# STATE OF NEW HAMPSHIRE
## BUREAU OF VOCATIONAL REHABILITATION

## PERFORMANCE AUDIT REPORT
## FEBRUARY 2021

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*To The Fiscal Committee Of The General Court:*

We conducted a performance audit of the New Hampshire Bureau of Vocational Rehabilitation (NHVR) to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The purpose of the audit was to determine whether NHVR's operations were efficient and effective during State fiscal years 2017 through 2019.

Given the length of this report and complexity of the audit's scope, we provide some insights into the report's structure.

- The report is assembled to be useful to several sets of potential readers with different needs, including the public, the General Court, policy committees, the NHVR, and the Department of Education (DOE).

- The report contains an executive summary, starting on page 1, that captures main themes and the most significant concerns arising from our work, and a recommendation summary, starting on page 5, summarizing our recommendations into a table.

Chapter 1 provides a brief background on NHVR and vocational rehabilitation in general. Each chapter following the background contains observations and recommendations addressing specific aspects of NHVR's management of the program.

- Chapter 2 generally discusses NHVR's internal control environment and incorporates deficiencies discussed in Chapters 3 through 8.
- Chapter 3 discusses the fiscal management practices that lead, in part, to NHVR's decision to implement an order of selection, which created a waitlist for services.

- Chapters 4 through 7 address deficiencies in each specific phase of the vocational rehabilitation process.
- Chapter 8 discusses deficiencies with overarching management responsibilities.
- Chapter 9 addresses other issues and concerns we identified in NHVR's operations.

Each observation contains detailed information generally intended to inform NHVR and DOE managers about specific deficiencies with management control systems. Some observations contain extensive details, and often similar facts, when describing weaknesses and their causes or likely causes. This repetition is partly because of the interrelationship between management control systems and is necessary to allow each observation to be understood independently from the rest. This information is not intended for general readers unless they have a specific interest in the observation's subject matter.

Office Of Legislative Budget Assistant

February 2021

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## ABBREVIATIONS AND GLOSSARY OF TERMS

| | |
|---|---|
| *2001 LBA Audit* | *Bureau Of Vocational Rehabilitation And Service Delivery* performance audit report released in 2001. |
| Act | Federal *Rehabilitation Act Of 1973* |
| Applicant | An individual who has submitted an application requesting vocational rehabilitation services but has not yet been determined eligible or ineligible. |
| CAP | Client Assistance Program - A State program established to inform and advise applicants and customers of all available benefits under the federal *Rehabilitation Act Of 1973*. |
| CRP | Community Rehabilitation Program |
| *CRP Handbook* | *Community Rehabilitation Program Operational Handbook* |
| Customer | An individual who has been determined eligible to receive vocational rehabilitation services. |
| CY | Calendar Year |
| DAS | Department Of Administrative Services |
| *Desk Reference* | *NHVR Counselor Desk Reference* in effect during the audit period |
| DOE | New Hampshire Department Of Education |

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|---|---|
| FATF | *Financial Aid Transmittal Form* |
| FFY | Federal Fiscal Year, starts on October 1 and ends on September 30. |
| FNA | Financial Needs Assessment |
| IPE | Individualized Plan For Employment |
| L-SD | Less Significant Disability |
| MOE | Maintenance Of Effort – a requirement placed on some federally funded grant programs to ensure funding remains constant from year to year. |
| MSD | Most Significant Disability |
| NHVR | New Hampshire Bureau Of Vocational Rehabilitation |
| Non-rehabilitated | Customers whose cases closed under circumstances other than rehabilitation. |
| OOS | Order Of Selection |
| PES | Post-employment Services |
| Pre-ETS | Pre-employment Transition Services - Services provided to students to facilitate the transition from school to post-secondary activities that are limited to five specific areas. |
| *Policy Manual* | *NH Vocational Rehabilitation Policy Manual* |
| Rehabilitated | Customers whose cases were closed after meeting certain federal requirements, including maintaining stable employment for at least 90 days. |
| RL | Regional Leader |
| SD | Significant Disability |
| SFY | State Fiscal Year, starts on July 1 and ends on June 30. |
| SSA | Social Security Administration |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |
| *State Plan* | *VR Portion Of WIOA State Plan For The State Of New Hampshire* |
| ULO | Unliquidated Obligation |
| VR | Vocational Rehabilitation |
| VRC | Vocational Rehabilitation Counselor, also known as counselor, classified in the State employment system as Is, IIs, or IIIs, to assist persons with disabilities to increase employment potential and optimize independence by recommending and providing comprehensive services. |
| WIOA | Federal *Workforce Innovation And Opportunity Act Of 2014* |

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## EXECUTIVE SUMMARY

The New Hampshire Bureau of Vocational Rehabilitation (NHVR), located within the Department of Education (DOE), was responsible for implementing a federal program designed to assist eligible individuals with disabilities to attain competitive integrated employment and economic self-sufficiency. To do this, NHVR was required to determine whether applicants were eligible for vocational rehabilitation services, assess the services needed to help them attain employment, and develop a plan to provide services. Federal law required states to provide services to all eligible individuals. If it cannot, states must establish the order in which it will select eligible individuals to receive services, commonly referred to as an order of selection (OOS). In May 2018, NHVR implemented an OOS. During State fiscal year (SFY) 2017, the last full year before NHVR the OOS, it spent $19.5 million. At the end of SFY 2017, NHVR had 3,609 individuals with open cases.

We found NHVR did not have an effective internal control system. An effective internal control system increases the likelihood an entity will achieve its goals, helps agencies safeguard assets, and helps managers achieve desired results through effective stewardship of public resources. However, NHVR's internal control system was not designed, implemented, and operating in a manner to ensure these objectives were consistently achieved. While NHVR had some internal controls and put additional controls in place during the OOS, these changes did not mitigate all existing weaknesses. NHVR did not have comprehensive administrative rules, clear policies and procedures, or consistent training and supervision. Additionally, NHVR's monitoring structure was limited in its ability to ensure noncompliance was identified and corrected timely.

We also found inconsistent adherence to management directives and controls intended to ensure compliance with federal requirements. Some controls were bypassed by both staff and management through document backdating which allowed NHVR to appear compliant with federal time limits in some cases. Backdating, coupled with inconsistent maintenance of required documentation, made some program data unreliable and compromised mandatory federal reporting, information available to external stakeholders, and NHVR's ability to measure its own performance. These weaknesses undermined organizational accountability and allowed some cases to avoid supervisory controls. The Rehabilitation Services Administration, NHVR's federal oversight agency, also commented on inconsistent documentation in some of NHVR's case records. In its review of NHVR encompassing federal fiscal years (FFY) 2016 through 2018, federal reviewers noted that some case records were missing required documentation, or the documentation found in the case record did not fully support the information NHVR transmitted in its federal reports.

Compounding these issues was management's assertion that scrutinizing costs at the individual case level was not their primary focus, which appeared to weaken fiscal controls. When addressing customers' immediate needs, some processes were in place to obtain a reasonable price. However, some processes were inconsistently followed and NHVR provided some services which appeared questionable for the customer to attain their employment goals. While addressing specific needs was critical to the customer's vocational rehabilitation process, ensuring all funds are used cost effectively was part of management's responsibility.

NHVR managed a complex mix of funding primarily consisting of federal funds and State general funds. It also had to ensure it met multiple federal financial requirements. Despite the complexity of its mix of funding, NHVR's financial activities operated with minimal oversight until Fall 2017. NHVR operated under the impression it had an excess of federal funds available for many years, and the NHVR Director reported providing little oversight over financial activities, as others within the DOE reportedly oversaw the program's financial personnel. In December 2017, DOE management started requiring quarterly reporting on NHVR's financial position. This increased oversight helped identify a probable shortfall, but did not fully identify the impending financial crisis until the early months of 2018. Periodic internal scrutiny earlier than fall 2017 would have likely revealed substantial flaws in NHVR's financial controls and could have resulted in an earlier detection of the impending financial crisis. NHVR's federal oversight agency made a similar finding, noting that NHVR did not maintain effective internal controls over some aspects of its federal grant to provide reasonable assurance that it was managing the grant in compliance with all federal laws and regulations.

Legislative and public financial oversight was hindered because NHVR's budget in the State's accounting system inflated the amount of federal funds actually available by millions of dollars over multiple years, including SFYs 2017 through 2019. To an outside observer, this created the perception that more federal funds were available than actually were, making the risk of a budgetary crisis appear low. However, this issue was resolved in the State budget submitted for SFYs 2020 and 2021.

In addition to an inflated State budget being submitted, NHVR's internal tracking of its primary federal grant also contained flaws. Prior to calendar year 2018, NHVR's internal records contained errors in the amount of federal award it carried over into the following FFY. Internal records projected that at the beginning of FFY 2013, NHVR would have carried over approximately $8.3 million from the prior year into FFY 2014. In actuality, the carryover was approximately $420,000 less. The discrepancy within the internal records expanded in subsequent FFYs. At the beginning of FFY 2017, NHVR's records projected it would carry over $9.5 million from FFY 2016. However, its actual carryover balance was only $5.7 million, approximately $3.8 million less than internal records reflected. Carryover was needed to fund current year expenditures. By early 2018, NHVR's revised internal records appeared to reasonably reflect its actual carryover balance. These deficiencies in its critical responsibility to properly manage financial resources resulted in NHVR implementing an OOS quickly and the creation of a waitlist for the first time in NHVR's almost 100-year history. Although waitlists were common in other states, this was the first time New Hampshire had ever had one.

After discovering its financial situation in early 2018, NHVR management reported determining it was overstaffed and had been overspending on customer services. We found NHVR and the DOE likely acted appropriately when they made the decision to implement an OOS. The information available to management at the time signaled an unsustainable fiscal situation requiring immediate action. NHVR projected that after using the current year's grant, State match, and program income, its SFY 2018 expenditures would produce an approximate $3.5 million deficit. The gap would need to be made up from its carryover, which would significantly deplete carryover funds. NHVR concluded this deficit would not be sustainable if immediate action was not taken. The OOS limited the number of customers NHVR served, ultimately decreasing its

spending on services. In addition, NHVR laid off employees or did not fill vacant positions, consolidated regional offices, and took other steps aimed at reducing spending. However, a year after estimating the near depletion of carryover funds in FFY 2018, NHVR's spending restrictions, combined with a reduction in customers being served and NHVR pursuing additional available federal funds, resulted in over $9.3 million of unspent federal funds in FFY 2019, which was carried over into FFY 2020. In December 2019, NHVR released all customers from the waitlist. As of November 2020, NHVR remained in an OOS but was able to serve all customers without first placing them on a waitlist.

