recommended mandatory training requirements for all personal care providers, periodic supervision by a qualified professional, and regular analysis of claims.

averages are also underestimated as the total cost is divided by the total recipients, but again, not all recipients were eligible or receiving personal care services for the full year.

[9] Personal Care Assistance, Office of the Legislative Auditor, State of Minnesota, January 2009 (www.auditor.leg.state.mn.us).

Recommendations:

We recommend the Bureau:

- **define when and how personal care services should be used,**
- **provide guidance for determining if a family member's care should be compensated or considered an informal support;**
- **strengthen oversight of PCSPs including periodically auditing some HCBC-ECI clients' use of PCSP services, to ensure consistency, relevancy, and reasonableness in the service PCSPs are providing; and**
- **require relevant and ongoing training requirements to ensure PCSPs are qualified and continually educated on service issues.**

The BEAS should seek Legislative guidance on using PCSPs.

Auditee Response:

We concur.

Personal care services were established within the waiver program following legislation that recognized that unlicensed caregivers could provide many home care services and that the licensed workforce was not adequate to meet the growing need for care. Simultaneously, the strong independent living movement in New Hampshire sought care options to allow consumers to direct their care, and budget limitations supported development of less expensive services. DHHS adopted certification and service rules for Personal Care Services in 2003.

BEAS has learned a great deal in the past six years and has identified several changes that are needed to both the service and the certification rules. Although neither rule will expire until 2011, BEAS has already begun the process of rewriting these rules. BEAS has convened a stakeholder workgroup to advise revisions to the certification rule, He-P 601, which will clearly identify the business responsibilities of any agency that provides personal care services to waiver participants, including training requirements and accountability.

The waiver eligibility and service rule, He-E 801, requires revisions to clarify the role of personal care service workers that offers specificity in terms of role definitions, training expectations, service authorizations and bureau monitoring processes. BEAS is nearing completion of an initial draft of He-E 801 that will be used as a starting point for a collaborative effort with stakeholders and provider groups. BEAS anticipates commencing work with interested stakeholders by August 2009 and having final draft completed by January 30, 2010, which will allow ample time for the rulemaking process. The New Hampshire Legislature validated the use of family members by identifying only responsible relatives as being eligible to be paid personal care workers. (RSA 161-I: 2. XII)

Observation No. 9

Clarify Costs And Use Of Personal Care Services

Some clients served by the HCBC-ECI waiver are eligible to receive two types of Medicaid personal care services: a PCSP through the waiver and personal care attendant (PCA) services through the Medicaid State Plan. PCSP services may be provided by any certified OQA or licensed home health agency in the State. A recipient must be eligible for HCBC-ECI and need services in order to receive PCSP services.

RSA 161-E:1 defines PCA services as being provided by non-family members to those "approved to participate in an independent living program." PCA services are provided only by Granite State Independent Living (GSIL), the only independent living center in the State. GSIL also provides PCSP services as an OQA. PCA services have more stringent requirements for eligibility including the recipient must be in a wheelchair, be able to self direct, require a minimum of two hours of care per day, and be 18 years of age or older. Overlapping PCSP and PCA services may occur for Medicaid clients in wheelchairs, who qualify for a PCA under the State Plan, and who are also receiving HCBC-ECI services and need PCSP services.

Authorization for PCSP services will be found in the plan of care. The plan of care does not identify PCA services. PCSP services are monitored by case managers according to RSA 161-I:6, while PCA services are reviewed every 60 days with the client and reassessed annually by nurses from GSIL. A client's PCA and PCSP may be the same person who is employed by GSIL for both services, or GSIL for PCA services and another agency for PCSP services.

In SFY 2008, 118 HCBC-ECI waiver clients received State Plan PCA services, as shown in Table 7. Of these 118 recipients, 87 also received PCSP services through the waiver. Further, PCSP services averaged 40 hours or more for 64 of the 87, with per recipient costs ranging from $37,000 to $102,000 per year, not including any other waiver services or case management fees. Sixty-two of the 87 cases received their PCSP services from GSIL. The average number of personal care services hours provided per client when PCA is included is 43, with a maximum of 110 hours per week, compared to 10 hours per week and a maximum of 58 hours for cases excluding PCA services. While the BEAS cannot deny a client PCA State Plan services, it could implement guidance on limiting or further assessing the amount of PCSP services available to clients already receiving PCA services.

The DHHS does not report PCA service costs as part of waiver costs. If these costs were included, the cost per client for personal care services in SFY 2008 would increase by approximately $2,000 per client, and the total cost of personal care services would increase by just over $3.5 million, or 24 percent. PCA services are ***not*** waiver services, but they are still part of the cost associated with maintaining a client in the home and should be included to accurately reflect the number of people remaining in their homes at a cost greater than the cost of nursing home care.

Table 7

SFY 2008 HCBC-ECI Client Costs For Personal Care Services

Personal Care Services	Number Of Clients	Total Costs[1]	Costs Per Client
PCSP Only	1,549	$ 13,803,021	$ 8,911
PCA Only	31	$ 870,172	$ 28,070
PCSP & PCA (Concurrently)	87	$ 3,796,035	$ 43,633
All Personal Care Costs	1,667	$ 18,469,228	$ 11,079
Total PCSP	1,636	$ 14,926,032	$ 9,123
Total PCA	118	$ 3,543,195	$ 30,027

Note: [1] All HCBC-ECI costs for PCSPs (fund code N) and PCA (fund code J), excluding PCA under State Plan (fund code A).
Source: LBA analysis of MMIS Data, Code T1019 for fund codes N and J.

A waiver recipient's plan of care does not detail whether PCA services are provided. Therefore, the Bureau and case managers may be unaware the recipient is receiving PCA services. PCA services are paid from fund code J and fund code A, State Plan Medicaid for LTC and State Plan Medicaid respectively. These fund codes are for provider payments for non-waiver services. PCSP services are paid from fund code N, or waiver services. Fund codes A and J are paid for 50 percent by the State and 50 percent by the federal government, while fund code N is paid for 50 percent by the federal government and 50 percent by the counties to a cap.

There is no Department or statutory guidance on when a PCA should be used in lieu of a PCSP, or a PCSP in lieu of a PCA, when the client is eligible for both. Without guidelines it is unclear:

- which service should be primary (although the BEAS noted State Plan services should be provided before waiver services),
- whether there should be a cap on the number of personal care service hours per week,
- how case management is notified about services not in the support plan and their responsibility for oversight, and
- whether the same worker should provide PCA and PCSP services for a single client.

Additionally, how these services are used may affect whether the State or the counties are responsible for the costs.

Recommendations:

We recommend the Legislature consider requiring the BEAS provide information on all Medicaid expenditures required for maintaining an HCBC-ECI recipient in a home or community-based setting by including provider payment costs such as PCA.

We recommend the DHHS establish policies for using both PCA and PCSP services and clearly define criteria establishing when to use one service in lieu of the other. The Department should increase its oversight and control when both types of personal services are provided to Medicaid clients.

Auditee Response:

We concur.

BEAS reports program expenditures in compliance with RSA 151-E:11, and will continue to follow Legislative direction.

As stated in the response to the prior observation, BEAS has begun the process of revising the waiver eligibility and service rule, He-E 801. These revisions will include guidelines defining how Personal Care Services are authorized and used. The relationship between PCSP and PCA services are not described in the current rule and will be included in the revised rule. Under consideration are specific instructions about how PCSP may be authorized for individuals who are eligible for PCA services.

Exhibit H of the BEAS HCBC-ECI waiver renewal application outlines in detail expectations provided to CMS to assure waiver services are authorized and managed responsibly and contribute positively to the quality of care received by individual participants. The first line of accountability for monitoring and assessing specific units of service and the efficacy of those units of services begins with the case manager. He-E 805.05, describes the responsibilities of the case manager. Case Management agencies are the "front line" of the quality assurance function relative to service oversight. As such, agencies are responsible for ensuring that services are adequate and appropriate for the participant's needs, and are being provided as described in the comprehensive care plan. Their monitoring is intended to determine when a participant's condition has changed, such that services must be adjusted. BEAS in turn is responsible for the monitoring of the case management agencies to assure the oversight practices in place are effective. The Bureau has just completed the first round of quality improvement reviews based on He-E 805. Incumbent upon the Bureau during these reviews is the assessment of personal care services.

PROGRAM MANAGEMENT AND OVERSIGHT

Communication, both internal and external, was identified as a weakness throughout this audit. Stakeholders and Bureau of Elderly and Adult Services (BEAS) employees reported concerns related to information dissemination and planning. Further, the quality and clarity of information released by the Bureau and the Department of Health and Human Services came into question as varying methodologies created apparent discrepancies in reported costs and clients served. Concerns over information technology and further analysis of the ServiceLink model were also identified as areas needing additional program management and oversight.

Observation No. 10

Improve Internal And External Communications

The BEAS reported working directly with stakeholders throughout the audit period. However, interviews with BEAS employees, case management agencies, ServiceLink personnel, and other stakeholders identified poor communication with the BEAS as a recurring problem. Identified communication issues include poor information dissemination, poor collaboration, frequent changes with limited planning, poor quality information, and limited written resources. There were also positive comments on the current relationship with the Bureau made by stakeholders. Three interviewees complimented the new Bureau Administrator's perspective and responsiveness. Others noted the relationship and communication with the BEAS is better than it used to be, though still requiring improvement.

The BEAS reported meeting and working with stakeholders on a number of issues during SFY 2008. The BEAS identified holding monthly meetings with representatives of all case management agencies to discuss issues related to client services. The BEAS provided specialized computer testing and training sessions, and support to case managers. Additionally, the BEAS worked with case management agencies to develop a targeted case management rule and to discuss risk management and quality improvement activities linked to the Home and Community-Based Care – Elderly and Chronically Ill (HCBC-ECI) waiver renewal applications. In addition, the BEAS identified working with the Home Care Association of New Hampshire on developing rate setting methodology for two home care services and worked with other stakeholders on the medical assessment instrument.

The Bureau initiated twelve community and five provider Listening Forums throughout the state, which were documented in a report by the State Committee on Aging. The Bureau participated in meetings with nine advisory committees working on issues relating to Long-Term Care (LTC). Additionally, the BEAS published a quarterly newspaper, *Aging Issues*, and developed and implemented B-NEWS, an electronic newsletter distributed to all BEAS providers; but which is no longer issued due to personnel constraints.

In spite of these activities, we observed poor communication and information dissemination pertaining to policy changes regarding newer policies, such as Medicaid In and Out for HCBC-

ECI recipients[10] and presumptive eligibility. Relevant stakeholders were unsure of or unfamiliar with the programs. Additionally, we received inconsistent responses to the same questions from different Department and ServiceLink employees, indicating inadequate internal communications. Specific differences include:

- explanations for information technology intake statuses,
- definitions and recording for application received dates,
- New Heights status and review process for LTC applicants already on Medicaid,
- whether and how far back nursing facility and HCBC-ECI eligibilities may be backdated, and
- whether the financial application must be completed before the medical application.

We also observed a general lack of understanding or clarity among BEAS personnel and stakeholders regarding presumptive eligibility, Medicaid In and Out, the status of the Money Follows The Person Demonstration Grant (also known as Community Passport Program), use of personal care services, and long-term care costs. One BEAS employee reported constant changes, stops, and restarts in programs and policies are confusing and difficult to communicate to all involved. This employee also noted these program and policy changes are managed using insufficient technology systems and implemented with too few resources.

Several interviewees also expressed concern over internal communication both within the BEAS and between the BEAS and the Division of Financial Assistance (DFA). One BEAS employee identified the environment as "fragmented."

Case management agencies and ServiceLink personnel identified concern over the informal dissemination of information. Personnel from all five case management agencies and two of five ServiceLink locations reported poor information dissemination and learning policy changes secondhand. Even the Bureau's handling of the program's name change from HCBC-ECI to Choices for Independence frustrated stakeholders. These frontline agencies are the face of the LTC system and expressed unease over not being able to provide accurate, relevant information to Medicaid applicants and clients.