Beginning in fall 2017, NHVR made substantial improvements to internal controls over its financial operations but controls were still being developed through the rest of the audit period. Internal controls over NHVR's programmatic operations still needed improvement. This report presents 46 observations with recommendations that are intended to help NHVR improve its internal controls and culture of accountability moving forward as it continues to serve individuals with disabilities in New Hampshire.

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## RECOMMENDATION SUMMARY

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
|---|---|---|---|---|
| 1 | 31 | No | Strengthen the New Hampshire Bureau of Vocational Rehabilitation's (NHVR) internal control system by developing a strategic plan and assigning accountability for implementation, assessing workforce needs, implementing a performance measurement system, implementing risk-based management practices, reviewing existing controls, ensuring managers understand importance of controls, ensuring quality information is available for decision-making, and continuously evaluating and improving its internal control structure. | Concur In Part |
| 2 | 52 | No | Further mature fiscal management by ensuring processes are fully documented, repeatable, have clearly defined roles, include metrics, and are monitored using a formal assessment. | Concur In Part |
| 3 | 60 | No | Improve eligibility signature authority and supervisory approval process by tracking status of counselors' signature authority, assigning appropriate authority to counselors, refining written policies and guidance, communicating policies clearly to staff, developing training on supervisory review processes, identifying data necessary to monitor compliance and refine processes, assessing compliance, and remediating identified deficiencies timely. | Concur In Part |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
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| 4 | 68 | No | Pursue federal guidance on whether backdating eligibility determinations is permissible. If backdating is found to be permissible, implement proper controls to ensure compliance with federal requirements and State laws including operationalizing requirements for what constitutes the official eligibility determination date, establishing written criteria for when backdating eligibility may be appropriate, establishing a process for requesting an eligibility determination be backdated, and assessing the accuracy of official eligibility determinations. | Concur In Part |
| 5 | 72 | No | Ensure eligibility determinations are made as soon as possible by instituting performance targets and documentation collection processes, defining support staff roles during the eligibility process, and identifying necessary information to monitor compliance and improve processes. | Concur In Part |
| 6 | 76 | No | Ensure compliance with the federal time limit for making eligibility determinations by operationalizing written requirements for timeliness of supervisory review and approval, monitoring staff compliance with time limits, and remediating deficiencies timely. | Concur In Part |

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| 7 | 81 | No | Pursue federal guidance on the permissibility of backdating eligibility extensions and the use of multiple extensions. If permissible, develop clear guidance on documenting and monitoring multiple eligibility extensions.<br><br>Improve compliance with eligibility extensions by instituting performance targets, establishing guidance on obtaining necessary documentation, adopting administrative rules, identifying information necessary for monitoring and analyzing the extension processes, monitoring staff compliance, and remediating deficiencies timely. | Concur In Part |
| 8 | 91 | No | Ensure exemptions for "exceptional and unforeseen circumstances" are consistent with federal regulations by defining and adopting the exemption process in administrative rules and policy, aligning training materials with State and federal requirements, identifying data necessary to monitor compliance and improve processes, measuring staff compliance, and remediating deficiencies timely. | Concur In Part |
| 9 | 96 | No | Ensure disability priority assignments are compliant and consistent by assessing the effectiveness of allowing regional leaders (RLs) to review decisions made by their own staff, assessing the feasibility of routine reviews by different RLs within an allowable timeframe, and addressing noncompliance timely.<br><br>Identify data necessary to monitor compliance with disability priority assignments and implement process improvements and assess staff compliance and remediate any deficiencies through training. | Concur In Part |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
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| 10 | 103 | No | Ensure guidance on eligibility requirements and disability priority criteria are accurate and comprehensive, and ensure guidance is internally and externally consistent with both NHVR and federal standards. | Concur In Part |
| 11 | 111 | No | Develop a process to ensure adequate documentation of eligibility determinations, by identifying necessary information to monitor compliance, measuring staff compliance, and remediating identified deficiencies timely. | Concur In Part |
| 12 | 117 | No | Ensure case records contain documentation required for cases where applicants were ineligible by identifying what information is necessary, ensuring training materials fully align with all requirements, monitoring compliance, assessing staff compliance with documentation requirements, and remediating deficiencies timely. | Concur In Part |

| Observation Number | Page | Legislative Action May Be Required | Recommendations | Agency Response |
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| 13 | 119 | No | Pursue federal guidance regarding how to ensure compliance with federal requirements to conduct trial work experience if no employer is willing to provide these experiences.<br><br>Improve compliance with the trial work experience requirements by adopting administrative rules, aligning training materials with federal and State requirements, ensuring guidance is consistent and comprehensive, and developing policies and procedures to ensure closure due to severity of disability contains all required trial work experience documentation.<br><br>Improve monitoring of trial work by identifying necessary data to implement process improvements, measuring and analyzing staff compliance, and remediating deficiencies timely.<br><br>Consider whether trial work experience could be expanded. | Concur In Part |
| 14 | 126 | No | Improve the individualized plan for employment (IPE) supervisory review and approval process by tracking signature authority, assigning appropriate signature authority and supervisory review responsibility, monitoring signature authority, developing written requirements for supervisory review of IPEs, routinely assessing effectiveness of controls, and developing procedures to ensure issues are timely and accurately addressed. | Concur In Part |

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| 15 | 131 | No | Improve oversight of IPEs by establishing a process to compare actual costs against IPE estimates, identifying allowable margins for deviations in IPE estimated costs to actual, identifying cases which have had little activity, and identifying and rectifying issues timely.<br><br>Evaluate the level of review needed, factors to trigger a review, documentation requirements, and personnel performing the review. | Concur In Part |
| 16 | 137 | No | Reassess current practices to ensure reasonable cost estimates are captured and all cases meeting the cost estimate threshold are flagged for review. The assessment should include determining the capability of electronic systems to adequality calculate multiple revised cost estimates and flag cases for review, determining methods for identifying and reviewing vendor-provided services estimated at $0, ensuring previous costs estimates are incorporated into the most current estimates, and ensuring services already paid for under older IPEs are retained as part of the cumulative cost estimates for the case. | Concur In Part |

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| 17 | 142 | No | Ensure compliance with federal IPE development timeliness requirements by pursuing federal guidance on compliance for customers on the waitlist; developing and implementing written requirements for supervisory review of IPEs; routinely measuring staff compliance; analyzing information to identify and remediate issues; and developing and implementing processes to identify, collect, monitor, and analyze data and information.<br><br>Pursue federal guidance on whether backdating IPE dates is permissible and implement controls to ensure compliance with federal requirements and State laws including: operationalizing requirements for what constitutes the official IPE date, establishing written criteria for when backdating may be appropriate, establishing a process for requesting an IPE date be backdated, and assessing the accuracy of official IPE dates. | Concur In Part |
| 18 | 151 | No | Improve compliance with federal and program extension requirements by developing written guidance on obtaining necessary documentation, including applicant signatures; ensuring rules, policies, and procedures clearly describe the extension process; refining training materials to align with federal and program requirements; and improving monitoring efforts.<br><br>Seek federal guidance to determine whether multiple extensions may be completed for each IPE and properly control the use of multiple extensions if permissible.<br><br>Ensure backdating of IPE extensions aligns with its determination of whether backdating is appropriate. | Concur In Part |

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| 19 | 156 | No | Ensure all IPEs are signed by the customer and continue to explore electronic signatures; analyzing the IPE process to identify gaps that may allow IPEs to go unsigned; developing a process to ensure only signed IPEs are enacted and effective; developing guidance of when it is appropriate to write on the customer's signature and date section of the IPE; developing guidance about what is considered a valid signature; and developing policies, procedures, and training. | Concur In Part |
| 20 | 161 | No | Develop policy with clear guidance, procedures, and monitoring mechanisms to verify internal controls are effective and consistent with federal requirements for when an IPE, amendment, or internal correction is appropriate. Update and implement training materials timely. | Concur In Part |
| 21 | 167 | No | Ensure customers' employment goals are consistent with federal requirements by ensuring counselors clearly document the rationale for employment goals and retain copies of assessments, ensuring counselors properly utilize available procedures to more effectively and timely address dissatisfaction or disagreements related to employment goals, establishing a process to periodically review counselors compliance with requirements, and ensuring IPEs accurately reflect the intended employment goal.<br><br>When establishing a process, ensure RLs periodically verify employment goals appropriately align with federal criteria. | Concur In Part |

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| 22 | 174 | No | Clarify whether goods and services not directly related to the employment goal are allowable under federal guidance, develop procedures to determine whether costs are in excess of the customer's normal expenses, incorporate supervisory review over assessments to ensure services appropriately reflect federal criteria and cost-effectiveness of the service, review usage of pre-IPE services and develop related guidance, and improve accuracy of customer records by clarifying when to delete services. | Concur In Part |
| 23 | 181 | No | Develop guidance for documenting whether comparable services and benefits were available, include all vocational rehabilitation services necessary to achieve the employment outcome on the IPE with cost estimates, ensure all IPEs exceeding threshold amounts receive supervisory review, and ensure cost data reported to all external entities is valid and accurate. | Concur In Part |
| 24 | 186 | No | Review current vehicle modification policies, guidance documents and practices to clarify and incorporate current activities; adopt comprehensive policies; document and retain all forms, reports, records, and approvals used in the vehicle modification process in the customer's file; and determine if any rules are needed for vehicle modifications. | Concur In Part |

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| 25 | 191 | No | Improve monitoring of customers attending college by standardizing document tracking, periodically reviewing customers' justification for part-time enrollment status, clarifying academic requirements, tracking failed classes and cease paying for retaken courses, establishing a formal waiver process, and increasing training on college monitoring.<br><br>Address potential gaps by ensuring college is required for the employment goal, documenting labor market research prior to committing funds, considering the impact of degenerative disabilities while enrolled, and developing policies on approving graduate studies.<br><br>Consider designating a coordinator to ensure customers attending college receive consistent treatment. | Concur In Part |
| 26 | 197 | No | Develop a standardized process to ensure computer technology purchase criteria have been met prior to approval and periodically review compliance and training on computer technology purchases. | Concur |
| 27 | 199 | No | Ensure counselors holistically assess customer progress toward achieving an employment outcome by assessing whether allowing substitutions to the annual review is compliant with federal law and ensuring all annual reviews are conducted timely, developing procedures and training on how to develop adequate criteria and assess customer progress against criteria, remedying conflicts within NHVR procedures and other internal controls for case monitoring, incorporating supervisory review processes into annual reviews, and developing more effective controls for case monitoring and documentation. | Concur In Part |