Stakeholders reported not being involved in developing and implementing the LTC program overall. Additionally, stakeholders said the BEAS is often non-responsive to suggestions, proposals, or ideas.

According to the U.S. Government Accountability Office's Internal Control Management and Evaluation Tool, communication is a necessary component to effectively manage internal controls. Management should ensure "pertinent information is identified, captured, and distributed to the right people in sufficient detail, in the right form, and at the appropriate time to enable them to carry out their duties and responsibilities efficiently and effectively." Both internal and external communication must be maintained in order to be effective. Finally, information sharing and communication must be based on accurate, relevant, and reliable data to ensure the BEAS meets its mission.

[10] A spend-down program for potential HCBC-ECI clients above the income eligibility level.

Recommendations:

We recommend DHHS improve its methods and procedures for disseminating information to relevant parties. The DHHS may consider consistently utilizing a variety of communication tools including, but not limited to: emails, list serves, web pages, training materials, policies, procedures, administrative rules, and periodic performance reports.

Auditee Response:

We concur.

Communication, both internal and external, has been identified as an area where the BEAS can make significant improvement and better serve stakeholders. We concur that during the audit period of State fiscal year 2008, The BEAS did not utilize, on a consistent basis, a release system to announce policies and procedures or disseminate information. Furthermore, we concur that information was distributed informally to our internal and external stakeholders and this has caused frustration. BEAS acknowledges that a standardized method of releasing policy and programmatic changes is necessary to ensure that information is disseminated in an organized, succinct and effective manner. Since SFY 2008, the BEAS has implemented a public release system that informs internal and external stakeholders of policy/programmatic changes as well as general information. Although this system is established, the public release process requires the standardization of policy that defines the release process, identifies the type of information that is subject to the process and identifies distribution points. The BEAS is currently drafting internal policies that will compliment the public release process. These policies will be completed by August 31, 2009. Once these policies are established and the public release process effectively utilized, it is anticipated that both internal and external stakeholders will see improvement in the area of communications within BEAS.

In addition to the public release process, BEAS has made significant effort to utilize a variety of communication tools that include public forums, provider forums, e-mails, webinars, focus groups, blogs and list serves for purposes of communication.

Open and collaborative communication between BEAS and internal/external stakeholders will remain a continuous and challenging endeavor. However, the areas referenced above are cited as a fair representation of the commitment BEAS has demonstrated in SFY08 and SFY09 to better serve our stakeholders. It is our goal to continue to find opportunities to share information and work collaboratively with our partners.

Observation No. 11

Improve LTC Data Reporting

The BEAS Medicaid populations require a higher proportion of Medicaid funds than other populations. According to the *New Hampshire Medicaid Annual Report: State Fiscal Year 2008*, the elderly are eight percent of the total Medicaid population but generate 26 percent of the total expenditures for all Medicaid services.[11] According to the report, recipients served by HCBC-ECI increased 20 percent while costs increased 31.9 percent from SFY 2006 to 2008. Clarity, transparency, accuracy, and consistency in reporting the State's costs are needed for ensuring fiscal responsibility.

The DHHS produces three different reports identifying the number of recipients, total costs, and per recipient costs for the HCBC-ECI program (Table 8). Two reports are prepared by the BEAS: one required by the Center for Medicaid and Medicare (CMS), and one by State law (RSA 151-E:11, II). The third report is prepared annually by the Office of Medicaid Business Policy (OMBP) and includes the cost of nursing facility care. Statistics for each report are generated using different methodologies, and provide seemingly inconsistent program measurements.

Table 8

SFY 2008 HCBC-ECI Costs Reported By The BEAS*

Report	Clients Served	Total Costs	Per Client Costs
RSA 151-E:11 (Program Management and Cost Controls) [1]	2,495	$40,315,871	$13,789[2]
Medicaid Annual Report	3,675	$46,031,921	$12,526
CMS 372 Report[3] (SFY 2007 Report)	3,128	$32,837,968	$10,498

Notes * The CMS 372 Report was not yet prepared for SFY 2008.
[1]The RSA 151-E:11 statistics use a monthly average number of clients.
[2]This reported cost excludes case management. Including case management the per recipient cost is $16,159.
[3]Data are based on costs incurred and unduplicated client count.
Source: LBA analysis of DHHS reports and data.

RSA 151-E:11 requires cost reporting on HCBC-ECI services by the BEAS. This reporting excludes provider payments (State Plan Medicaid) and does not identify a methodology for determining the cost of nursing facility care, HCBC-ECI costs, or recipients served. RSA 161-I:4, IV, also requires quarterly reporting of HCBC-ECI costs and the number of recipients served, but again does not include any methodologies for reporting this information. Also, the BEAS does not prepare this report but rather considers the Medicaid Annual Report as a satisfactory response to RSA 161-I:4. As shown in Table 8, for the one year we have both

[11] This includes all Medicaid services, not just those administered by the BEAS.

reports' statistics for HCBC-ECI costs, BEAS' reporting and OMBP reporting on total HCBC-ECI costs differ by $5.7 million.

Our analysis of nursing facility costs based on SFY 2008 data from the Medicaid Management Information System (MMIS) is shown in Table 9. Depending on the inclusion or exclusion of Medicaid Quality Incentive Program[12] (MQIP) payments and utilizing total or average numbers of recipients served, the cost of nursing facilities per recipient may vary as much as $29,411. These costs can be compared to the Intermediate Care Nursing Facility costs identified in the DHHS Medicaid Annual Report for SFY 2008 which reports serving 6,211 recipients for a total cost of over $195 million or $31,461 per recipient.

Table 9

SFY 2008 Nursing Facility Costs

Description	Clients Served		Per Client Costs
Using Total Number Of Clients	6,224	$187,776,703	$30,169
Using Total Number Of Clients With MQIP	6,224	$257,148,895	$41,315
Using Average Number Of Clients	4,316	$187,776,703	$43,507
Using Average Number Of Clients With MQIP	4,316	$257,148,895	$59,580
Source: LBA analysis DHHS reporting and MMIS data.			

LTC stakeholders and case management agencies both expressed concern and frustration regarding the Department's Medicaid LTC data reporting. Four of five stakeholders we interviewed questioned the reliability of LTC information reported by the Department.

We identify a number of reasons for the varying numbers in DHHS reports:

- Recipients served may represent total number of recipients (Medicaid Annual Report) receiving services in a given year or average number of recipients (RSA 151-E:11 Report) receiving services during a certain time period.

- In the RSA 151-E:11 Report, the cost of case management is excluded from the per recipient cost, even though it is a required HCBC-ECI service.

- The reported total cost of nursing facilities may or may not include millions of dollars from the MQIP. This is a fee collected by the Department of Revenue Administration from nursing facilities as identified in RSA 84-C titled, Nursing Facility Quality Assessment. These funds are credited to the Nursing Facility Trust Fund established by RSA 151-E:14, paid to nursing facilities based on the number of Medicaid bed days and other factors such as Medicaid Supplemental Payments, and matched by the federal

[12] The Medicaid Quality Incentive Program consists of the Nursing Facility Quality Assessment fee and a Medicaid Supplemental Payment.

government. These funds are inconsistently included in the nursing facility costs, which increases the per recipient cost. For example, in SFY 2008, $69.4 million in MQIP payments increased annual per recipient costs by $16,073 from $43,507 to $59,580, as shown in Table 9.

- Although not part of the HCBC-ECI waiver and not required by law to be included in any reporting, State Plan Medicaid costs are three times higher for HCBC-ECI clients than they are for nursing facility clients. In SFY 2008 State Plan Medicaid costs averaged $1,201 for nursing facility clients compared to $3,647 for HCBC-ECI clients. This is due in part to nursing facilities reportedly covering some medical and dental services, where HCBC-ECI clients would require State Plan Medicaid coverage. State Plan Medicaid are provider payments made for any Medicaid service not covered in the waiver or nursing facility care and are available to waiver and nursing facility clients. State Plan Medicaid costs for LTC recipients are paid for by the BEAS through a separate fund code from all other non-LTC State Plan Medicaid costs. These are not waiver services. These costs should be considered when comparing the cost of maintaining someone in the community or a nursing facility. This issue was identified in our 2007 financial audit of the BEAS.[13] Table 10 below demonstrates the differences in cost reporting when including and excluding State Plan Medicaid for LTC in HCBC-ECI costs.

Table 10

SFY 2008 HCBC-ECI Costs

Description	Clients Served		Per Client Costs
Using Average Number of Clients Excluding State Plan Medicaid	2,495	$46,092,435	$18,474
Using Total Number of Clients Excluding State Plan Medicaid	3,829	$46,092,435	$12,037
Using Average Number of Clients Including State Plan Medicaid	2,495	$60,057,962	$24,071
Using Total Number of Clients Including State Plan Medicaid	3,829	$60,057,962	$15,685

Source: LBA analysis of MMIS date for HCBC-ECI clients from fund code J and fund code N.

The variability of the total costs and per recipient costs found in the three tables demonstrates the potential difficulty the Legislature or public may have in understanding LTC costs. Differing methodologies and considerations for these reports, as well as lack of transparency, definition, and consistency inhibits clearly summarizing the costs of the State's LTC Medicaid system.

[13] Observation No. 19 of the *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*.

Recommendations:

We recommend the DHHS increase clarity and consistency in reporting LTC costs in reports not required by the State Plan. Specifically, the BEAS should:

- **seek clarification from the Legislature on desired cost methodologies and report format (particularly, client counts, averaging, MQIP payments, and other related State Plan Medicaid costs associated with LTC clients);**
- **make LTC cost data readily available on its website for public inspection; and**
- **provide methodologies used to generate reports to all users of agency data and reporting.**

Auditee Response:

We concur.

BEAS will seek clarification from the Legislature on desired cost methodologies, the inclusion of State Plan Medicaid Cost and Medicaid Quality Incentive Payments (MQIP) and report format for LTC Data Reporting.

Observation No. 12

Ensure High Cost HCBC-ECI Plans Are Properly Approved

According to the HCBC-ECI waiver, the State should refuse LTC services to any otherwise eligible client when the State reasonably expects the cost of services would exceed 100 percent of the cost of a Medicaid-funded institution for the client. According to Administrative Rules He-E 801.03(a) (7) and (8), to be eligible for services under HCBC-ECI, a client's needs must be met at a cost "the same as, or lower than" the Medicaid nursing facility costs, and if the per diem cost exceeds the average nursing home costs then HCBC-ECI "shall not be offered to the individual." According to a BEAS official, if the cost of the support plan written by the nurse is greater than 100 percent of the cost of a nursing home placement, no part of the plan can be offered to an HCBC-ECI applicant.

While these rules specify costs for all applicants will be compared to the average Medicaid cost of nursing facility care, the BEAS also takes into consideration the potential higher costs of services for a client requiring a skilled nursing facility. As a result, providing home-based LTC services for these clients, while exceeding the average nursing facility costs, may still be less expensive than institutional placement. This may be a cost efficient decision; but it is not allowable under the current Administrative Rules or Medicaid. A BEAS official commented the current Administrative Rules need to be updated and some initial efforts have begun.

HCBC-ECI *applicant* support plans may not be greater than the average nursing facility costs. However, the HCBC-ECI waiver allows changes to existing HCBC-ECI *client* plans of care, written by the case manager, to exceed the average nursing home cost. According to the waiver, if a HCBC-ECI client's condition changes and additional services are needed to assure the client's health and safety, those services may be authorized even if they exceed the cost limits.

The number of HCBC-ECI clients requiring the DHHS Commissioner's approval to continue receiving high cost LTC services may vary widely depending on the methodology used to calculate the average nursing home cost. According to RSA 151-E:11, II, "[n]o 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." The statute does not specify what methodology should be used to determine the average annual nursing home cost.

We estimate at least 19 HCBC-ECI clients should have required the Commissioner's approval, based on their total HCBC-ECI costs for SFY 2008, using the most conservative methodology for identifying clients receiving high cost LTC services. We reviewed these 19 files and found four contained proper documentation of an approval. Table 11 shows the number of high cost cases using two other methods for calculating nursing home average costs, and the total number of recipients, and how they could affect the number of care plans needing approval. The number of approvals required range from a low of 19 to a high of 449.

Table 11

Effect Of Methodology On The Number Of HCBC-ECI Plans Of Care Needing Approval

	Methods Of Calculating Nursing Facility Average Costs Per Client					
Nursing Facility Costs	I ($257 million)		Excluding MQIP		Excluding MQIP	
Divided By	Average Number Of Recipients (4,31		Average Number of R (4,316		Total Number Of Recipients (6,224)	
	Average	80% Of Average	Average	80% Of Average	Average	80% Of Average Cost
Annual Cost of Nursing Facility Care Per Client	$ 59,580	$ 47,664	$ 43,501	$ 34,800	$ 30,608	$ 24,486
Per Diem Cost Of Nursing Facility Care Per Client	$ 163	N/A	$ 119	N/A	$ 84	N/A
HCBC-ECI Service Plans Requiring Commissioner's Approval	19		143		449	

Notes: [1] The MQIP involves a fee collected by the Department of Revenue Administration from nursing facilities as identified in RSA 84-C titled, Nursing Facility Quality Assessment. These funds are credited to the Nursing Facility Trust Fund established per RSA 151-E:14, transferred to the DHHS, matched by the federal government, and redistributed to the nursing facilities based on the number of Medicaid bed days and other factors as Medicaid Supplemental Payments.
Source: LBA estimates based on SFY 2008 BEAS and MMIS data.

The Bureau should be able to identify and document high cost cases using a clearly defined methodology. High cost cases should receive proper oversight and approval by Department management and be regularly assessed to ensure balance between the needs of clients, their desire to remain in their homes and communities, and additional costs, such as case management, to care for them outside of a nursing facility. This information is also important so management and the Legislature may make informed policy decisions and provide oversight to the LTC Medicaid program.

Recommendations:

We recommend the BEAS seek additional guidance from the Legislature on defining high cost cases. The BEAS should seek guidance on whether to:

- **include MQIP costs;**
- **use the average or total number of HCBC-ECI clients and, if the average number, a methodology for how this is determined;**
- **evaluate the high costs for clients requiring skilled nursing to the average nursing facility cost or the average skilled nursing facility cost; and**
- **include case management costs to calculate the applicant's initial support plan, to ensure services are not offered if the cost of the HCBC-ECI support plan is higher than the average per diem Medicaid cost of nursing facility.**

Further, we recommend the Bureau update its rules, polices and procedures to improve oversight of the high cost cases and ensure responsible management of program funds.

Auditee Response:

We concur.

This observation addresses two separate issues. The first issue is the identification of high cost HCBC-ECI plans which require Commissioner approval under RSA 151-E:11, II. BEAS has a sound methodology in place to identify HCBC-ECI clients whose cost exceed 80% of the average annual cost for the provision of services to a person in a nursing facility. BEAS compares the cost of care for each HCBC-ECI recipient to the average annual cost of nursing facility care per recipient.

While RSA 151-E:11 does not specify whether or not MQIP should be included in the annual cost for nursing facility services, BEAS has taken the position that MQIP should be part of the nursing facility costs. MQIP is a cost that is paid out to nursing facilities based on the number of client Medicaid bed days they served and is part of the cost of providing nursing facility care. The nursing facility cost is divided by the average number of nursing home services recipients. If the total number of recipients were used it would give an individual who spent one day in a nursing home the same weight as an individual who received nursing facility services for the whole year. The coverage cost would be diluted and the calculation would not provide an accurate reflection of what it costs to provide nursing facility services. The average number of

individuals receiving nursing facility care is determined by dividing the number of bed days paid in a month by the number of days in the previous month.

The cost of providing HCBC-ECI services is compared to average cost of nursing facility care. The cost of case management is included in the HCBC cost. Those HCBC plans that exceed 80% of the average annual nursing facility cost are flagged as high cost cases. The average or total number of HCBC-ECI clients is not used to identify high cost cases. The average number of HCBC-ECI clients is used to ensure that the average annual cost for the provision of services in home based care does not exceed 50 percent of the average annual cost for the provision of services to persons in a nursing facility (another requirement under RSA 151-E:11, II).

When a case is identified as a high cost case BEAS seeks the Commissioner's approval. However, the observation identifies some files did not include proper documentation of an approval. BEAS will update its policies and procedures to ensure that the appropriate approval is sought, obtained and documented.

The other issue addressed by this observation is the eligibility determination for HCBC-ECI. Specifically, what costs are included in an applicant's initial support plan and how that support plan is compared to the cost of nursing facility care. BEAS concurs with the recommendations. BEAS compares the cost of the HCBC-ECI applicant's support plan to the average Medicaid cost of nursing facility care. If the support plan exceeds the cost of nursing facility care than the applicant would not be eligible for HCBC-ECI. However, there are instances where a HCBC-ECI applicant requires atypical[14] or highly specialized services such as services for a ventilator dependent individual. These needs could only be met at a nursing facility or a distinct part of a nursing facility that devotes its services exclusively to highly specialized care. If the HCBC-ECI applicant required highly specialized services the cost of the support plan would be compared to the average cost of atypical nursing facility services. However, as pointed out in the observation the cost of the applicant's support plan should be compared to the average cost of nursing facility care. BEAS concurs that it may be valuable to seek guidance on whether to evaluate the costs for clients requiring atypical nursing care to the average facility cost or the average atypical nursing care facility cost.

We concur with the recommendation, to include case management costs in the calculation of the applicant's initial support plan. Although this is a State Plan service, BEAS will include its cost because it is a required service for waiver participants.

[14] The observations and recommendations reference "skilled nursing." However the terminology used throughout He-E 800 is "atypical nursing care."

Observation No. 13

Ensure Proper Quality Controls For Options Data Integrity

The Options system, used by BEAS nurses, ServiceLink staff, case managers, and other Bureau personnel, allows the BEAS to monitor the progress of an application for LTC services through the medical eligibility determination process. Separately, an applicant must also submit an application for financial eligibility, which is monitored in the New Heights system by the DFA. After each unit determines the application meets medical and financial requirements, the applicant is approved and LTC services are entered in the "case" side of Options.

One of the basic components of the Options system is the ability to monitor when information is entered and processed. Throughout the intake period, the system tracks when an application is received, the date the intake is entered by ServiceLink personnel, the date of the nurse's medical assessment, the date of the nurse's medical eligibility determination, and the date a case technician enters the eligibility determination into New Heights. The accuracy of these dates depends on consistent data entry procedures by agency personnel statewide. However, we found such procedures are inconsistent, and verifying dates with corresponding paperwork is difficult.

From our sample of 157 applicant medical eligibility files from SFY 2008, we determined 80 percent (126 out of 157) of the files either had unsupportable or questionable data entered into Options. Fifteen of the 126 files were missing the medical application, 104 applications lacked a date stamp to indicate when they were originally received, and seven had a date stamp that did not match the date the application was listed as "received" in Options. In addition, personnel at one DHHS district office and one ServiceLink location each stated medical applications are not entered into Options as "received" until the applicant has collected and delivered all necessary financial paperwork to meet Medicaid approval. This information contrasts with procedures reported by other staff and ServiceLink locations.

The U.S. Government Accountability Office's internal control standards for accuracy of database information provide oversight measures including: "1) the agency's data entry design features contribute to data accuracy, 2) data validation and editing are performed to identify erroneous data, 3) erroneous data are captured, reported, investigated, and promptly corrected, and 4) output reports are reviewed to help maintain data accuracy and validity." There is evidence some of these steps are currently in place. Options is programmed to ensure that illogical data values are not entered, and every six months, the software is upgraded by improving system functions and removing program errors. On occasion, output reports are generated to review data but with no apparent focus on data accuracy or validity. Otherwise, in order to ensure the program is being administered accurately, best practices suggest at a minimum, data entered into the Options system should correspond to properly documented paper files. In the event of a catastrophic incident affecting electronic data, the BEAS relies on paper files to serve as backups for intake and case information, and proper documentation would help mitigate such a disaster.

Individualized training on the Options system is available for new employees. However, we found inconsistent procedures regarding prompt data entry. The BEAS has no formal procedures to check the validity of dates entered into the system.

Verifying the timeliness of eligibility determinations requires data management quality procedures. Without the ability to verify when information is entered into Options, no true measures of timeliness may be assessed. This leaves the system open to misdated information and an inability to accurately determine the length of time applicants wait for Medicaid LTC eligibility determinations. This weakness would be amplified if a disaster affecting electronic data forced the BEAS to use paper backups.

Recommendation:

We recommend the BEAS develop and implement a method to verify the accuracy of data entered into Options.

Auditee Response:

We concur.

Data validation output reports will be run monthly, by the Options Business Systems Unit, and forwarded to BEAS LTC program areas for action. BEAS LTC program areas will review the reports, compare a sample to the paper files, and ensure that erroneous data are captured, reported, investigated, and promptly corrected. Documentation of these reviews will be maintained by the LTC program areas. The LTC and ServiceLink Administrators will determine and promulgate procedures for consistent data entry.

Observation No. 14

Improve Options Management Controls

The BEAS management information system, Options, supports both its adult protective services and Medicaid LTC programs. We limited our review of Options to its support of the LTC program. Along with DHHS staff, Options is used by ServiceLink personnel and case management agencies. DHHS Bureau of Data Management staff enter service authorizations and LTC counselors enter client demographic information. Options interfaces with the State's Integrated Financial System for certain vendor and provider payments and check processing. Options does not interface with other DHHS information systems such as the Medicaid Management Information System and New Heights. Options has ad hoc queries, reporting, and analysis capabilities. Options contains sensitive client data including names, addresses, phone numbers, dates of birth, social security numbers, and Medicaid ID numbers.

Risk Management

We found no formal, comprehensive, and periodically updated risk assessment of the Options system identifying exposures, assessing the potential impacts of various risks on the Bureau, and identifying needed control measures. Risk assessment is one of five components of management controls and is instrumental to identifying risks which could inhibit attaining Bureau goals and objectives.

Access Controls

Access controls are policies and procedures designed to ensure technology systems are used according to management's authorization. Controls limit access to those authorized to process or maintain a particular system. We found numerous weaknesses in Options' access controls:

- Formal, quarterly reporting identifies users no longer requiring Options access. Through a "regular process," according to a BEAS manager, separation notices are sent by Human Resources, but former employees may retain access for up to three months. Further, the Bureau does not record when former user accounts are inactivated; consequently, we were unable to determine whether user inactivation occurred timely. BEAS managers are instructed to review a list of system users on a quarterly basis. We found no evidence supporting routine, ongoing examinations of any other security-related reports were conducted.

- The Bureau does not have written policies and procedures for disposing computers and related equipment. The Department of Information Technology (DoIT) has a statewide media sanitization policy encompassing certain hardware. Hardware and operating systems owned by ServiceLink and case management agencies with access to Options remain unaddressed.

- Criminal background checks are conducted for BEAS and DoIT staff with system access. However, checks for ServiceLink and case management employees are not conducted by the State and delegated to those entities without State oversight.

- The BEAS does not have an adequate policy on hardware encryption; there are no comprehensive, written procedures to control the physical security of State-used hardware; and there are only vague physical security requirements for State-issued operating systems used by non-State entities. State-used operating systems and databases did not universally have encryption before January 2009, and as of April 9, 2009, one still did not, creating a gap in security. At least one non-State entity maintained duplicate client databases but data security is not regulated or overseen by the State.