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| 28 | 207 | No | Conduct risk-based assessment of authorizations to consider how to better manage expenditures while delivering services timely, the appropriateness of allowing authorization to be issued for services not on the most current IPE and allowing vendors to start service before authorizations are issued. | Concur In Part |
| 29 | 212 | No | Seek federal clarification regarding whether receiving retirement and survivor benefits from the Social Security Administration exempts customers from the Financial Needs Assessment (FNA) and clearly align administrative rules, policy, and training.<br><br>Develop a mechanism to remind counselors to complete the FNA when non-exempt services are added to the IPE and implement a monitoring system to ensure timely completion.<br><br>Ensure consistency in the FNA process by clearly defining who is a financial dependent, developing methodology to determine financial contribution, and developing a process to track customer payments towards the cost of services. | Concur |
| 30 | 216 | No | Strengthen processes for verifying customers are exempt from completing the FNA through developing clear and comprehensive guidance on the documentation requirements for each type of exemption, verifying required documentation that a customer demonstrates financial need before authorizing payment for applicable services, considering personnel assigned to review the documentation for compliance, monitoring for compliance, and providing additional training as necessary. | Concur |

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| 31 | 221 | No | Develop policies, procedures, and administrative rules ensuring all requirements imposed on vendors are consistently applied, service agreement contracts contain signatures from both parties and addresses vendors with multiple employees, vendors are setup using completed service agreements through a system of segregated duties, and explore managing a list of active vendors using the electronic case management system.<br><br>Assess the risk associated with allowing vendors who have not received a background check to work directly with customers and develop procedures to mitigate risk.<br><br>Develop performance metrics, procedures ensuring quality vendor reports are obtained prior to payment, clear definitions for the vendor incentive program, and conduct routine analysis.<br><br>Codify complaint and disciplinary procedures in administrative rules and service agreements, as well as disseminate the results of disciplinary actions taken against vendors when appropriate. | Concur In Part |

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| 32 | 227 | Yes | Implement the statutory requirement to recover costs from customers receiving disability-related awards or settlements in administrative rules, that includes a process for identifying potential future awards and settlements and determining the State and federal portion.<br><br>Determine if payment plans are allowable under existing statute. If the authority does not exist and NHVR determines it should be granted, then petition the Legislature to amend statute accordingly. If payment plans are determined allowable or authorized through legislative action, adopt administrative rules describing the repayment process. Additionally, develop internal policies on when legal action against noncompliant customers is appropriate and develop a tracking system to record repayments.<br><br>Improve controls over payments made directly to customers by modifying existing procedure to limit the amount of reimbursement and advance payments, as well as require proper documentation prior to reimbursing customers. | Concur In Part |
| 33 | 231 | No | Develop policies and procedures verifying the transfer of goods to customers and document follow-up. | Concur In Part |

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| 34 | 236 | No | Improve guidance on case closure timeliness by developing a comprehensive process to review cases potentially requiring closure, identifying ways to assist counselors during the case closure process, and ensuring all guidance on case closures is consistent.<br>Improve monitoring by identifying information needed to assess compliance and improve case closures, measure staff compliance, and remediate deficiencies timely. | Concur In Part |
| 35 | 244 | No | Ensure counselors verify customers' employment and obtain federally required documentation. Also ensure accurate wage reporting, ensure counselors understand criteria for closing cases as rehabilitated, and update written policies and procedures for verifying employment. | Concur In Part |
| 36 | 248 | No | Ensure all cases closed as rehabilitated contain all required documentation and meet requirements prior to closure. Codify additional guidance in administrative rules, policies, procedures, and training materials.<br>Develop a process to monitor compliance by identifying necessary data, operationalizing information collection processes, assessing staff compliance, and remediating deficiencies timely. | Concur In Part |

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| 37 | 255 | No | Ensure cases closed as non-rehabilitated contain proper documentation consistent with federal regulations and NHVR requirements. Codify additional guidance for ineligible and non-rehabilitated closures in administrative rules, policies, procedures, and training materials.<br><br>Develop a process to monitor compliance by identifying necessary data, operationalizing information collection processes, assessing staff compliance, and remediating deficiencies timely. | Concur |
| 38 | 259 | No | Improve compliance with post-employment service (PES) requirements by adopting rules, ensuring guidance addresses how to determine when needs are too complex or comprehensive for PES. Develop guidance to ensure rehabilitated cases are appropriately re-opened to provide PES and contain all documentation.<br><br>Assess staff compliance and improve monitoring by identifying necessary data and information to analyze compliance, timeliness of PES case openings, length of time PES cases have been open, and remediate deficiencies timely. | Concur In Part |

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| 39 | 268 | Yes | Promulgate rules for all activities outlined in RSA 200-C and any requirements imposed on external parties. Also implement all programs required under RSA 200-C and adopt corresponding rules. If certain programs are not needed, petition the Legislature to amend statute.<br><br>Conduct a comprehensive assessment of current rules to determine whether they accurately reflect federal laws, regulations, and align with NHVR practices.<br><br>Consider seeking legislation to move rulemaking authority from the Board of Education to the Commissioner to more clearly link the authority and responsibilities of NHVR to one entity. | Concur In Part |
| 40 | 273 | No | Improve policies and procedures by formally updating the *NH Vocational Rehabilitation Policy Manual* with all policies governing the provision of rehabilitation services; centrally locating other policies, procedures, guidance, and practices which do not govern the provision of rehabilitation services; issuing additional guidance to personnel practices which have already been adopted and formalized; ensuring policies and procedures follow the State Rehabilitation Council process; incorporating a periodic review process; developing formal communication processes; complying with federal requirements related to interpretations of federal law, regulations, and guidelines; and implementing policies and procedures consistently and objectively. | Concur In Part |

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| 41 | 278 | No | Adopt administrative rules for customers to request a waiver. Rules should include an application form, required documentation, clear and specific criteria, and ensure consistent management oversight and approval.<br><br>Additionally, better integrate the FNA process into the waiver process when considering waivers associated with customer costs. | Concur In Part |
| 42 | 282 | No | Conduct a formal assessment of responsibilities delegated to counselors and RLs and consider the risk associated with increasing the proportion of activities that do not receive review, the complexity of each delegated activity, and opportunities to prioritize upper management's role in high risk activities. | Concur In Part |
| 43 | 287 | No | Improve compliance with counselor education requirements by reviewing whether current requirements are appropriate, ensuring requirements are met upon hire, and ensuring the requirement to obtain a graduate degree to retain employment or be promoted is enforced.<br><br>Improve caseload management and performance by developing performance metrics clearly linked to goals and objectives, developing a measure of case complexity to appropriately allocate caseloads, measuring staff performance against expected levels, and developing a system to identify and timely address staff noncompliance with requirements. | Concur In Part |

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| 44 | 296 | No | Develop a strategic training program by linking training efforts to agency goals, assessing training and staff needs to allocate resources effectively, and establishing processes to utilize performance and other data, developing training policies and procedures, incorporating federally required training activities into the *VR Portion Of WIOA State Plan For The State Of New Hampshire*, and establishing periodic evaluation processes to ensure training materials remain relevant and adequate. | Concur In Part |
| 45 | 301 | No | Develop a comprehensive data governance strategy that includes developing organizational objectives and aligning the data collected in the information system to support those objectives, communicating a commitment to quality information and data priorities, and developing procedures to improve data quality. | Concur In Part |
| 46 | 305 | No | Continue efforts to transition customer records to a comprehensive electronic records system, including developing policies and procedures specifying which records require electronic uploading and standards for what is considered a complete file.<br>Also develop policies and procedures addressing securing and tracking customer files, routinely reviewing files and remedying issues found, ensuring confidential information is properly maintained, and appropriately limiting access to third-party records. | Concur In Part |

## CHAPTER 1: BACKGROUND

The federal government has regulated vocational rehabilitation (VR) since 1920, with a goal of assisting individuals with disabilities in becoming meaningfully and gainfully employed. The federal *Rehabilitation Act of 1973* (Act) intended to improve efficiency, effectiveness, and accountability of state VR programs, and emphasized services for individuals with the most severe disabilities. The Act also extended and revised the authorization of grants for state VR programs administered by the federal Department of Education's Rehabilitation Services Administration. To be eligible for federal funds, the Act required states to submit a state plan for providing VR services and to designate an agency to administer the state plan.

Amendments to the Act during the 1980s and 1990s established programs designed to assist individuals with the most severe disabilities in achieving competitive employment outcomes. The amendments also required state programs provide information necessary for individuals to make an informed choice when developing their individualized plan for employment (IPE), selecting services, and selecting providers. Additionally, these amendments required the federal Rehabilitation Services Administration to annually review and periodically monitor state VR programs and their performance, and required state VR agencies to establish and maintain standards for counselor qualifications. In May 2019, the Rehabilitation Services Administration conducted a monitoring review of the New Hampshire Bureau of Vocational Rehabilitation (NHVR), which encompassed federal fiscal years (FFY) 2016 through 2018. The report was released in late 2020.