- No written policies or procedures for security controls exist over access to Options. No policy or guidance is provided to ServiceLink and case management agencies. For some non-State entities, a written agreement is in place and they are required to sign forms with the State's third-party fiscal agent, but without State oversight, this is a weak control. There was no requirement during the audit period for State employees to sign security statements acknowledging Bureau policy. Signed statements as a condition of State employment started after our audit period but do not include ServiceLink and case management employees.

Disaster Recovery And Business Continuity

Disaster recovery and business continuity plans are essential components of management's control of technology systems supporting business operations and provide reasonable assurance the Bureau will be able to recover from loss or destruction of essential facilities, hardware, software, or data. The Bureau's continuity of operations plan (Plan) was developed from a disaster recovery plan. Both are currently featured in the same plan. A revised disaster recovery plan is in draft format. The BEAS Plan is incomplete on several levels:

- The Plan does not include non-State entities. One such entity reported maintaining some client information on paper but had no confidence in recreating a full history or a full plan of care if Options failed. Another reported maintaining in its own database all information maintained in Options, so if Options failed they would have back up.

- While the Plan establishes priorities, it does not include detailed operating procedures. Whether the BEAS could ensure business continuity with its current Plan is questionable, particularly absent a validation test. The Plan does not incorporate forms or other control documents to use in a disaster. Plan guidance consists of "…utilizing paper documentation. Forms will be used if available. In the absence of forms, pertinent information will be collected…" This component of the Plan establishes *what* is to be done, but not *how*.

- There is no written BEAS policy describing backup procedures, although server-level procedures are conducted by the DoIT. BEAS procedures require the Bureau to simply "…maintain current versions of the files, documents, computer software, and databases in their continuity implementation plan."

- There is no systematic update process for either the current Plan or the disaster recovery plan in development.

- The Plan has not been tested as a whole, only components.

Input, Processing, And Output Controls

Input controls help ensure transactions and data are accurately entered into Options, have been authorized and recorded, are complete and input only once, and have been properly converted into a machine-readable format. *Processing* controls help ensure all transactions or data are processed as authorized, no authorized transactions are omitted, and no unauthorized transactions are added. These controls include using automated edits and logic tests coded into applications, as well as automated control total verification. *Output* controls are designed to ensure accurate processing results and ensure only authorized personnel receive the output.

Our 2007 *Bureau Of Elderly And Adult Services Financial And Compliance Audit Report for SFY Ended June 30, 2007*, reported the Bureau lacked formal review and approval policies and procedures for inputting information into Options. We concluded Options data entry errors would likely go unnoticed and lack of formal policies and procedures contributed to the

condition. Significant aspects of Bureau operations could be negatively affected as a result. We recommended, and the Bureau concurred, controls for all significant aspects of Bureau operations should be established. The Bureau reported procedures would be implemented to review Options data input. However, during our current audit we found no:

- preprocessing review of source documents for error detection prior to data input,
- requirements for source document approval by someone other than the preparer,
- system-generated summary or detail reports showing the transaction types input and approved for each user other than a blank and invalid report issued and reviewed monthly, and
- review of controls in place to ensure sufficiency to account for all transactions.

Training

Training helps ensure employee competency and is an essential component of management control. Options training is inconsistently offered to State employees and non-State entities. Training is reportedly provided to State employees when new versions are deployed, but regular training for new staff is reportedly ad hoc. Non-State entities are not included in the Options training program. One entity reported implementing its own Options training.

Recommendations:

We recommend the DHHS, in conjunction with the DoIT and non-State entities where applicable, improve Options management controls by:

- **assessing risks system-wide, documenting a risk control plan, and implementing risk control measures including State- and non-State owned system components;**
- **implementing security policies and procedures, revising procedures where necessary to include client data protection, regardless of whether handled by State or non-State employees;**
- **ensuring access by former employees, both State and non-State, is terminated upon separation;**
- **requiring State and non-State employees undergo initial background checks;**
- **developing, testing, implementing, and training State and non-State employees on comprehensive disaster recovery and business continuity plans;**
- **reviewing current input, output, and processing controls to enhance data integrity, ensure authorizations are not lost, and provide users needed flexibility; and**
- **improving user training and ensuring all users are trained.**

Auditee Response:

We concur.

Risk Management –

An Options risk management plan will be written and updated/reviewed annually.

Security Policies and Procedures –

State employees have always been governed by Human Resource directed Ethics, Confidentiality and Computer Use Agreement policies. The ServiceLink Network and Independent Case Managers are governed by the Healthcare Insurance Portability and Accountability Act. ServiceLink contracts contain provisions in P-37 regarding the confidentiality of data and Independent Case Managers are covered by the Medicaid Provider Enrollment Agreement. In March 2009, BEAS decided to reinforce these security policies by implementing an Options Authorized User Agreement, which was made mandatory for all State and non-State Options users.

- *BEAS will work with the DHHS Chief Information Officer and DoIT to determine the appropriate written policies and procedures for system access, disposing of computers and related equipment, hardware encryption, control of the physical security of hardware, and client data security for non-State entities.*
- *March-April 2009 – Options authorized user agreements were obtained for all active Options users.*
- *For SFY 2010 ServiceLink contracts, new language was added to Exhibit I, Health Insurance Portability and Accountability Act., to accommodate more strict standards. Public Law 104-191 and with the Standards of Privacy and Security of Individually Identifiable Health Information, 45 CFR Part 160 and 164 and those parts of the Health Information Technology Act applicable to business associates.*

System Access Termination –

The DHHS Bureau of Human Resources directs all DHHS supervisors to submit a System Access Request for all new hires, transfers, and terminations within DHHS. System access requests should be submitted at least two weeks prior to the effective date of the hire, transfer or termination. Case Manager and ServiceLink managers are instructed to contact the Options Helpdesk immediately upon termination of an employee. The quarterly "regular process" report review referenced above is done as a double check to ensure no one was missed.

- *New fields will be added to the Options user accounts to track termination request dates.*
- *More rigorous procedures will be developed requiring immediate notification of termination.*
- *Options training will be updated to include user account maintenance procedures.*

Background Checks –

Criminal Records, DHHS Division for Children, Youth, & Families Central Registry and BEAS State Registry are all checked as a condition of DHHS and DoIT employment. As an

enrolled Medicaid provider, Independent Case Managers are required to check the Medicare/Medicaid Exclusion Database routinely, as well as for new hires. They are governed by RSA 151, He-W 500, and He-E 805 rules that specifically require confirmation that each employee is not on the NH Central Registry of abuse, neglect or exploitation pursuant to RSA 169-C:35 or the BEAS State Registry established pursuant to RSA 161-F:49. ServiceLinks are required to check the BEAS State Registry and are governed by the licensing requirements of their fiscal agent. All parties are also required to abide by the Healthcare Insurance Portability and Accountability Act.

- *BEAS will investigate and implement appropriate Department requirements for background checks.*

Disaster Recovery/Business Continuity –

The BEAS Disaster Recovery plan will be updated to include detailed operating procedures and specific forms to use in case of Options unavailability. It will also be updated to include our non-State business partners; ServiceLink and Independent Case Managers.

The Business Systems Unit will work with DoIT to document Options system recovery procedures and test system recovery. This will be dependent upon the availability of DoIT resources.

The plans will be updated and reviewed annually.

User Training –

With the addition of significant changes in an Options release, formal hands-on training is scheduled for all applicable users, e.g., Case Manager training was held in July 2007 and again in July/August 2008. All non-State entities were included in initial Options User training. After the initial rollout, the ServiceLink Program Administrators opted to perform their own semi-annual/new user training for ServiceLink personnel. As new users come on board during the year, training is scheduled one-on-one by calling the Options Helpdesk.

- *Options Release training will be held for all users in May and November to review the changes for the release. May 2009 training was held on 5/15 and 5/20/09.*
- *New user accounts will not be released until that user has scheduled training.*
- *Focused training sessions, per business area, will be held quarterly.*

Observation No. 15

Review Performance Of The ServiceLink Model

During SFY 2008 there were ten ServiceLink contracts, accounting for 13 locations across the State. ServiceLink provides information, planning, and referral to the public for long-term care services and is not limited to Medicaid. The ServiceLink concept developed from Chapter 388,

Laws of 1998, requiring a system of community-based focal points providing information and referral services to elderly and chronically ill adults. The goal was to develop single entry points and coordinate service within each region. Statewide implementation of the ServiceLink model was completed in January 2007.

Each ServiceLink location operates independently, leading to variation. The model intends for each ServiceLink to meet the needs of their specific, unique communities. A BEAS official noted there are standards for all ServiceLink locations; however, we found each location's physical space, site, approach, community partners, and services vary. We also found different approaches to processing LTC eligibility, different levels of timeliness, and different opinions on how the system works.

ServiceLink personnel have five working days from receipt of the completed LTC application to enter the application into Options. However, different practices for recording application-received dates did not allow equal comparison of timeliness among ServiceLink locations. In one of the five ServiceLink locations where we interviewed personnel, the recording method always underestimates the amount of time to enter the application into the system. Table 12 provides an overview of ServiceLink locations and their respective processing times.

The original ServiceLink proposal in 2000 called for a "Focal Point" to coordinate local and community support systems and serve as a source of information, provide outreach, recruit and train volunteers, and assist in "identification of strengths and gaps in [the] State's long term care infrastructure." Additionally, the proposal called on "Focal Points" to establish a free standing 501(c)3[15] organization within a year of contract initiation and generate revenues to maintain additional community supports the State may not fund. In SFY 2008 three ServiceLink locations were freestanding 501(c)3 entities. A BEAS official reported the 501(c)3 requirement was never enforced due to the cost and the fact the current model works. However, 501(c)3 status may allow each ServiceLink to do more fundraising and grant writing to further support the program and the populations served.

BEAS and district office personnel, case management agencies, and stakeholders hold varying opinions on the purpose and success of the ServiceLink model. Interviewees reported concerns such as duplication of effort between each ServiceLink and the Department and identified ServiceLink as a wasteful model, which used too much funding and failed to streamline or improve the LTC application process. Other interviewees identified strengths such as a one-stop shop, a community presence, and an informational resource and support system during a potentially emotional process. ServiceLink personnel themselves noted reducing duplication for the consumer. BEAS personnel reported ServiceLink attempts to bring together a fragmented LTC system and has improved communication between stakeholders.

[15] A 501(c)3 is a non-profit charitable organization under the Section 501(c)3 of the Internal Revenue Code.

Table 12

SFY 2008 ServiceLink LTC Applications And Average Processing Times

ServiceLink	Number of Applications Received	Average Calendar Days to Process	Percent Over Five Calendar Days to Process
Coos	250	4	23
Strafford	428	4	22
Monadnock	349	5	18
Belknap	221	5	16
Lebanon	149	3	14
Manchester	782	3	13
Seacoast	349	3	10
Salem	246	2	8
Merrimack	632	2	6
Carroll	226	1	5
Nashua	481	1	4
Sullivan	215	1	3
Littleton	184	1	2

Note: Variation in ServiceLink data entry processes creates inaccurate reporting of timeliness.
Source: LBA analysis of Options data for all LTC applicants SFY 2008.

Recommendations:

We recommend the BEAS review:

- **ServiceLink practices, revise policies and procedures for the LTC eligibility process for ServiceLink where needed, and provide training and guidance to encourage consistency in the application process throughout the State;**
- **the ServiceLink model, which has been in full operation for over two years, to ensure it meets anticipated needs and expectations of the populations served; and**
- **the requirement for ServiceLink locations to obtain a 501(c)3 status with the ability to seek supplemental or additional funding potentially adding services and support to the community served and the program.**

Auditee Response:

We concur.

The BEAS will review the practices of ServiceLink and the structure of the ServiceLink model itself to ensure that the program meets the needs and expectations of its target population. BEAS will continue its practice of onsite program and operational reviews of each ServiceLink site to document adherence to program guidelines and to require corrective action plans to address areas of noncompliance with program guidelines and procedures. The procurement process for the next round of ServiceLink contracts will begin in September with the drafting of a request for proposal to be released next January. Both the request for proposal and the scope of service included in the new contracts will strengthen the requirements for each ServiceLink to comply with constant standards and guidelines.