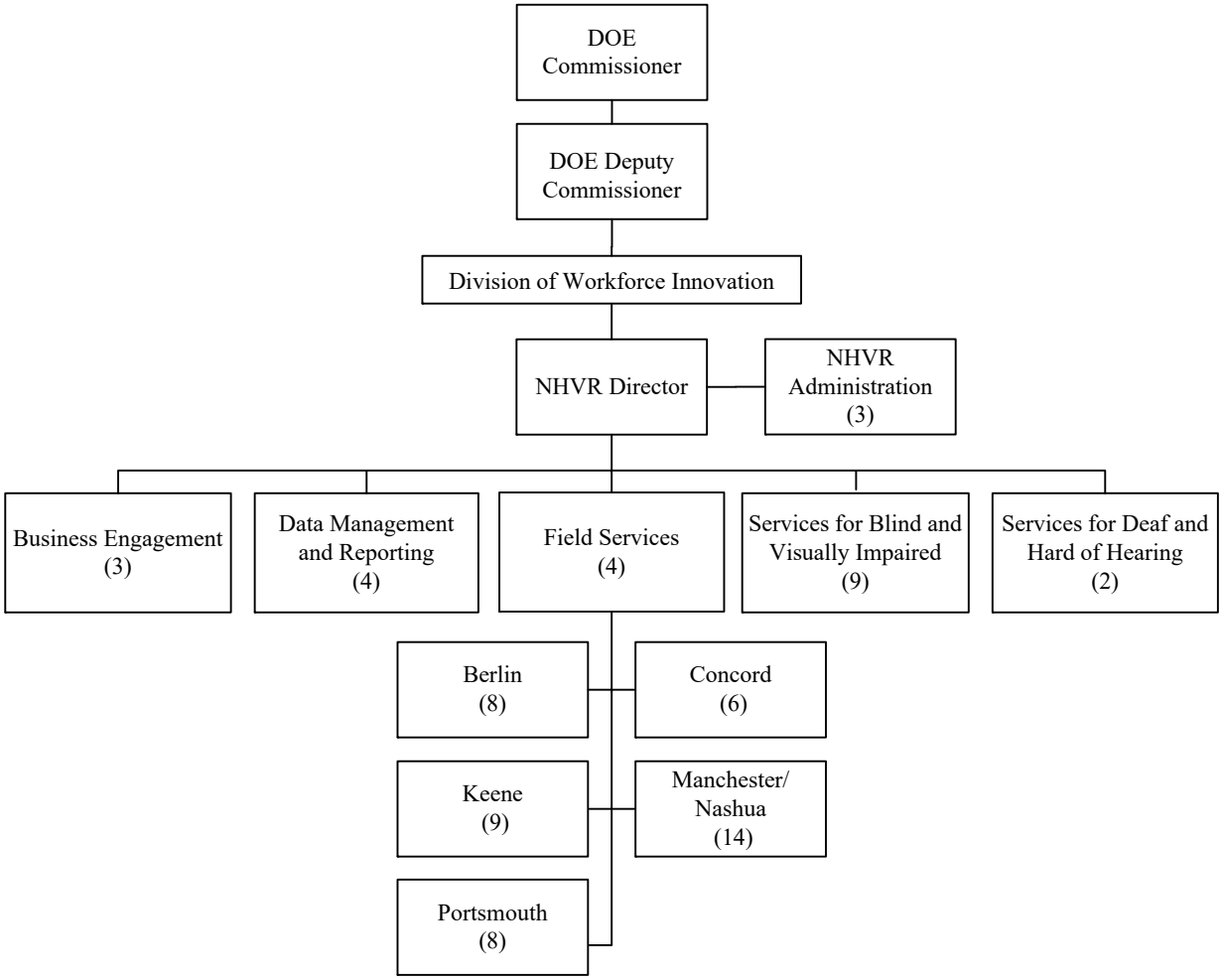
Congress reauthorized the Act, as amended, through the federal *Workforce Innovation and Opportunity Act* (WIOA) in 2014, to increase access to employment, education, training, and support services, particularly for individuals with barriers to employment. WIOA strengthened the alignment of VR and other workforce development programs by requiring unified strategic planning, common performance accountability measures, and a one-stop delivery system, as well as established specific requirements for state programs. Specifically, WIOA emphasized the achievement of competitive employment in an integrated setting. WIOA also required VR agencies to make pre-employment transition services available to students with disabilities and to allot at least 15 percent of federal funding to provide these services.

### Vocational Rehabilitation In New Hampshire

The NHVR, within the New Hampshire Department of Education (DOE), was responsible for administering VR services from five regional offices. Each regional office consisted of a regional leader (RL), vocational rehabilitation counselors, and support staff. As of March 2019, NHVR had 71 positions, 33 of which were counselor positions. The NHVR also received support from accounting staff in the DOE Office of Business Management. Figure 1 shows NHVR's organization as of March 2019.

**Figure 1**

**NHVR Organization As Of March 2019**




Note: Counselors in Services for Blind and Visually Impaired served customers throughout the State.

Source: LBA analysis of NHVR staffing information.

### *Eligibility Process*

Federal laws and regulations established eligibility requirements to determine whether applicants were eligible for VR services. Applicants meeting all requirements were determined to be eligible and could proceed with the vocational rehabilitation process; those not meeting all requirements were ineligible and had their case closed. To be determined eligible, an applicant must:

1. have a physical or mental impairment;
2. have an impairment that results in a substantial impediment to employment;
3. require rehabilitation services to prepare for, secure, retain, or regain employment; and

4. intend to achieve an employment outcome.

Federal law and regulations required NHVR to make eligibility determinations within 60 days of an application, except under specific circumstances where the VR agency and applicant agreed to a specific extension of time. Exemptions from the 60-day time limit were permitted for exceptional and unforeseen circumstances beyond the control of NHVR or if the applicant required a trial work experience to explore their abilities, capabilities, and capacity to perform in a work situation. These requirements allowed NHVR to ensure each applicant received a timely determination, and applicants with the most severe disabilities received a thorough eligibility assessment.

After submitting an application, an applicant met with their assigned counselor for an intake appointment. Intake initiated an assessment to determine an applicant's eligibility. As part of the assessment, the counselor gathered and reviewed information, including medical and psychological records, to determine whether the applicant met the eligibility requirements. Federal law required NHVR to use existing and current information, to the maximum extent appropriate. If existing information did not describe an applicant's current functioning or was unavailable or insufficient to make an eligibility determination, NHVR could provide further assessments to obtain the necessary information. After reviewing all information, the counselor or a supervisor made an eligibility determination.

***Developing An Individualized Plan For Employment***

After being determined eligible for services, customers worked with counselors to develop an IPE. An IPE was a written document describing the customer's employment outcome or goal and the services necessary to achieve the chosen goal. Federal law and regulations required NHVR to develop an IPE as soon as possible, but no later than 90 days after an eligibility determination, unless the customer and NHVR agreed to an extension. Federal regulations required IPEs include specific components such as an employment goal, services necessary to achieve the employment goal, and criteria to evaluate customer progress. Federal law also required the IPE be amended if there were substantive changes in the employment goal, services to be provided, or providers of the services. IPEs and amendments were not effective until they were agreed upon and signed by both the customer and qualified counselor.

According to federal regulations, the employment goal was to be "selected by the individual consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice." To facilitate the process of choosing the employment goal and necessary services, customers completed a comprehensive assessment with their counselor. Federal law required NHVR to use existing and current information, to the maximum extent possible, which included documentation reviewed while assessing eligibility. If additional information was needed, customers could complete further assessments designed to assist with identifying their goal and necessary services. Federal law specified assessments be used to evaluate pertinent areas that affected the employment and rehabilitation needs of the individual such as areas related to the customer's interests, education, skills, functional capacities, and employment opportunities.

### *Provision Of Services*

Customers could receive a wide variety of services to help them achieve their employment goal as outlined on the IPE. Necessary services were chosen based on the customer's disabilities, barriers to employment, and employment goal. The type and scope of services included vocational counseling and guidance, services related to job readiness such as college training or job development, job preparation skills such as resume writing and interviewing, and services that aided customers in overcoming barriers to employment such as rehabilitation technology or personal assistance services. Counselors provided some services, while other services were provided by community rehabilitation program vendors or other entities.

After the IPE was developed, federal regulations required counselors to annually assess progress towards achieving the employment goal with the customer. While IPE monitoring was an ongoing process, the annual review allowed a formal opportunity for counselors and customers to determine whether additional services were needed or whether the employment goal needed to be reassessed.

### *Case Closure*

Once a customer obtained the employment goal described in their IPE, counselors monitored them to ensure their employment was stable. After at least 90 days of stable employment without needing VR services, the case could be closed as rehabilitated. Customers could obtain post-employment services up to a year after a rehabilitated closure, if needed.

Cases were closed as non-rehabilitated if the customer did not achieve the employment goal described in the IPE. Counselors could close a case if customers were not participating in services, moved, stopped communicating with the counselor, or no longer needed services. Once the case was closed, a non-rehabilitated customer needed to reapply to receive additional services and was not eligible to receive post-employment services.

## Order Of Selection

Federal regulations required states to provide the full range of services identified in its state plan to all individuals determined eligible for VR services. If a state determined it could not serve all eligible customers due to lack of funds or staff, it had to enter an order of selection (OOS). Under an OOS, states were required to continue to serve customers who were receiving services prior to the implementation of the OOS. States had to establish the order they would follow in selecting all other customers for services, but were required to ensure those with the most significant disabilities were served first. Federal law and regulations required states to consult with their state rehabilitation council regarding the need to enter an OOS and the order in which services were to be provided.

### *NHVR's Decision To Implement An OOS*

In an amendment to the *VR Portion Of WIOA State Plan For The State Of New Hampshire* (*State Plan*) submitted on May 4, 2018, NHVR projected it would "not have sufficient resources to serve all eligible individuals who apply for services in the remaining months of FFY 2018 and into FFY

2019." DOE and NHVR management first identified a potential funding shortfall at a December 2017 meeting to review program finances. According to NHVR and DOE management, financial information indicated NHVR was spending more each year than it received in federal revenue. Management concluded the current rate of spending would not be sustainable and that NHVR's funds could be exhausted in the next few years. In early 2018, management found the financial information presented at its December 2017 meeting was inaccurate and showed more in funds than NHVR had available, accelerating the seriousness of NHVR's financial situation. After exploring potential cost savings and containment measures, management reported several factors contributed to its decision to implement an OOS, including:

- overstaffing;
- overspending, including on customer services;
- a requirement that 15 percent of federal funds be spent on pre-employment transition services; and
- a decline in its federal grant award.

On May 1, 2018, NHVR met with the State Rehabilitation Council, its advisory council, and reported that it intended to implement an OOS on May 7, 2018. A public hearing was held on May 3, 2018 to solicit input from stakeholders. Members of the State Rehabilitation Council and the public both expressed frustration with the process, including its timing and lack of transparency. On May 4, 2018, the State Rehabilitation Council voted not to support NHVR's implementation of an OOS at that time. Members noted they had not been fully and timely informed NHVR had financial concerns, nor had they been provided with specific information as to how NHVR determined there were not sufficient resources to serve all customers.

### *Effect Of The OOS On NHVR Customers*

Despite the State Rehabilitation Council's opposition, NHVR implemented an OOS on May 7, 2018. Customers with an effective IPE continued to receive services. Customers without an effective IPE and those determined eligible after OOS implementation were placed on a waitlist and assigned to one of three disability priority categories:

- Most Significant Disability (MSD) – NHVR's administrative rules defined this category as a customer with a significant physical or mental impairment seriously limiting two or more functional capacities in terms of an employment outcome, and who was expected to require two or more VR services over six months or longer. NHVR's *State Plan* noted the definition was updated in April 2018, and customers were assigned to the MSD category if they had serious functional limitations in three or more areas and required three or more VR services.
- Significant Disability (SD) – NHVR's administrative rules defined this category as a customer with a significant physical or mental impairment seriously limiting one or more functional capacities in terms of an employment outcome, who was expected to require multiple VR services over an extended period, and who had one or more disabilities.
- Less Significant Disability (L-SD) – The *State Plan* defined this category as all other customers who did not meet the criteria for the MSD or SD categories.

NHVR began releasing customers from the waitlist in September 2018. At its peak in December 2018, over 1,100 customers were on the waitlist, consisting mostly of MSD and SD customers. NHVR released customers from the waitlist based on their disability priority category and application date. When determining how many customers to release from the waitlist and when, NHVR's OOS management group reportedly considered factors such as counselor caseloads, regional office capacity, and how many customers from prior releases were still in the process of developing IPEs, while the NHVR Director reviewed finances to ensure customers could be served. Customers were released in groups ranging in size from 100 to 300. By December 27, 2019, NHVR had released all customers and was serving customers in all priority categories. Although NHVR reported it no longer had a waitlist, as of November 2020 it was still in an OOS.