OTHER ISSUES AND CONCERNS

In this section, we present issues we consider noteworthy, but not developed into formal observations. The Legislature and the Department of Health and Human Services (DHHS) may wish to consider whether these issues and concerns deserve further study or action.

Assess Changes In The BEAS Nurse Workloads

During our file review, we assessed several steps in the medical eligibility determination process to identify bottlenecks. We assessed the timelines for the following steps:

- ServiceLink to enter an application into Options,
- application accepted (have a status in New Heights),
- appointment with a Bureau of Elderly and Adult Services (BEAS) nurse,
- BEAS nurses and operations submit paperwork and enter determination into Options, and
- medical and financial eligibility completed and entered in New Heights.

Based on the analysis of our sample, the time to schedule a nurse's visit and the time required for the nurse to submit and the Bureau to enter the medical determination paperwork are the longest parts of the process.

For cases which should have been processed within 45 days and a final determination of "eligible" was made by the BEAS, we found the average completion time for the medical side of the process was 48 calendar days (median 36 days). Within this process, the time from the application accepted date to the nurse's visit date is 27 days (median 19 days). The time for the BEAS nurses and operations to process the required paperwork from the date of the nurse's determination is an additional 13 days (median 8 days).

If the BEAS was able to reduce the time required for these two components of the process, several days and potentially weeks could be eliminated from the time to become medically eligible. Since the audit period, the BEAS has implemented a program where nursing facilities may process medical determinations for nursing facility Medicaid Long-Term Care (LTC) applicants. The BEAS expects this to decrease the workload of BEAS nurses and reduce the time required to obtain a nurse's visit.

We suggest the BEAS assess how recent changes to the nurse's workload has affected the timeliness of processing Medicaid LTC applications and identify more ways of decreasing the time it takes nurses to visit applicants and process the paperwork to ensure time standards are met.

Auditee Response:

We concur.

BEAS is committed to continuous quality improvement and as such developed specific performance indicators linked to the medical eligibility determination (MED) process. The continuous monitoring of those indicators has led to process improvements that have reduced wait time for level of care assessments. The BEAS is responsible for determining medical eligibility for LTC services provided in a nursing facility or those services offered as an alternative to nursing facility placement as described in 42CFR 441.302 (c) (1) and section 1919 (a) of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) indicate that 42 CFR 435.911 "Timely determination of eligibility" relates solely to financial eligibility time frames, not medical eligibility. In the audit period, the following time frames were noted:

	Average
Total activity completion time:	*48 calendar days*
	34 working days
Application accepted to RN visit:	*27 calendar days*
	19 working days
Processing / Eligibility	*13 calendar days*
	9 working days

** The Options system is programmed to count by calendar days. When establishing the actual time frame available to complete the process relative to productivity, one must consider actual workdays available.*

Process improvements that have occurred since the audit period that have impacted the MED assessment process have involved the:

- *Development of nursing competencies;*
- *Development of nursing performance standards;*
- *Cessation of the paper MED assessment process;*
- *Conversion to an electronic MED process where assessment data can be immediately sent to the state office from the field to be processed;*
- *Assignment of nurses to complete assessments based on volume as opposed to geographic areas;*
- *Training of the nursing staffs from more than 85% of the nursing facilities statewide to conduct the face-to-face interview portion of the MED process;*
- *Reformatting of the MED instrument to make it more efficient and user friendly: and the*
- *Elimination of the requirement a participant must have a second MED when a HCBC-ECI participant is admitted to a nursing facility and then discharged to Home and Community-Based Care – Elderly and Chronically Ill (HCBC-ECI) services unless otherwise due for a redetermination of eligibility.*
- *Multiple days of consultation and training from MEDSTAT (a national technical assistance provider authorized to consult on behalf of CMS regarding the quality assurance/quality improvement initiative for participants in HCBC-ECI and nursing*

facility processes) provided to the staffs of BEAS, New Hampshire Independent Case Management Association, and other providers in the following areas:

- *Automation of the MED;*
- *Medical assessment instruments;*
- *Medical assessment processes;*
- *Service plan development; and*
- *Risk assessment.*

- *Quality Improvement Indicators were developed to assess that:*
  - *Individuals applying for nursing facility and HCBC-ECI services are evaluated in a timely manner utilizing the MED instrument;*
  - *Participants receiving HCBC-ECI services understand and are satisfied with the HCBC-ECI services they are receiving; and*
  - *Individual support plans are adequate to meet the needs identified in participant support plans.*

Further changes in the model are anticipated as the Department works to involve additional stakeholders in the process. Timeframes will continue to be measured throughout this process change.

Evaluate the Medical Evaluation Determination Form And Medical Evaluation Process

During the audit period, BEAS nurses completed the MED form to determine the eligibility of Medicaid LTC applicants. The MED is a 10-page form used to assess the applicant's activities of daily living, cognition, and capacity to care for themselves. Before the implementation of the MED, medical evaluations were based on a two-page form, 276 A and B, which required a doctor's signature. According to two DHHS officials, in the former model almost no one was denied for services, the BEAS could not process the forms as quickly as they were coming in, and there may have been an institutionalization bias as they were often completed by nursing facilities.

According to two DHHS officials, the MED model provides several advantages to the determination process. Administered by a nurse in a face-to-face meeting, this process allows for a more "holistic" approach where the form, the nurse's observation, and the applicant's interactions create a more thorough picture of the applicant's current environment. The nurses are able to extend additional assistance if there are issues such as alcohol abuse, depression, or other ailments. The MED is also used to develop the nurse's support plan, which is then used as a baseline for measuring the projected cost of care for a HCBC-ECI recipient.

While the MED provides these features, there are some concerns over the usefulness of this instrument. Two out of five stakeholders and three out of five case management agencies expressed concerns over the value and relevance of the information collected, the amount of time it takes for a nurse to meet an applicant and complete the MED, and the potential duplication existing in the process where the nurses develop a support plan using the MED while case management agencies develop their own plan of care using their evaluation tools, and providers again assess clients prior to providing services.

Timeliness in determining eligibility for LTC services is a concern. Four BEAS officials, three stakeholders, and one case management agency employee noted requiring a nurse to complete the MED may not be necessary and causes delays in the process due to staffing shortages. Several other suggestions such as the determination being completed by case management agencies, social workers, or other trained parties were identified as ways to shorten the delay in the eligibility determination.

The Bureau recognized this problem and has recently implemented a program where nursing facilities can complete the medical determination process. While this process should reduce the nursing workload, it does reintroduce one of the drawbacks associated with the original 276 Form. What incentive is there for a nursing facility to move applicants back out into the community in lieu of institutional care or find them ineligible? That being said, the nursing facility determinations are reviewed by State nurses, which allow the Department to say it is still in control of the process.

We suggest the BEAS continue to reevaluate its process and seek efficient and effective ways to make determinations, while considering costs, timeliness, and the well-being of the applicant.

Auditee Response:

We concur.

42 CFR 441.302 State Assurances relates to waiver requirements for HCBC-ECI services. Paragraph (c) Evaluation of need requires an initial evaluation of need for the level of care provided in a hospital, nursing facility or intermediate care facility when there is reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home and community based services. RSA 151-E:3 reflects section 1919 (a) of the Act by describing a person being clinically eligible for nursing facility care because the person requires 24-hour care for one or more of the following purposes: (1) Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services; (2) Restorative nursing or rehabilitative care with patient-specific goals; (3) Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or (4) Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence.

Prior to the development of the original 16 page form, CMS was consulted regarding the use Form 276 A, B, C to establish medical eligibility. CMS determined that the information provided through this form was not adequate. Further, a national survey determining the content contained in the instruments states used to assess eligibility for nursing facilities and determined eligibility for level of care, indicated all 50 states had adopted instruments that included demographic, personal, clinical, functional and activities of daily living data along with plans of care recommendations that are used to develop a weighted score that determines eligibility.

New Hampshire's MED instrument allows for the gathering of clinical information in a comprehensive manner that establishes reasons for the individual requiring a specific level of care. The MED instrument was approved for use in January of 2006. The Department agreed to use the instrument for a full year and then reassess. A comprehensive review of the instrument was conducted under the direction the Medical Director of the BEAS, a nationally recognized leader in the development of best practices in elder care. The Medical Director's leadership resulted in several significant changes to the MED instrument; those changes included a reformatting of the instrument; the addition of drop down menus and the insertion of three objective instruments to assess cognition, depression and substance use. The preceding 2008 changes resulted in nurses being able to complete the MED assessment process within 60 minutes. The changes were presented and approved as required by RSA 151-E:3 Eligibility.-III. by the Health and Human Services Oversight Committee.

Critical to the assessment process is the development of a plan of care. The information collected from the MED enables the nurse responsible for developing the plan of care to be able to do so based on the self-reported information provided by the applicant. That information enables the creation of a needs assessment that serves as a preliminary treatment plan and service authorization. Upon receipt of the information contained within the MED, all providers have a solid foundation from which they are able to develop a comprehensive treatment plan for individual waiver participants. The information is current, objective and drives service authorization. It is the expectation of the Department, that as individual providers become more knowledgeable of the participant's needs over time that the support plan will be further refined to identify in considerably more detail the clinical needs of the individual.

The Department will continue to monitor and evaluate the MED instrument and process. It is anticipated the process will undergo several iterations, driven by participant satisfaction surveys, medical reviews of the assessment instrument and evaluation of process time frames through quality improvement activities.

Improve Oversight Of Service Provision

The BEAS conducts very little oversight of providers and case management agencies. According to a BEAS official, the Bureau does not currently conduct oversight to ensure that the services being provided are those authorized in the plans of care. There is also no oversight of the *quality* of services being provided. However, this same official notes the BEAS is currently developing a plan for auditing the presence and quality of these services, to be implemented during calendar year 2009.

While case management agencies have been tasked with monitoring service provision for HCBC-ECI cases through State Law and rules, the BEAS is responsible for oversight of case management. Administrative Rule He-E 805.10 requires participant satisfaction and complaint reports by case management agencies be prepared quarterly; however, according to case management agencies, while these reports are prepared, the DHHS does not request or review them and one case management agency noted the case management function is not really

monitored. Additionally, this same rule allows the Bureau to monitor case management agencies and requires the monitoring be done "at least annually."

As identified in our 2007 financial audit of the BEAS,[16] the Bureau does not reconcile the services authorized, or the cost of services authorized, to the claims made by providers. Without monitoring, once a provider is authorized, they would be able to bill for any HCBC-ECI service in any amount, with no verifications. One case management agency, who also handles billing for the State for one program, created a position for monitoring authorized services and costs to claimed services and costs, as the inconsistencies are often significant. Without monitoring this process, it is unclear whether the Bureau is incurring costs for unauthorized services. BEAS personnel noted this issue should be corrected when the Options system communicates with the new Medical Management Information System (MMIS) system, including information on services and the amount of services authorized. The DHHS did not meet the January 2009 implementation date for the new MMIS system, as stated in its response to our 2007 audit. According to a BEAS official, the implementation of MMIS has been pushed back to July 2010.

We suggest the Bureau continue to improve its oversight of LTC services and providers including increasing its review of authorizations and payments while it awaits implementation of the new MMIS.

Auditee response:

We concur.

BEAS recognizes the benefits of more intensive provider and service monitoring recommended by the LBA. The HCBC-ECI waiver re-approval by CMS included approval of the first Quality Management Strategy for the New Hampshire waiver program. The first systematic evaluation of each case management provider agency was recently completed by a joint Division of Community Based Care-BEAS site visit team. This should prove to be a valuable step in evaluating the quality and level of direct program monitoring that is occurring at the case management level and will help guide further oversight activities.

[16] Observation No. 17 of *the 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*.