**Vocational Rehabilitation Grants To States**

NHVR was funded through a mix of federal funds, State general funds to satisfy the matching requirements of the federal grants, and agency income. Table 1 shows NHVR revenues and expenditures during State fiscal years (SFY) 2017 through 2019.

**Table 1**

**NHVR Revenue And Expenditures, SFYs 2017 Through 2019**

| | 2017 | 2018 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Federal Revenue | $ 15,601,332 | $ 14,909,825 | $ 9,519,251 |
| Agency Income | 247,842 | 301,944 | 318,887 |
| General Funds | 3,658,642 | 3,551,174 | 2,919,432 |
| **Total Revenue** | **$ 19,507,816** | **$ 18,762,943** | **$ 12,757,570** |
| **Expenditures** | | | |
| Personnel | $ 4,590,641 | $ 4,534,334 | $ 3,522,387 |
| Personnel Benefits | 2,778,167 | 2,722,371 | 2,193,695 |
| Client Services | 10,229,519 | 9,681,849 | 5,602,220 |
| Rents – Other Than Leases | 391,012 | 396,675 | 296,900 |
| Transfers To Other Agencies | 519,624 | 683,197 | 575,251 |
| Indirect Costs | 453,284 | 290,209 | 241,836 |
| Equipment | 179,305 | 173,930 | 93,345 |
| Travel | 175,959 | 111,150 | 99,840 |
| Current Expenses | 93,338 | 60,609 | 47,931 |
| Other | 96,967 | 108,619 | 84,165 |
| **Total Expenditures** | **$ 19,507,816** | **$ 18,762,943** | **$ 12,757,570** |

Note: Revenues may be higher than the amount awarded because states can draw down on funds in subsequent years, if they obligated the matching portion in the year the grant was awarded.

Source: LBA analysis of NHVR Statements of Appropriations.

The Act provided states with Vocational Rehabilitation State Grants to operate VR programs, which accounted for the majority of NHVR revenue. Under the Act, the federal share was set at 78.7 percent, with states required to match at least 21.3 percent of allowable program costs. Any federal funds awarded but not obligated and expended before the start of the next year, could be carried over to the next year, provided states obligated its matching portion in the year the grant was awarded. The Act also included a maintenance of effort requirement which reduced a state's grant if the state's non-federal match was less than the match from two years prior. For example, if the state's 2019 match was less than the amount matched in 2017, the state's grant award for 2020 would be reduced by the shortfall. Grants were distributed annually based on a statutory formula which considered the state's population and per capita income. NHVR was awarded between $10.9 million and $11.4 million during FFYs 2017 through 2020.

### *Additional NHVR Grant Funding*

NHVR managed three additional federal grants to provide assistance to individuals with disabilities who needed employment support after they started working and individuals who were blind or visually impaired.

- Supported Employment Services Grant – Grant funds supplemented the Vocational Rehabilitation State Grant to assist individuals with the most significant disabilities after they obtained a supported employment outcome, but still required ongoing supported employment services. NHVR was awarded $300,000 annually and served 602 customers with supported employment plans in SFY 2018.
- Independent Living Services for Older Individuals Who Are Blind Grant – Grant funds were used to support services for individuals 55 years and older who were blind or severely visually impaired and needed independent living services. NHVR was awarded $225,000 annually and served 540 individuals in SFY 2018.
- Independent Living, Part B Grant – Grant funds were distributed by NHVR to entities providing independent living services to individuals with significant disabilities. Services included transportation, case coordination, or home modifications. NHVR was awarded approximately $338,000 annually and providers served 2,195 customers in SFY 2018.

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## CHAPTER 2: GOVERNANCE

Governance is "the act or process of providing oversight or authoritative direction or control… and refers to the framework of rules and practices by which [an entity] oversees strategy setting and the management of the organization. Effective governance ensures accountability, fairness, and transparency in the organization's relationship with its various stakeholders…" As part of its overall framework, management must design and implement an effective internal control structure that aligns with its governance structure. Internal controls are processes put in place by an organization's management to provide reasonable assurance an entity will achieve its operational, reporting, and compliance goals. Internal controls serve as the first line of defense in safeguarding assets and help managers achieve the desired results through effective stewardship of public resources. An effective internal control system increases the likelihood an organization will achieve its objectives.

Internal control systems encompass five components: control environment, risk assessment, control activities, information and communication, and monitoring. Each component contributes to the control structure in the following ways:

- control environment provides the discipline and structure to help an organization achieve its objectives;
- risk assessment identifies and assesses an organization's internal and external risks as it seeks to achieve its objectives;
- control activities are the actions management establishes through policies and procedures to achieve its objectives and respond to risks;
- information and communication address the quality of the information management and personnel communicate and use to support the internal control system; and
- monitoring encompasses the activities management establishes to assess the quality of its performance over time.

All components must be properly designed, implemented, and functioning. For a system to be effective, these components must operate together.

**Observation No. 1**

### Improve NHVR Internal Control Structure

During the audit period, the New Hampshire Bureau of Vocational Rehabilitation's (NHVR) system of internal controls over its programmatic operations was not fully developed, resulting in a management approach which hindered program efficiency and effectiveness, and contributed to deficiencies from prior audits dating back 20 years remaining unresolved. While NHVR made substantial improvements to internal controls over its financial operations beginning in fall 2017, some controls were still being developed during the rest of the audit period. Additionally, internal controls over NHVR's program operations still contained weaknesses.

Management is responsible for overseeing the strategic direction and accountability of the organization including overseeing the design, implementation, and operation of the internal control system. Controls are meant to ensure operational efficiency and effectiveness, reliable reporting, and compliance with laws and regulations. Management was responsible for periodically evaluating the design and implementation of the system to ensure it functions as intended, and correcting deficiencies timely when they are identified.

However, NHVR did not establish adequate internal controls to ensure accountability and efficient operations. NHVR management stated there was no formal strategic plan for the organization. After implementing an order of selection (OOS) in May 2018, NHVR developed a *Financial And Operational Plan* which contained elements that could be used to begin the strategic planning process but did not constitute a strategic plan. Additionally, there was no clear connection between its daily activities and its mission, goals, and objectives because performance management information, meant to help NHVR gauge progress towards its goals, consisted of mainly output measures, measuring how many activities were performed instead of the quality of outcomes produced. Risk assessment activities, which were meant to identify potential threats to NHVR achieving its objectives, were not incorporated into routine operations and resulted in limited preparation when NHVR had to implement an OOS. As a result, during the implementation of the OOS and immediately after, NHVR management reported prioritizing development of OOS policies and procedures and training staff on the new processes. This delayed routine administrative activities including improvements to its internal controls. Controls such as administrative rules, policies, procedures, and training, which were meant to ensure consistency and repeatability of services, were informal, not comprehensive, and resulted in inconsistent application. Monitoring activities, which were meant to help identify areas of improvement and noncompliance, were not always effective or were reactive, identifying areas of noncompliance only after they had occurred with no system to rectify mistakes.

**Control Environment**

The environment within which an entity operates affects the overall quality of the internal control system by defining the agency's objectives and structuring activities to achieve these objectives. To ensure an effective control environment, management must exercise proper oversight, establish an authority structure, assign appropriate responsibilities, ensure staff competency, and hold staff accountable. Additionally, management must lead by example and demonstrate the importance of integrity and ethical value through its directives, attitudes, and behavior. NHVR needed to strengthen these structures as indicated below.

***A Stronger Culture Of Accountability Was Needed***

Management's directives, attitude, and behaviors reflect the integrity and values it expects throughout the organization. A strong organizational culture is particularly important as employees are responsible for implementing and operationalizing management controls, and for reporting issues to management so they can be addressed timely. Without an emphasis on these values, an organization's ability to identify and respond to risk may be incomplete or inappropriate, control activities may not be effective, and monitoring may be insufficient to identify and remediate deficiencies. We found NHVR's control environment needed strengthening. Management's

directives were not complete or comprehensive, and adherence to existing directives was sometimes inconsistent. Staff reported some policies were not consistently applied and some processes were unclear. Staff and regional office management placed an emphasis on not appearing on weekly case monitoring reports. Consequently, controls intended to ensure compliance with federal time limits were avoided by both staff and management through backdating.

As stewards of public resources, NHVR was responsible for ensuring federal and State funds were used efficiently and effectively. However, some members of NHVR management indicated costs were reviewed in the aggregate, across all cases, instead of for individual customers as the customer's needs were paramount and needed services would be provided regardless of the cost. While the needs of the customer should be a primary driver of the services provided, ensuring funds are used sensibly and expenses were properly reviewed when appropriate were part of management's responsibility. As we discuss in Observation No. 22, we found NHVR at times, paid for services that did not appear related to the customer's employment goal or appear to meet federal requirements. Some services provided did not appear necessary for the customer's employment goal, and as we discuss in Observation No. 19, services were sometimes paid for before required documents were signed by the customer. Additionally, as we discuss in Observations No. 15, No. 16, and No. 32, some controls intended to ensure supervisory review of potentially costly cases could be avoided.

Finally, management acknowledged the need to hold staff accountable for repeated mistakes and ensure deficiencies were addressed. However, there was no mechanism to ensure deficiencies found during supervisory review were corrected timely or at all. Two members of management indicated they hoped staff were fixing issues identified by supervisors but were not sure. All these factors contributed to the erosion of accountability.

***Workforce Planning Was Needed***

NHVR did not conduct workforce planning, succession planning, or have a way to ensure continuity of operations if key personnel left the organization. NHVR management indicated a need to consider succession planning especially for regional leader (RL) positions but had not started the process. Workforce planning encompasses a strategy to align staffing with an organization's current and future mission and goals and developing strategies to acquire, develop, and retain staff to achieve these goals. Before the audit period, NHVR training, policy development, and performance monitoring responsibilities were spread among five positions. As personnel left the organization, these responsibilities were transferred to one central office manager who ultimately became responsible for agency-wide training, developing policies and procedures including maintaining the *VR Portion Of WIOA State Plan For The State Of New Hampshire (State Plan)* and other federal requirements, and monitoring agency performance. In 2018, an RL left the organization, and these responsibilities were transferred to this same central office manager for over a year until a new RL was hired in late November 2019. Consequently, management struggled to maintain effectiveness in areas such as employee training and policy development during the audit period.

***Process To Evaluate Counselors Performance Against Expected Standards Was Needed***

Management must establish processes to evaluate staff performance against expected standards, hold staff accountable, and address deviations in a timely manner. While the *NHVR Counselor Desk Reference (Desk Reference)* outlined goals for the expected number of activities counselors should perform each month, it also stated counselors "should be held accountable for those performance areas for which they have control." According to NHVR management, performance standards needed to be updated and were not used to gauge staff performance as some of the processes were out of counselors' control. Instead, management reported using weekly case monitoring reports to identify cases exceeding established timeframes. However, there was no process to ensure counselors addressed noncompliant cases on these reports, or to ensure they were resolved. As a result, some cases appeared on weekly case monitoring reports for months without being resolved. According to the NHVR Director, supervisors needed to hold counselors more accountable for mistakes as repeated mistakes were occurring without resolution.

***Process To Ensure Staff Met Qualifications Needed Improvement***

Management must demonstrate a commitment to recruit, develop, and retain competent employees. As we discuss in Observation No. 43, while the *State Plan* required counselors to attain a master's degree, NHVR did not fully enforce or monitor this requirement. Additionally, as we discuss in Observation No. 44, counselor training was outdated; sometimes conflicted with NHVR policy practice or federal guidance; and was not comprehensive, further hindering NHVR's ability to ensure counselors could adequately perform their duties.

**Risk Assessment**

Management is responsible for identifying, analyzing, and responding to risks; considering the potential for fraud risks including theft and misappropriation of assets; and identifying, analyzing, and responding to changes that could affect internal controls. NHVR did not conduct formal risk assessments. While NHVR had a process to conduct case reviews, NHVR management reported case reviews had not been completed since 2014. When supervisors were reviewing cases during the audit period, management reported this information was not used for programmatic improvements. Consequently:

- Risk Of Implementing An OOS Was Not Fully Considered – The possibility of needing to implement an OOS was identified in our *Bureau Of Vocational Rehabilitation And Service Delivery* performance audit released in 2001 and was a known risk for almost two decades. However, by 2018, NHVR had not developed a contingency plan, policies, or procedures in the event an OOS would be needed. Consequently, policies and procedures had to be created to accommodate and implement new processes within months. Organizational turbulence was ongoing throughout the audit period placing on hold routine work such as updating policies, procedures, and administrative rules; monitoring agency performance; and general training. A formal, comprehensive risk assessment could have helped identify the need to create contingency plans which could have helped NHVR with a smoother transition to OOS by having policies and procedures already in place.

- Case Monitoring Did Not Ensure Compliance With Federal Time Limits – The risk of noncompliance with federal time limits was not adequately considered. NHVR relied on weekly case monitoring reports as a significant part of its monitoring mechanism. However, instead of actively monitoring cases which were *approaching* the federal time limits, weekly case reports highlighted cases that were *already past* the federal time limits, essentially already out of compliance with federal laws and regulations, leaving no opportunities to correct deficiencies before they occurred.

**Control Activities**

Control activities include the policies, procedures, and other mechanisms management implements to achieve its objectives and respond to risks. In addition to policies and procedures, additional control activities can include establishment of performance measures and indicators, management review of actual performance or functional activities, controls in the information technology systems, and accurate and timely processing of transactions. NHVR's control activities were not fully developed, resulting in:

- Policies, Procedures, And Administrative Rules Were Not Comprehensive – As we discuss in Observations No. 39, and No. 40, NHVR did not have comprehensive policies, procedures, and administrative rules; policies and procedures were not centralized; administrative rules and policies sometimes conflicted with themselves and federal requirements; and staff reported policies and procedures were not always clear. Formal and informal policies and procedures were not comprehensive and were inconsistently implemented. Additionally, after implementing an OOS, some requirements established in NHVR policy were in direct conflict with administrative rules.
- Supervisory Review Was Not Always Effective – NHVR required supervisors to review all work performed by a Vocational Rehabilitation Counselor I, including eligibility determinations, disability priority assignments, individualized plans for employment (IPE), and authorizations for services. After implementing an OOS, NHVR required supervisors to review the work of all counselors. NHVR also required each case file to contain a *File Review Form*, which was meant to ensure certain documents were contained in the file. Upon case closure, these forms were reviewed by a supervisor before the case file was transferred to the central office for archiving. Finally, each month, supervisors were required to review a sample of cases which were selected by the central office. However, these reviews did not always identify and address missing documentation in case files including financial needs assessments and medical and other documentation supporting a customer's disabilities. Supervisory review also did not detect inconsistencies in eligibility determination and disability priority assignments, unsigned or backdated IPEs and amendments, inaccuracies in IPE estimated service costs, or expired IPEs. Finally, flaws in the supervisory review process allowed IPE services which may have been unrelated or unnecessary to achieve the employment goal, and reasons for case closure that were inaccurate or not supported by all required documentation to go undetected.
- Controls In The Electronic Case Management System Were Not Always Effective – NHVR programmed the electronic case management system to ensure certain tasks were performed timely and cases requiring review received it. However, some controls did not

fully function as intended. For example, the case management system required supervisory review for IPEs estimated to cost a certain amount. However, as we discussed in Observation No. 16, some IPEs with estimated costs exceeding those amounts could avoid review under certain circumstances. Additionally, the *Desk Reference* required counselors to enter at least one case note demonstrating what happened in the case every 90 days. The electronic case management system implemented this control by identifying whether counselors entered case notes at a specific frequency; however, as we discuss in Observation No. 27, this could be bypassed by entering even one character in the case note. Additionally, as we discuss in Observations No. 4 and No. 17, records were frequently backdated, which bypassed controls established in the case management system and at times allowed noncompliant actions to appear compliant with federal time limits when they were not.

**Information And Communication**

To make effective management decisions, address risk, and evaluate performance, an entity needs relevant, accurate, timely, and reliable information. Additionally, management must communicate this information internally and externally to those responsible for achieving and monitoring objectives, addressing risks, and supporting the internal control system. NHVR could not measure the program's effectiveness because it either did not have accurate and comprehensive data or did not adequately analyze the data it collected.

- Inaccurate Budget Data Were Used To Make Program Decisions – Prior to implementing the OOS, NHVR's financial systems were managed with little oversight and financial records were not readily available for management examination. Regardless, NHVR management relied on these systems to consistently project millions of dollars in carryover funds each year and used this information to expand program activities. However, early in calendar year 2018, shortly after the Commissioner's December 2017 meeting to review program finances, NHVR discovered a $3.8 million discrepancy in its available funds and was forced to implement an OOS within months. At the time, stakeholders expressed alarm at how quickly the process was occurring as they were not made aware of any financial problems prior to the decision.
- Inaccurate Customer Categorization Negatively Affected OOS Response – According to NHVR management, prior to the OOS, placing customers in appropriate disability priority categories was not a primary focus because there was no waitlist for services. As a result, we found historic priority category information was not always accurate. However, when it implemented the OOS, NHVR used this information to project how much it would cost to serve customers in each priority category on its waitlist, as well as how long, on average, it would take to serve customers in each priority category. This information was shared with stakeholders and was used to estimate when NHVR could potentially exit the OOS.
- Backdating Compromised Accuracy And Reliability Of Management Information – Some staff and supervisors were aware of and engaged in backdating. Staff backdated eligibility determinations, dates when IPEs were developed, and other documents. This practice hindered NHVR's ability to determine whether activities were conducted timely and

identify areas for improvement or additional training, as well as allowed NHVR to appear to meet federal performance standards when it may not have.

- Inaccurate Data Compromised Federal Reporting – NHVR was required to report data to the Rehabilitation Services Administration, NVHR's federal oversight agency, which required vocational rehabilitation agencies to report certain data elements to assess compliance with federal time limits. Backdating eligibility determinations and IPEs compromised data necessary for determining compliance with these federal requirements. Additionally, NHVR was required to meet certain performance indicators including the percentage of customers exiting the program with an employment outcome (i.e., those categorized by NHVR as rehabilitated), and the number of customers receiving an employment outcome compared to those in the previous period. As we discuss in Observation No. 36, NHVR recorded some cases as rehabilitated even though they were not fully supported by federally required documentation. Mis-categorizing rehabilitated cases skewed NHVR's rehabilitation rate.

**Monitoring**

Management must establish ongoing monitoring activities to assess its internal control system, evaluate results, and correct deficiencies in a timely manner. As part of this system, management must establish a baseline with which to compare actual results, ensure ongoing activities such as supervisory activities and reconciliations occur, and remediate internal control deficiencies it finds, including resolving audit findings, in a timely manner.

- Performance Measures Were Not Connected To Goals Or Mission – As a federal program, NHVR was required to collect and report specific information and meet federal requirements. However, NHVR did not have a comprehensive performance measurement system to assess outcomes and did not develop internal targets or measures to gauge its progress over time. For example, NHVR did not have targets for monitoring and improving compliance rates for eligibility and IPE development time limits. Additionally, counselor performance was measured qualitatively and did not clearly connect to NHVR's overall mission and objectives of helping disabled customers obtain and retain quality jobs. NHVR required counselors process a specific number of applications, develop a certain number of IPEs, and close a certain number of cases each month. However, there was no indicator that measured the quality or efficiency of counselors when performing each of these activities. Finally, NHVR required counselors to enter a case note into the electronic case management system every 90 days. However, there was no system to monitor whether case notes were comprehensive or adequately explained decisions made or how the case was progressing.
- Some Monitoring Activities Were Not Effective – Most of NHVR's monitoring activities were reactive, identifying noncompliance after it already occurred. NHVR did not have a process to ensure deficiencies identified in the weekly case monitoring reports were resolved or to ensure they were not repeated. As a result, cases remained on weekly reports, sometimes for months, without resolution. Other mechanisms which could be used to identify deficiencies and improve performance including results of monthly internal audits and case closure file reviews were not analyzed or shared with regional offices.

- Prior Audit Findings Were Not Resolved Timely – NHVR management did not resolve audit findings from our *Bureau Of Vocational Rehabilitation And Service Delivery* performance audit released in 2001 and our *DOE Financial And Compliance Audit Report For The Year Ended June 30, 2000* in a timely manner. Findings related to financial approvals and controls over authorization levels, oversight of case files including missing documentation, noncompliance with federal time limits requirements, and accuracy of program and caseload data were unresolved. Our current audit found these issues persisted, as nine of 12 Observations relevant to our current audit were still unresolved, and an additional three were still in process. The complete status of prior audit findings can be found in Appendix D.