CONCLUSION

The Department of Health and Human Services (DHHS) has a number of opportunities to improve the eligibility determination process, service provision, communication, and program management of the Bureau of Elderly and Adult Services' (BEAS) Medicaid long-term care (LTC) program. Although the program is generally functioning as intended, it is hindered by a complex application process, limited supply of certain home-based services, insufficient controls over personal care services, inconsistent program statistics, variability in how the program is administered statewide, and inadequate communications within the Department and with Medicaid LTC system partners.

We found the Medicaid LTC eligibility determination process can be protracted, frequently lasting longer than the 45 days[17] allowable under federal law. The process is disjointed, with financial determinations handled by the Division of Family Assistance (DFA) and medical determinations handled by the BEAS. Although this division of labor is understandable given the nature of the application process, a lack of coordination between the DFA, the BEAS, and their respective management information systems can at times prolong the application process, creating delays for applicants in receiving needed services.

The DHHS should better structure the eligibility process to account for and track both financial and medical determinations within federal time standards. In addition, the Department should improve its documentation of what causes delays; it appears not all delays we identified were caused by Department inaction; however, insufficient documentation in the files made identifying causes for delays in applications extremely difficult.

Financial management reporting methods make it difficult to monitor expenditures of LTC funds, and create confusion over the *true costs* of LTC services and the value of the Home and Community Based Care – Elderly and Chronically Ill (HCBC-ECI) waiver. The BEAS uses multiple reporting methods for nursing facility and HCBC-ECI expenditures, complicating cost comparisons. Since cost savings are one reason the State opted to allow LTC recipients the option of receiving HCBC-ECI services, the inability to accurately compare costs means the Legislature may be unable to determine whether the HCBC-ECI program is achieving one of its intended goals. Additionally, the BEAS demonstrates a lack of transparency in how it calculates high-cost HCBC-ECI cases and reports on program costs, again making it difficult to determine the true costs of community-based care as opposed to institutional care.

We have identified poor communications, both within the DHHS and between the Department and relevant stakeholders, as a weakness needing correction. Although this is still the case, stakeholders we interviewed reported relations with the Department have improved somewhat in the recent past. There are signs the Department, and particularly the BEAS, has been making an

[17] The 45-day time standard applies to applications for regular and LTC Medicaid services. A 90-day standard applies to applications for programs classified as Aid to the Permanently and Totally Disabled (APTD). When applicants apply for *both* LTC and APTD, the Department is allowed to complete its determination within the longer, 90-day period.

increased effort to facilitate communications with stakeholders and clients. These efforts, if sustained, may result in improved LTC service provision. Additionally, the Bureau hopes to facilitate the medical application process by allowing non-BEAS employed nurses and other medical personnel to conduct medical eligibility assessments. These improvements, while significant, will require perseverance by the Department if it is to overcome the weaknesses identified in this report.

APPENDIX A

BUREAU RESPONSE TO AUDIT

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF ELDERLY & ADULT SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4680 1-800-351-1888
Fax: 603-271-4643 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Nancy L. Rollins
Associate Commissioner

June 24, 2009

The Honorable Marjorie K. Smith, Chair
Fiscal Committee of the General Court
Legislative Budget Assistant's Office
State House, Room 102
Concord, NH 03301

Re: Medicaid Long-Term Care Performance Audit.

Dear Chairman Smith:

Thank you for the opportunity to comment on the Department of Health and Human Services (DHHS) Bureau of Elderly and Adult Services (BEAS) Performance Audit of the Medicaid Long-Term Care System. The Audit Report, written by the Legislative Budget Assistant's Audit Division under the leadership of Jay Henry, Senior Audit Manager was completed in June of 2009. The Department wishes to express sincere thanks to Mr. Henry and the audit team for the time, energy and effort demonstrated as they reviewed each function linked to the provision of long-term care services. The team was professional, competent and respectful throughout the audit process always persevering to assure they had an accurate, thorough understanding of the complex long-term care system.

The purpose of the audit, as outlined by the Legislative Performance Audit and Oversight Committee, was to answer the following question: "Is the DHHS efficiently and effectively managing and coordinating eligibility determinations and service provisions for the State's Medicaid long-term care system for seniors and adults with disabilities?" In order to address the question the audit effort focused on the Department's

- Financial and medical eligibility determination process,
- Management and coordination of service provision, and
- Oversight of case managers, providers, and costs.

The Department concurs or concurs in part with each of the final audit observations and was encouraged the observations validated the strategic direction within the long-term care arena. Many of the observations support activity either already underway and offered a consultative perspective that helped to further define activity and direction. With the continued support of the Governor and Legislature, New Hampshire's frail and elderly can look forward to an integrated, comprehensive network of available services. The Department is proud of its success thus far while fully recognizing the enormity of the challenges that lay ahead.

Please feel free to contact me at 271-4394 or at Kathleen.F.Otte@dhhs.state.nh.us should you have any questions regarding the Department's response to the Audit report and its observations.

Sincerely,

Kathleen F. Otte
Bureau Administrator
Bureau of Elderly and Adult Services

KFO/mml

APPENDIX B

PROVIDER AVAILABILITY SURVEY

Confidentiality Statement

Your responses are for audit purposes only. According to State law (RSA 14:31-a (II)), audit work papers, such as surveys are not public records. However, work papers used to support our final report may be made available by a majority vote of the Fiscal Committee after a public hearing showing proper cause. Regardless, it is our policy not to name you specifically in our report. Also, we will not identify you or your employer within the survey results. All answers will be provided in the aggregate in our audit report.

Survey Directions

Please answer the following questions based on your experience with providers in each county for Home and Community Based Care for Elderly and Chronically Ill (HCBC-ECI) clients. For the following questions, please type your response in the box or on the line corresponding to the appropriate question. If you are unsure of where a specific county or town is, please refer to the map and listing of towns within each county on pages 9 and 10 of this survey.

Survey

1. Please identify the counties from which you have sought HCBC-ECI services for your clients:

Number of Respondents for Each County*	County
4	Belknap
3	Carroll
6	Cheshire
8	Coos
12	Grafton
20	Hillsborough
5	Merrimack
13	Rockingham
8	Strafford
5	Sullivan

Note: *Although 46 surveys were returned, the total number of respondents is 84 as many respondents provide services in more than one county.

Service Availability

Please tell us about the availability of long-term care services just in the counties you have sought HCBC-ECI services. We do not expect you will have firsthand knowledge about all ten

New Hampshire counties; therefore, you are not expected to have answers for all ten of the following tables.

2. In the tables below, please use the following scale, 1 to 4, to identify the availability of service providers in each county where:

   1 = readily available, with multiple provider choices
   2 = available, with limited provider choices
   3 = not readily available, with limited provider choices
   4 = not available

COMPILED STATEWIDE SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	23	Yes	8	Yes	11	Yes	33
	2	35	No	50	No	45	No	40
	3	12	Don't Know	12	Don't Know	12	Don't Know	4
	4	6						
	76		70		68		77	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	33	Yes	0			Yes	3
	2	40	No	73			No	65
	3	4	Don't Know	2			Don't Know	5
	4	0						
	77		75				73	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	33	Yes	8	Yes	51	Yes	32
	2	37	No	65	No	20	No	38
	3	9	Don't Know	5	Don't Know	6	Don't Know	9
	4	0						
	79		78		77		79	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	30	Yes	20	Yes	37	Yes	22
	2	33	No	50	No	32	No	46
	3	15	Don't Know	6	Don't Know	7	Don't Know	9
	4	2						
	80		76		76		77	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	37	Yes	8	Yes	24	Yes	28
	2	35	No	66	No	48	No	43
	3	7	Don't Know	3	Don't Know	6	Don't Know	6
	4	1						
	80		77		78		77	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	43	Yes	11	Yes	14	Yes	6
	2	34	No	61	No	57	No	68
	3	3	Don't Know	4	Don't Know	6	Don't Know	4
	4	0						
	80		76		77		78	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	11	Yes	44			Yes	24
	2	22	No	16			No	35
	3	37	Don't Know	13			Don't Know	15
	4	8						
Total Responses	78		73				74	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	7	Yes	28	Yes	13	Yes	27
	2	15	No	21	No	28	No	24
	3	38	Don't Know	21	Don't Know	23	Don't Know	19
	4	13						
Total Responses	73		70		64		70	

BELKNAP COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	1	Yes	1	Yes	0
	2	4	No	3	No	2	No	4
	3	0	Don't Know	0	Don't Know	1	Don't Know	0
	4	0						
Total Responses	4		4		4		4	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	0	Yes	0			Yes	0
	2	4	No	4			No	4
	3	0	Don't Know	0			Don't Know	0
	4	0						
Total Responses	4		4				4	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	1	Yes	3	Yes	4
	2	2	No	2	No	1	No	0
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	3		3		4		4	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	2	Yes	2	Yes	2
	2	0	No	0	No	1	No	0
	3	1	Don't Know	0	Don't Know	0	Don't Know	0
	4	1						
Total Responses	3		2		3		2	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	1	Yes	0	Yes	4
	2	1	No	2	No	4	No	0
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	3		3		4		4	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	0	Yes	0	Yes	0
	2	1	No	4	No	4	No	4
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	4		4		4		4	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	0	Yes	3			Yes	2
	2	1	No	0			No	2
	3	3	Don't Know	0			Don't Know	0
	4	0						
Total Responses	4		3				4	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	1	Yes	1	Yes	2
	2	0	No	0	No	1	No	2
	3	2	Don't Know	2	Don't Know	1	Don't Know	0
	4	2						
Total Responses	4		3		3		4	

1 = readily available, with multiple provider choices
2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

CARROLL COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	0	Yes	1
	2	1	No	0	No	0	No	2
	3	0	Don't Know	1	Don't Know	1	Don't Know	0
	4	2						
Total Responses	3		1		1		3	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	1	Yes	0			Yes	0
	2	2	No	2			No	1
	3	0	Don't Know	0			Don't Know	1
	4	0						
Total Responses	3		2				2	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	2	Yes	1
	2	3	No	2	No	0	No	1
	3	0	Don't Know	1	Don't Know	1	Don't Know	1
	4	0						
Total Responses	3		3		3		3	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	1	Yes	1
	2	2	No	2	No	0	No	0
	3	0	Don't Know	1	Don't Know	2	Don't Know	2
	4	1						
Total Responses	3		3		3		3	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	1	Yes	1
	2	3	No	3	No	1	No	1
	3	0	Don't Know	0	Don't Know	1	Don't Know	1
	4	0						
Total Responses	3		3		3		3	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	0	Yes	0	Yes	0
	2	1	No	3	No	2	No	2
	3	0	Don't Know	0	Don't Know	1	Don't Know	1
	4	0						
Total Responses	3		3		3		3	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	0	Yes	2			Yes	1
	2	1	No	0			No	0
	3	1	Don't Know	0			Don't Know	1
	4	1						
Total Responses	3		2				2	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	2	Yes	1	Yes	1
	2	0	No	0	No	0	No	0
	3	2	Don't Know	0	Don't Know	1	Don't Know	1
	4	1						
Total Responses	3		2		2		2	

1 = readily available, with multiple provider choices
2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

CHESHIRE COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	0	Yes	1	Yes	2
	2	4	No	3	No	3	No	2
	3	0	Don't Know	0	Don't Know	0	Don't Know	2
	4	0						
Total Responses	5		3		4		6	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	2	Yes	0			Yes	1
	2	2	No	5			No	4
	3	2	Don't Know	0			Don't Know	1
	4	0						
Total Responses	6		5				6	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	0	Yes	2	Yes	0
	2	3	No	5	No	3	No	5
	3	1	Don't Know	0	Don't Know	0	Don't Know	1
	4	0						
Total Responses	6		5		5		6	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	3	Yes	3	Yes	0
	2	3	No	3	No	2	No	5
	3	2	Don't Know	0	Don't Know	0	Don't Know	1
	4	0						
Total Responses	6		6		5		6	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	0	Yes	0	Yes	0
	2	3	No	5	No	5	No	5
	3	1	Don't Know	0	Don't Know	0	Don't Know	1
	4	0						
Total Responses	6		5		5		6	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	1	Yes	0	Yes	0
	2	3	No	4	No	5	No	5
	3	0	Don't Know	0	Don't Know	0	Don't Know	1
	4	0						
Total Responses	6		5		5		6	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	0	Yes	4			Yes	1
	2	2	No	2			No	3
	3	4	Don't Know	0			Don't Know	2
	4	0						
Total Responses	6		6				6	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	1	Yes	0	Yes	2
	2	1	No	3	No	2	No	1
	3	5	Don't Know	2	Don't Know	3	Don't Know	3
	4	0						
Total Responses	6		6		5		6	

1 = readily available, with multiple provider choices
2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

COOS COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	1	Yes	0	Yes	1
	2	4	No	5	No	4	No	6
	3	3	Don't Know	2	Don't Know	3	Don't Know	0
	4	1						
Total Responses	8		8		7		7	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	1	Yes	0			Yes	0
	2	6	No	7			No	6
	3	0	Don't Know	0			Don't Know	0
	4	0						
Total Responses	7		7				6	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	1	Yes	5	Yes	4
	2	6	No	7	No	2	No	3
	3	1	Don't Know	0	Don't Know	1	Don't Know	1
	4	0						
Total Responses	8		8		8		8	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	1	Yes	3	Yes	3
	2	5	No	7	No	4	No	4
	3	1	Don't Know	0	Don't Know	1	Don't Know	1
	4	0						
Total Responses	8		8		8		8	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	0	Yes	1	Yes	1
	2	4	No	8	No	6	No	6
	3	1	Don't Know	0	Don't Know	1	Don't Know	0
	4	0						
Total Responses	8		8		8		7	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	0	Yes	0
	2	7	No	7	No	7	No	8
	3	1	Don't Know	0	Don't Know	1	Don't Know	0
	4	0						
Total Responses	8		7		8		8	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	1	Yes	3			Yes	1
	2	6	No	5			No	7
	3	0	Don't Know	0			Don't Know	0
	4	1						
Total Responses	8		8				8	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	2	Yes	1	Yes	1
	2	2	No	4	No	5	No	7
	3	5	Don't Know	2	Don't Know	2	Don't Know	0
	4	0						
Total Responses	8		8		8		8	

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2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

GRAFTON COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	1	Yes	1	Yes	1
	2	2	No	4	No	6	No	9
	3	6	Don't Know	4	Don't Know	2	Don't Know	0
	4	2						
Total Responses	10		9		9		10	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	1	Yes	0			Yes	1
	2	9	No	10			No	9
	3	0	Don't Know	0			Don't Know	0
	4	0						
Total Responses	10		10				10	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	1	Yes	6	Yes	4
	2	8	No	9	No	3	No	6
	3	2	Don't Know	1	Don't Know	2	Don't Know	1
	4	0						
Total Responses	11		11		11		11	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	4	Yes	5	Yes	3
	2	7	No	4	No	4	No	6
	3	4	Don't Know	2	Don't Know	2	Don't Know	2
	4	0						
Total Responses	11		10		11		11	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	2	Yes	5	Yes	4
	2	8	No	8	No	5	No	6
	3	2	Don't Know	0	Don't Know	1	Don't Know	1
	4	0						
Total Responses	11		10		11		11	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	3	Yes	0	Yes	1
	2	6	No	6	No	8	No	9
	3	2	Don't Know	0	Don't Know	2	Don't Know	0
	4	0						
Total Responses	10		9		10		10	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	0	Yes	6			Yes	4
	2	4	No	1			No	3
	3	5	Don't Know	2			Don't Know	2
	4	1						
Total Responses	10		9				9	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	5	Yes	2	Yes	3
	2	0	No	1	No	3	No	2
	3	7	Don't Know	1	Don't Know	1	Don't Know	3
	4	3						
Total Responses	10		7		6		8	

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2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

HILLSBOROUGH COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	9	Yes	2	Yes	5	Yes	9
	2	9	No	15	No	9	No	9
	3	1	Don't Know	2	Don't Know	2	Don't Know	1
	4	0						
Total Responses	19		19		16		19	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	9	Yes	0			Yes	0
	2	9	No	18			No	17
	3	1	Don't Know	1			Don't Know	1
	4	0						
Total Responses	19		19				18	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	16	Yes	0	Yes	12	Yes	3
	2	3	No	18	No	6	No	15
	3	1	Don't Know	2	Don't Know	0	Don't Know	1
	4	0						
Total Responses	20		20		18		19	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	12	Yes	4	Yes	10	Yes	1
	2	6	No	14	No	9	No	17
	3	2	Don't Know	2	Don't Know	0	Don't Know	1
	4	0						
Total Responses	20		20		19		19	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	16	Yes	0	Yes	5	Yes	0
	2	3	No	18	No	13	No	17
	3	1	Don't Know	2	Don't Know	1	Don't Know	2
	4	0						
Total Responses	20		20		19		19	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	16	Yes	2	Yes	6	Yes	1
	2	4	No	16	No	12	No	17
	3	0	Don't Know	2	Don't Know	1	Don't Know	1
	4	0						
Total Responses	20		20		19		19	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	3	Yes	14			Yes	5
	2	3	No	2			No	9
	3	12	Don't Know	4			Don't Know	5
	4	1						
Total Responses	19		20				19	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	4	Yes	6	Yes	1	Yes	5
	2	6	No	9	No	10	No	9
	3	7	Don't Know	4	Don't Know	5	Don't Know	4
	4	1						
Total Responses	18		19		16		18	

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2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

MERRIMACK COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	0	Yes	2
	2	2	No	1	No	1	No	1
	3	0	Don't Know	1	Don't Know	2	Don't Know	0
	4	0						
Total Responses	2		2		3		3	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	2	Yes	0			Yes	0
	2	1	No	3			No	2
	3	0	Don't Know	0			Don't Know	1
	4	0						
Total Responses	3		3				3	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	0	Yes	3	Yes	1
	2	1	No	3	No	0	No	2
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	3		3		3		3	
Homemaker Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	0	Yes	2	Yes	0
	2	0	No	3	No	1	No	3
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	3		3		3		3	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	0	Yes	2	Yes	1
	2	1	No	3	No	1	No	2
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	3		3		3		3	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	0	Yes	2	Yes	0
	2	0	No	3	No	1	No	3
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	3		3		3		3	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	1	Yes	3			Yes	2
	2	0	No	0			No	0
	3	2	Don't Know	0			Don't Know	1
	4	0						
Total Responses	3		3				3	
Respite Care	Answer		Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	2	Yes	1	Yes	2
	2	0	No	0	No	0	No	0
	3	3	Don't Know	1	Don't Know	2	Don't Know	1
	4	0						
Total Responses	3		3		3		3	

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2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

ROCKINGHAM COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		**Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count		Count	Answer	Count	Answer	Count
	1	9	Yes	0	Yes	2	Yes	11
	2	4	No	11	No	11	No	2
	3	0	Don't Know	2	Don't Know	0	Don't Know	0
	4	0						
Total Responses	13		13		13		13	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	11	Yes	0			Yes	0
	2	2	No	12			No	12
	3	0	Don't Know	1			Don't Know	1
	4	0						
Total Responses	13		13				13	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	6	Yes	3	Yes	9	Yes	10
	2	5	No	9	No	3	No	2
	3	2	Don't Know	1	Don't Know	1	Don't Know	1
	4	0						
Total Responses	13		13		13		13	
Homemaker Services	Answer		Answer	Count	Answer	Count	Answer	Count
	1	8	Yes	4	Yes	5	Yes	4
	2	3	No	8	No	6	No	7
	3	2	Don't Know	1	Don't Know	1	Don't Know	2
	4	0						
Total Responses	13		13		12		13	
Nursing Services	Answer		Answer	Count	Answer	Count	Answer	Count
	1	7	Yes	3	Yes	5	Yes	8
	2	5	No	9	No	7	No	3
	3	0	Don't Know	1	Don't Know	1	Don't Know	1
	4	1						
Total Responses	13		13		13		12	
Personal Care Services	Answer	Count		Count	Answer	Count	Answer	Count
	1	8	Yes	3	Yes	4	Yes	1
	2	5	No	9	No	9	No	11
	3	0	Don't Know	1	Don't Know	0	Don't Know	1
	4	0						
Total Responses	13		13		13		13	
Residential Care	Answer		Answer	Count			Answer	Count
	1	3	Yes	3			Yes	1
	2	1	No	3			No	8
	3	7	Don't Know	4			Don't Know	2
	4	2						
Total Responses	13		10				11	
Respite Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	2	Yes	5	Yes	5	Yes	5
	2	3	No	3	No	4	No	3
	3	4	Don't Know	4	Don't Know	3	Don't Know	3
	4	3						
Total Responses	12		12		12		11	

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2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

STRAFFORD COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer		Answer	Count	Answer	Count	Answer	Count
	1	4	Yes	1	Yes	1	Yes	5
	2	3	No	6	No	6	No	2
	3	1	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	8		7		7		7	
Home Delivered Meals	Answer	Count	Answer	Count			Answer	Count
	1	5	Yes	0			Yes	0
	2	2	No	7			No	7
	3	0	Don't Know	0			Don't Know	0
	4	0						
Total Responses	7		7				7	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	2	Yes	6	Yes	7
	2	3	No	5	No	1	No	0
	3	1	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	7		7		7		7	
Homemaker Services	Answer		Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	2	Yes	4	Yes	7
	2	4	No	5	No	3	No	0
	3	1	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
	8		7		7		7	
Nursing Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	3	Yes	2	Yes	3	Yes	6
	2	4	No	5	No	4	No	1
	3	1	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
	8		7		7		7	
Personal Care Services	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	5	Yes	1	Yes	2	Yes	3
	2	3	No	6	No	5	No	4
	3	0	Don't Know	0	Don't Know	0	Don't Know	0
	4	0						
Total Responses	8		7		7		7	
Residential Care	Answer	Count	Answer	Count			Answer	Count
	1	3	Yes	3			Yes	4
	2	2	No	2			No	2
	3	1	Don't Know	2			Don't Know	1
	4	1						
Total Responses	7		7				7	
Respite Care	Answer		Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	2	Yes	1	Yes	3
	2	0	No	0	No	1	No	0
	3	2	Don't Know	4	Don't Know	4	Don't Know	3
	4	3						
	5		6		6		6	

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2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

SULLIVAN COUNTY - SUMMARY OF MEDICAID PROVIDER ELIGIBILITY SURVEY

HCBC-ECI Services	Please rate the availability of each service		Is there an extended wait for HCBC-ECI clients for this service?		Do LTC providers require a minimum block of time beyond service need before accepting an HCBC-ECI client?		Have providers refused taking HCBC-ECI clients because of low reimbursements?	
Directions – For each service listed below:	Enter a **1, 2, 3, or 4** based on the scale above		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**		Enter **Yes**, **No**, or **Don't Know**	
Adult Day Care	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	2	Yes	0	Yes	1
	2	2	No	2	No	3	No	3
	3	1	Don't Know	0	Don't Know	1	Don't Know	1
	4	1						
Total Responses	4		4		4		5	
Home Delivered Meals	Answer	Count	Answer	Count				Count
	1	1	Yes	0			Yes	1
	2	3	No	5			No	3
	3	1	Don't Know	0			Don't Know	0
	4	0						
Total Responses	5		5				4	
Home Health Aid	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	0	Yes	3	Yes	2
	2	3	No	5	No	1	No	3
	3	1	Don't Know	0	Don't Know	1	Don't Know	0
	4	0						
Total Responses	5		5		5		5	
	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	0	Yes	2	Yes	1
	2	3	No	4	No	2	No	4
	3	2	Don't Know	0	Don't Know	1	Don't Know	0
	4	0						
Total Responses	5		4		5		5	
	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	0	Yes	2	Yes	3
	2	3	No	5	No	2	No	2
	3	1	Don't Know	0	Don't Know	1	Don't Know	0
	4	0						
Total Responses	5		5		5		5	
	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	1	Yes	1	Yes	0	Yes	0
	2	4	No	3	No	4	No	5
	3	0	Don't Know	1	Don't Know	1	Don't Know	0
	4	0						
Total Responses	5		5		5		5	
	Answer	Count	Answer	Count			Answer	Count
	1	0	Yes	3			Yes	3
	2	2	No	1			No	1
	3	2	Don't Know	1			Don't Know	1
	4	1						
Total Responses	5		5				5	
	Answer	Count	Answer	Count	Answer	Count	Answer	Count
	1	0	Yes	2	Yes	0	Yes	3
	2	3	No	1	No	2	No	0
	3	1	Don't Know	1	Don't Know	1	Don't Know	1
	4	0						
Total Responses	4		4		3		4	