**Recommendations:**

**We recommend NHVR management strengthen its internal control system by:**

- **creating and maintaining a strategic plan with measurable goals, objectives, targets, and timelines for completion;**
- **assessing current and future workforce needs, identifying staffing gaps, and establishing a plan to ensure future staffing needs are met;**
- **developing and implementing a performance measurement system with measures tied to the strategic plan, establishing agency-wide targets and quantifiable outcomes, measuring performance, and comparing against targets;**
- **assigning accountability for implementation and performance of the strategic plan;**
- **establishing, documenting, and implementing formal risk management policies and processes tied to the strategic plan and objectives;**
- **conducting periodic risk assessments to identify, analyze, and respond to program risks, and establish risk tolerances;**
- **reviewing existing controls to ensure they are sufficiently designed, operating as intended, not bypassed, and regularly monitored;**
- **ensuring managers understand and demonstrate the importance of adequate controls through their own adherence, establishing procedures to follow up on identified deficiencies, and timely addressing deviations;**
- **ensuring information used for making management decision is reliable, accurate, and timely; and**
- **establishing and implementing policies to continuously monitor and evaluate the effectiveness of the internal control structure, incorporating procedures for resolving results of audits and other assessments, and clearly assigning responsibility for timely resolution.**

*NHVR Response:*

*NHVR concurs, in part with the recommendations. NHVR make the following remarks related to the auditor's observations:*

1. *Observation number one, appropriately, identifies that internal control deficiencies identified as far back as 20 years ago had not been addressed until December 2017 and*

*some still needed to be addressed. The bureau has spent considerable time and effort since December 2017 making improvements to its system of internal control. Much of that effort has taken place while managing an order of selection and a pandemic. Nonetheless, the bureau agrees with the importance of building strong controls while also acknowledging the shared responsibility of the auditors to provide timely follow up of audit recommendations to ensure that strong and appropriate actions are taken.*

2. *The audit report indicates the bureau has no formal strategic plan and "there was no clear connection between its daily activities and its mission, goals and objectives." The bureau has a state plan that is valid for four years. This is a unified plan created with the other core partners in the Workforce Innovation Opportunity Act. It describes bureau goals, objectives and measurements for those objectives and is ultimately approved by the Rehabilitation Services Administration. It is the strategic plan for the bureau.*
3. *The audit report states that the bureau's performance management information "consisted of mainly output measures, measuring how many things were produced instead of the quality of outcomes produced." In fact, these performance management measures implemented after December 2017 included both output and qualitative aspects across the missional goals of the bureau. These included weekly performance dashboards measuring referrals, applications, eligibility determinations, plans for employment, wages attained, among others. Further, these managerial dashboards are not static, but over time, measures are added or adjusted to reflect process areas that may need emphasis or scrutiny by management to effect desired changes.*
4. *NHVR works with disabled individuals to provide them pathways toward employment and productive engagement as important members of our communities. Many important factors are considered when determining the nature and type of service needed to meet this goal, including the cost for the service. The audit report indicates "the scrutiny of cost was not a primary focus as the customer's needs were paramount and needed services would be provided regardless of cost." The audit team after multiple conversations did not fully understand that cost is one of many factors that is considered in making a service determination for each unique individual. This does not mean that NHVR, since 2017, has not carefully monitored its budgets and client services to manage in a fiscally prudent manner.*
5. *The audit report states, "There was no mechanism to ensure deficiencies found during supervisory review were corrected timely or at all." Supervisory review of staff work represents the real-time, day-to-day management of bureau activities. This includes regular and continuous interaction with staff to ensure activities are carried out in accordance with policy. As a practical matter, that may be simply meeting with the staff member and asking them to make changes to an eligibility, plan, etc. and processing those real time.*
6. *The audit report states that, "Management must establish processes to evaluate staff performance against expected standards, hold staff accountable, and address deviations in a timely manner." The bureau follows the employee performance evaluation process as defined in the state collective bargaining agreement, designed to evaluate staff*

*performance. In addition, the bureau has many methods and metrics used to manage the on-going activity of the bureau which also contribute to staff performance management.*

7. *The audit report states that, "Risk of Entering an OOS Was Not Fully Considered." The bureau simply disagrees with this statement. Incalculable effort, analysis, conversation and consideration went into the important decision to enter into an order of selection. The audit report further goes on to state that, "The possibility of entering an OOS was identified in our 2001 LBA Audit and was a known risk for almost two decades." The bureau again reiterates the importance of an effective audit program to have timely follow up to its own audit recommendations to ensure implementation. Failure to timely follow up the 2001 audit is a contributing factor to the very deficiency identified by the auditors and all parties can and should be more responsive.*
8. *The audit report states that, "Organizational turbulence was ongoing throughout the audit period placing on hold routine work such as updating policies, procedures, and administrative rules; monitoring bureau performance." The "audit period" referred to by the auditors includes a period prior to December 2017, when the governance structure was improved, through the period of the order of selection. It is factual that the bureau did not prioritize updates to policies and procedures during the initial period of the order of selection. This was not a result of "organizational turbulence," as the audit report states, but due to deliberate prioritization of service delivery during the initial stages of the order of selection.*
9. *The audit report states, "… after implementing an OOS, some requirements established in NHVR policy were in direct conflict with administrative rules." In entering the order of selection, certain eligibility criteria were modified, and approved by the Rehabilitation Services Administration, in order to better facilitate the service of individuals during the order of selection. Such changes, which were implemented immediately, during the order of selection, then needed to be reflected in the bureau rules. The bureau acknowledges as stated above, that updates to the rules were not prioritized in the early period of the order of selection. The bureau is updating all aspects of its rules to ensure approved Rehabilitation Services Administration practices are correctly reflected in rule.*
10. *The audit report identifies backdating of counselor eligibility determinations, dates when IPEs were developed, and other documents, as a means of circumventing internal controls. Counselors are permitted to enter data up to 14 days beyond the actual activity date. Such accommodation reflects that often counselors are working in the field and do not have access to the AWARE system to enter notes real time. Also, counselors working a full load of clients may have sequential client meetings that do not allow them to enter client information real time. The bureau does acknowledge that by permitting back-dating, it is possible for a counselor to misrepresent the timeliness of client interactions in the system. Such risk is currently mitigated through supervision. The bureau will evaluate the effectiveness of this control.*
11. *The audit identified that prior to December 2017, "placing customers in appropriate disability priority categories was not a primary focus because there was no waitlist for services." In managing through the order of selection, the bureau built financial models that used historical disability categories, cost and service times as assumptions. The*

*auditors point out that this potentially faulty information may have affected the model presentations. The bureau acknowledges this, but further points out that the manner in which such data were used involved broad enough tolerances as to make them effective for the modeling purposes, and ultimately the models served their function effectively.*

12. *The audit report overly generalizes the system of internal control as well as managerial control and oversight when it states, "Most of NHVR's monitoring activities were reactive, identifying noncompliance after it already occurred." The bureau acknowledges that there are always opportunities for improvement and strives for a state of continuous improvement. The bureau deploys a combination of both preventative and detective controls, and believes that there is an important role for both. The audit report seems to imply an over reliance by the bureau on detective controls – "reactive" to noncompliance. The bureau will evaluate opportunities to shift its balance between preventative and detective controls.*
13. *The audit report states that, "NHVR management did not resolve audit findings from our 2001 LBA Audit and our DOE Financial And Compliance Audit Report For The Year Ended June 30, 2000 in a timely manner." The bureau has spent considerable time and effort since December 2017 making improvements to its system of internal control. Much of that effort has taken place while managing an order of selection and a pandemic. Nonetheless, the bureau agrees with the importance of building strong controls while also acknowledging the shared responsibility of the auditors to provide timely follow up of audit recommendations to ensure that strong and appropriate actions are taken. Of all personnel involved with this particular audit, only audit staff participated in the 2000 and 2001 audits and would have needed context to address some of those recommendations.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR has expanded the Vocational Rehabilitation Counselor (VRC) III role to implement leadership development across the bureau.*
- *NHVR will ensure each VRC has a plan to meet the VRC II requirements within 5 years of hire if that is consistent with the career goals of the individuals. This will require conversations with the Department of Personnel and changes to supplemental job descriptions. It is estimated this change to the requirement will require at least a year to complete.*
- *NHVR has released an RFP to contract with an entity to develop and implement a quality assurance system to provide additional internal controls, risk assessments and monitoring efforts to VR Counselor and Supervisor duties. It is estimated this work will occur over a year and a half once work commences.*
- *NHVR will continue its staff training practices to ensure staff have complete understanding of policies and all staff understand their content and responsibilities.*

**LBA Rejoinder:**

**We considered each NHVR remark in light of our audit work and believe the Observation and recommendations are valid. In many of NHVR's remarks they purport that controls were instituted in December 2017 and all deficiencies were fixed as a result. While DOE and NHVR started to rectify some of the problems outlined in this report, many of the weaknesses continued to exist after December 2017. NHVR's claims that many things were fixed at that time is inaccurate and was not found in our audit work.**

**Contrary to NHVR's Remark 2, NHVR management reported it did not have a strategic plan. Strategic planning consists of ensuring operations, program administration, resource allocation, and outcomes align with – and are supported by – a clear mission, goals, specific objectives, and a strategy to achieve these objectives. These elements should be clearly linked and formally documented. Strategic planning serves as the foundation for performance measurement and helps to demonstrate outcomes. Strategic plans should reflect external compliance requirements, as well as internal goals and objectives; have corresponding implementation plans and performance measures; be implemented timely and effectively; and be broadly understood by employees and key stakeholders. While NHVR has a *State Plan* which contains elements that can be used for strategic planning purposes, it does not constitute a formal strategic plan.**

**Performance management information referenced in Remark 3 – number of referrals, number of applications, number of eligibility determinations, and the number of IPEs developed – are all quantitative output measures. While NHVR collects output information on customers' wages, it did not establish benchmarks against which customers' wages could be compared. For example, one of the goals of the *Rehabilitation Act of 1973* is to "empower individuals with disabilities to maximize employment, economic self-sufficiency, [and] independence…" NHVR management and staff also reported that helping customers achieve economic self-sufficiency and independence are important goals of the program. However, it did not establish any measures to determine whether customers were achieving these goals, an outcome measure.**

**In Remark 7, NHVR states the LBA Audit Division should have had "timely follow up to its own audit recommendations to ensure implementation. Failure to timely follow up the 2001 audit is a contributing factor to the very deficiency identified by the auditors and all parties can and should be more responsive." The LBA Audit Division does not work for the Department of Education and is not part of NHVR's system of internal controls. Statutorily, the LBA Audit Division can only initiate performance audits "as the fiscal committee shall specifically direct." The function of the LBA Audit Division is to conduct audits to identify areas of improvement; it remains DOE management's responsibility to ensure findings and recommendations are addressed timely.**

## CHAPTER 3: FISCAL MANAGEMENT

Poor internal controls and a lack of management oversight of NHVR's finances, specifically its primary federal grant prior to the fall of 2017, resulted in the New Hampshire Department of Education (DOE) and New Hampshire Bureau of Vocational Rehabilitation (NHVR) being unaware of a potential funding shortfall. These control weaknesses along with other financial factors, triggered the need to enter an order of selection (OOS) in May 2018, limiting which customers could be immediately served. Financial management requires proper planning, directing, monitoring, organizing, and controlling an entity's financial resources in an efficient and effective manner. During the audit period, DOE management recognized and began to remedy major deficiencies with the planning, directing, and monitoring of NHVR fiscal operations, including its budgeting, tracking of federal carryover funds, and lack of written policies and procedures. However, further improvements were needed.