1 = readily available, with multiple provider choices
2 = available, with limited provider choices
3 = not readily available, with limited provider choices
4 = not available

3. Please provide any additional comments or concerns on service availability:

Please respond here:

- Nine respondents reported agencies believe reimbursement rates are too low and some agencies are limiting HCBC-ECI clients due to low reimbursement rates. Some agencies do not use PCSPs at all due to the low rates. Also, low reimbursement rates for in-home respite care make it unusable and the Family Caregiver Support Grants are unavailable to HCBC-ECI clients.
- Six respondents stated residential care and assisted living are not often available and providers often prefer private pay clients. Many residential care options are not wheelchair accessible.
- Six respondents replied respite care is not available or is limited and only one nursing home in the North Country provides respite care.
- Four respondents stated services and providers are sparse in portions of the State, including the Upper Valley area (Hanover, Lebanon, W. Lebanon, Enfield, Canaan) and the North Country to include Belknap and Carroll counties.
- Three respondents replied there is a shortage of home health aides and homemakers in the North Country. Difficulties staffing on weekends and evenings is evident statewide.
- Three respondents cited lack of transportation as a major issue. Securing transportation for clients is difficult and some clients must cancel medical appointments due to lack of available transportation.
- Two respondents stated some agencies would not provide services to a client unless that client requires "skilled nursing." The client is discharged once "skilled nursing" is no longer required.
- Two respondents stated providers often require minimum time allotments. These minimum time allotments raise the cost of care and may be unnecessary depending on the needs of a particular client.
- Two respondents reported using multiple providers in order to provide necessary services to a single client. Continuity of care is often disrupted by the utilization of multiple providers.

Personal Care Service Providers

4. Please type an X in the boxes marked true or false below responding to the following comments on personal care service providers (PCSPs).

True	False	Comment
39	0	PCSPs can be a very useful element of a HCBC-ECI client's plan of care.
35	4	Without PCSPs, more of your HCBC-ECI clients would enter nursing facilities sooner.
37	2	Without PCSPs, fewer of your HCBC-ECI clients would have access to needed services.
19	18	Guidance from the DHHS on how and when to use PCSPs is adequate.
19	16	The use of PCSPs is being adequately monitored for abuse.

5. Please provide any additional comments or concerns you have on personal care service providers (PCSPs):

Please respond here:

- Eighteen respondents often use Personal Care Service Providers (PCSPs) because PCSPs provide personal care as well as transportation and are often a cost savings to the State. In addition, clients often prefer their caregiver to be someone with whom they are acquainted.
- Twelve respondents recommended additional oversight of PCSPs to prevent abuse. One provider uses professionals as PCSPs instead of family members to reduce the likelihood of abuse. Providers state often clients will not complain about family members who provide the care as PCSPs.
- Five respondents replied there is a lack of training and information for staff and providers regarding HCBC programs. These respondents suggested written clarification from the State regarding roles of PCSPs, nurses, and other caregivers is necessary.
- Two respondents reported services and providers are sparse in portions of the State, including the Upper Valley area (Hanover, Lebanon, W. Lebanon, Enfield, Canaan) and the North Country to include Belknap and Carroll counties.
- Two respondents cited lack of transportation as a major issue. Securing transportation for clients is difficult and some clients must cancel medical appointments due to lack of available transportation.
- Two respondents have concerns using PCSPs, as PCSPs cannot provide the same services as a Licensed Nursing Assistant, such as dressing changes.

6. Please provide any additional comments on the availability of Medicaid waiver services for your clients. What are the biggest challenges and concerns?

Please respond here:

- Nine respondents replied lack of transportation as a major issue. Securing transportation for clients is difficult and some clients must cancel medical appointments due to lack of available transportation.
- Six respondents stated residential care and assisted living are not often available and providers often prefer private pay clients. Many residential care options are not wheelchair accessible.
- Six respondents stated there is a waiting list for some programs, such as the Acquired Brain Disorder waiver. Clients are often automatically put under a HCBC-ECI waiver when they would be a "better fit" under different waivers (Developmentally Disabled, Acquired Brain Disorder, etc). In addition, clients with mental health needs are not receiving or requesting services, or they become dependent on HCBC-ECI. Respondents also stated it is difficult to find appropriate services for younger clients.
- Four respondents replied respite care is not available or is limited and only one nursing home in the North Country provides respite care.

- Four respondents stated providers often require minimum time allotments. These minimum time allotments raise the cost of care and may be unnecessary depending on the needs of a particular client.
- Three respondents replied it is difficult for clients to find funds for dental work, including dentures.
- Two respondents reported agencies believe reimbursement rates are too low and some agencies are limiting HCBC-ECI clients due to low reimbursement rates. Some agencies do not use PCSPs at all due to the low rates. Also, low reimbursement rates for in-home respite care make it unusable and the Family Caregiver Support Grants are unavailable to HCBC-ECI clients.
- Two respondents reported services and providers are sparse in portions of the State, including the Upper Valley area (Hanover, Lebanon, W. Lebanon, Enfield, Canaan) and the North Country to include Belknap and Carroll counties.
- Two respondents believe the process for approval is too long.

APPENDIX C

CURRENT STATUS OF PRIOR AUDIT FINDINGS

The following is a summary of the status of 17 observations related to the Medicaid long-term care (LTC) program contained in prior audit reports. Related Observations are contained in our:

- *2003 Division of Elderly and Adult Services Home- and Community-Based Care Performance Audit;* and
- *Bureau of Elderly and Adult Services – Financial and Compliance Audit Report for the Year Ended June 30, 2007*

Copies of audits issued prior to 1999 may be obtained from the Office of Legislative Budget Assistant Audit Division, 107 North Main Street, State House, Room 102, Concord, NH 03301-4906. Audit reports issued after 1999 may be obtained online at our website http://www.gencourt.state.nh.us/lba/index.html.

Status Key			
Fully Resolved	●	●	●
Substantially Resolved	●	●	○
Partially Resolved	●	○	○
Unresolved	○	○	○

Our *2003 Division of Elderly and Adult Services Home- and Community-Based Care Performance Audit* contained 11 observations on the Medicaid LTC program related to our current audit.

No.	Title	STATUS		
1.	Uniformly Provide Assessment And Counseling	●	●	○
2.	Ensure Consistency For Allowable Costs In Authoritative Documents	●	○	○
3.	Ensure Plans Of Care Reflect All Needed Services	●	●	○
4.	Ensure Consumers Receive Needed Services	○	○	○
5.	Ensure Consumers Receive Only Authorized Services	○	○	○
6.	Improve Controls Over Claims Submitted For HCBC-ECI Services	○	○	○
11.	Strengthen Process For Outsourcing HCBC-ECI Cases	●	●	●
12.	Consistently Collect And Retain Complaint Information	●	○	○
13.	Improve Consumer Complaint Process	○	○	○

No.	Title	STATUS		
14.	Improve State Registry	●	●	●
18.	Strengthen Program Quality Assurance Controls	○	○	○

Our *Bureau of Elderly and Adult Services – Financial and Compliance Audit Report for the Year Ended June 30, 2007* contained six observations on the Medicaid LTC program related to our current audit.

No.	Title	STATUS		
11.	Evidence Of Medical Eligibility Determination Should Be Retained.	●	●	●
17.	Controls Should Be Established To Limit HCBC Services To HCBC Services To Plan Of Care	○	○	○
18.	Quality Controls Should Be Implemented For Case Manager Activities	●	○	○
19.	Reporting Of HCBC-ECI Waiver Costs Should Be Expanded	○	○	○
20.	Policies And Procedures Should Be Established For Documenting HCBC Client Status	○	○	○
24.	Administrative Rules Should Be Kept Current	●	●	○

OFFICE OF LEGISLATIVE BUDGET ASSISTANT
PREVIOUSLY ISSUED PERFORMANCE AUDIT REPORTS

TITLE OF REPORT	DATE
Liquor Commission	April 2009
Service Contracting	March 2009
Department of Resources and Economic Development Division of Parks and Recreation Revenues of the State Park Fund	September 2008
Fleet Management	September 2008
Office of Information Technology	July 2008
State of New Hampshire Succession Planning	July 2008
Board of Medicine	April 2008
Department of Fish and Game	January 2008
Department of Environmental Services Alteration of Terrain and Wetlands Permitting	August 2007
Insurance Department Consumer Protection Functions	August 2007
Department of Education No Child Left Behind Fund Distribution	February 2007
Insurance Procurement Practices	September 2006
Enhanced 911 System	January 2006
Department of Education Adequate Education Grant Data	December 2004
Board of Mental Health Practice	November 2004
Home Care for Children with Severe Disabilities	April 2004
Department of Corrections Division of Field Services	December 2003
Judicial Branch Administration	November 2003

TITLE OF REPORT	DATE
Department of Health and Human Services Division of Elderly and Adult Services Home and Community-Based Care	April 2003
Department of Corrections – Inmate Health Care	January 2003
Department of Corrections – Sexual Harassment and Misconduct	October 2002
Department of Environmental Services Performance-Based Budgeting	March 2002
Department of Safety – Division of Fire Safety	November 2001
Department of Education – Construction and Renovation Programs	September 2001
Department of Health and Human Services Division for Children, Youth and Families Foster Family Care	September 2001
Department of Education – Bureau of Vocational Rehabilitation and Service Delivery	August 2001
Department of Transportation – Bureau of Turnpikes Performance-Based Budgeting	April 2001
Judicial Branch – Family Division Pilot Program	January 2000
Year 2000 Computing Crisis – Special Report – Update	July 1999
Special Education – Catastrophic Aid Program	July 1999
Year 2000 Computing Crisis – Special Report	March 1999
Juvenile Justice Organization	November 1998
Marine Patrol Bureau Staffing	March 1998
Health Services Planning and Review Board	January 1998
Economic Development Programs	October 1997
Job Opportunities and Basic Skills Training Program	May 1997

TITLE OF REPORT	DATE
Child Support Services	December 1995
Multiple DWI Offender Program	December 1995
Managed Care Programs for Workers' Compensation	November 1995
State Liquor Commission	July 1994
Property and Casualty Loss Control Program	November 1993
Child Settlement Program	March 1993
Workers' Compensation Program for State Employees	January 1993
Prison Expansion	April 1992
Developmental Services System	April 1991
Department of Administrative Services Division of Plant and Property Management State Procurement and Property Management Services	June 1990
Mental Health Services System	January 1990
Hazardous Waste Management Program	June 1989
Review of the Indigent Defense Program	January 1989
Review of the Allocation of Highway Fund Resources to Support Agencies and Programs	March 1988
Review of the Public Employees' Deferred Compensation Plan	December 1987
Review of the Management and Use of State-Owned Passenger Vehicles and Privately Owned Vehicles Used at State Expense	August 1984
Management Review of the Policies and Procedures of the Division of Plant and Property Management	June 1984

Copies of previously issued reports may be received by request from:

State of New Hampshire
Office of Legislative Budget Assistant
107 North Main Street, Room 102
Concord, New Hampshire 03301-4906
(603) 271-2785

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