In a report encompassing federal fiscal years (FFY) 2016 through 2018 and released in late 2020, NHVR's federal oversight agency had similar findings. The Rehabilitation Services Administration found NHVR did not maintain effective internal controls over some aspects of its federal grant to provide reasonable assurance it was managing the grant in compliance with all laws and regulations. Federal reviewers noted "these control deficiencies suggest elevated risk to NHVR's effectiveness and efficiency of operations, reliability of reporting, and compliance with applicable laws and regulations…." They further stated the risk would be "greatly reduced through management's development of internal controls at a level of detail necessary to address the complexity of its systems." Specifically, federal auditors noted NHVR submitted inaccurate and incomplete financial reports in FFYs 2017 and 2018 and seemed to lack an understanding of federal regulations governing its grant. Federal reviewers specifically noted that in FFY 2018, a data entry error resulting in a $1.9 million discrepancy in a financial report should have been detected during the verification process before the report was signed and submitted. Federal reviewers attributed these deficiencies, in part, to the high rate of turnover in financial staff. Reviewers also noted NHVR was not in compliance with requirements to obtain federal approval before incurring some expenditures and did not have written procedures governing the process. Additionally, reviewers found NHVR did not allocate the cost of one position even though that position performed some non-VR related activities.

### Discovering The Need To Implement An OOS

Prior to October 2017, financial information was reportedly not effectively provided to the NHVR Director. As a result, NHVR management reported having a limited understanding of NHVR's finances. During this time, NHVR financial staff were embedded in the program and reported directly to the DOE Deputy Commissioner. In October 2017, the DOE transferred NHVR financial personnel to the DOE's central business office under the supervision of the chief financial officer. This structure segregated financial duties and afforded DOE and NHVR management increased oversight.

As part of the increased oversight structure, DOE and NHVR management began conducting quarterly meetings in December 2017 to review program finances. The initial meeting indicated

NHVR could experience a funding shortfall as early as the beginning of FFY 2021. Following this meeting, the DOE and NHVR began exploring ways to reduce program spending and other cost saving measures. However, by the beginning of calendar year 2018, NHVR and DOE discovered the information provided at the December 2017 meeting was not accurate and had shown approximately $3.8 million more in funds than NHVR had available. According to an amendment to the *VR Portion of WIOA State Plan for the State of New Hampshire FY-2016* submitted in May 2018, NHVR projected it would "not have sufficient resources to serve all eligible individuals who apply for services in the remaining months of FFY 2018 and into FFY 2019." NHVR management reported the program was overstaffed and overspending on customer services. Consequently, NHVR implemented an OOS in May 2018 and DOE began monitoring program expenditures with NHVR management more frequently.

**NHVR Program Funding**

NHVR managed a dynamic mix of State general funds, multiple federal grants, and reimbursements from the Social Security Administration (SSA). NHVR also had to ensure it met the federally required state-to-federal match ratio, and it spent a consistent amount of State funds each year to meet a federal maintenance of effort (MOE) requirement. Additionally, starting in July 2014, the federal government required at least 15 percent of the vocational rehabilitation (VR) grant be reserved for pre-employment transition services for students with disabilities who could potentially be eligible for services. This requirement reportedly reduced the amount available to provide services for adults with disabilities and further complicated the management of program expenditures.

As shown in Figure 2, NHVR relied on multiple funding sources to support operations and typically brought forward unused grants into the next fiscal year. These funding sources included:

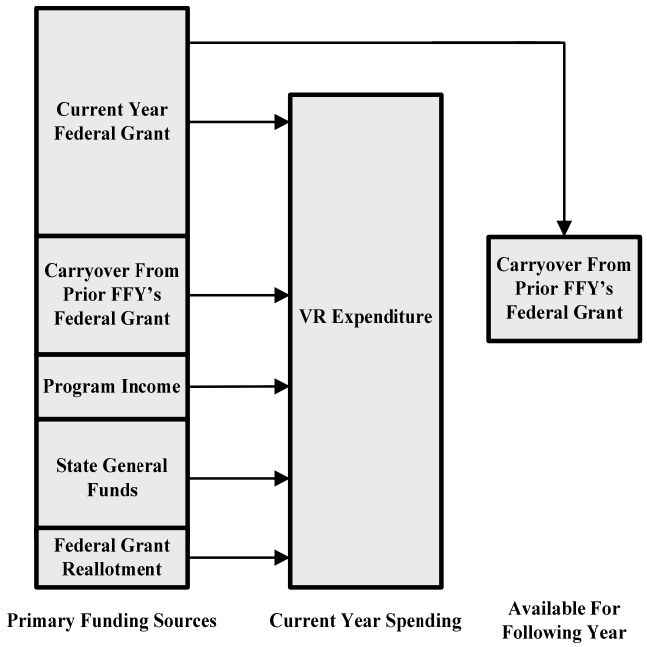
- Current Year Federal Vocational Rehabilitation Grants To States – At the start of each FFY in October, NHVR was awarded its current FFY grant. NHVR had two FFYs to spend the grant, assuming the program met the state match by September 30 of the FFY the grant was awarded. NHVR did not have to start drawing down on the current year federal grant until it used all unspent funds from the previous FFY's grant.
- Carryover From Prior FFY's Federal Grant – Any federal grant dollars not spent within the FFY the grant was awarded could be brought over to the next FFY as carryover funding. Carryover funding was used to fund operations first, before NHVR started drawing down on the current year's grant. Historically, NHVR relied heavily on millions of dollars in carryover funding from prior grants each year which allowed it to cover of shortfalls in current year funding.
- Program Income – NHVR received payments from the SSA for helping customers receiving disability benefits to obtain and maintain employment. Program income from the SSA was sporadic and dependent on customers obtaining employment consistent with specific SSA program requirements. Regulations required NHVR to spend funding from this source before accessing grant funding.
- State General Funds – NHVR was required to match at least 21.3 percent of the total grant amount for it to access its full federal grant. In addition to ensuring an adequate match,

NHVR was required to uphold an MOE requirement equal to the amount of State expenditures matched two FFYs ago. If there was an MOE shortfall, it would be deducted from the next year's federal grant award.

- Federal Grant Reallotment – In July of each FFY, the federal Rehabilitation Services Administration re-allotted appropriations returned by agencies that could not meet their match. Agencies who exceeded their match requirement could request a reallotment of these funds. In the two FFYs leading up to the OOS, NHVR did not request any available reallotment funds. NHVR applied for and received reallotment funds in both FFYs 2018 and 2019.

**Figure 2**

**NHVR Primary Funding Sources And Carryover**




Source: LBA analysis of NHVR documents.

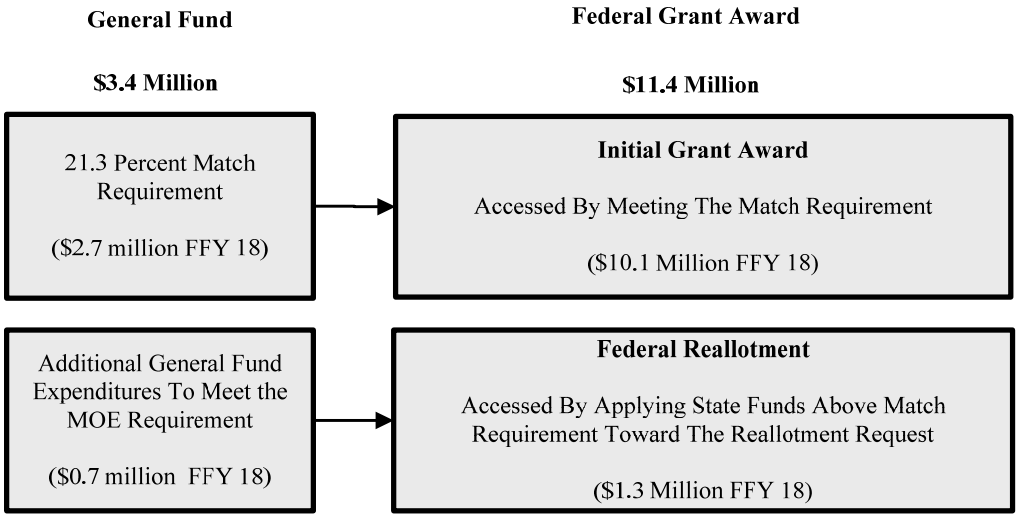
***State-federal Match For Vocational Rehabilitation Grants To States***

Figure 3 illustrates how State general funds were used to access the federal Vocational Rehabilitation Grants To States in FFY 2018. To initially receive the grant, State funds must equal at least 21.3 percent of total VR program funding, and the federal grant will fund the remaining 78.7 percent of the program. Therefore, for every dollar NHVR spent in State general funds, it received approximately $3.70 in federal funds, up to its initial grant award. Additional State funding allocated to reach the MOE requirement mitigated the risk of an MOE penalty against future federal awards. Every additional general fund dollar spent to achieve the MOE, above what was required for the initial match, could be used as the State match to pursue additional federal funding through the reallotment process. States were not guaranteed the same matching rate during

reallotment as they were for the initial grant. For example, in FFY 2018, NHVR received approximately $2.00 in federal funds for every additional State dollar spent.

**Figure 3**

**General Fund Expenditures In Relation To Federal Grant Award, FFY 2018**




Source: LBA analysis of NHVR documents.

### *Grants Awarded On An FFY Basis*

The federal government awarded the VR Grants to States on an FFY basis, which ran from October 1 to September 30. In contrast, the State fiscal year (SFY) ran from July 1 to June 30. DOE and NHVR management were required to develop and monitor two budgets covering different timeframes. NHVR was required by State law and mandated by the State financial system to maintain a budget on an SFY basis, but also needed to maintain an internal budget on an FFY basis to manage the federal VR grant. While an accurate and effectively managed State budget was important, NHVR's ability to manage and monitor its internal budget on an FFY basis was vital to ensuring financial solvency.

## Inadequate Financial Oversight Of NHVR's Budget

Prior to NHVR entering an OOS, NHVR did not have a systematic, consistent, or repeatable way of accurately tracking and budgeting its expenditures. Specifically, these financial systems were managed with little oversight, and did not have well-documented and effective methodologies available for management examination. In December 2017, DOE management began examining the financial status of NHVR. Although NHVR was approaching a funding shortfall, the State budget during the audit period contained misleading estimates on the amount of federal appropriations available, obscuring the impending financial challenge from external oversight including the Legislature, the Department of Administrative Services, and other stakeholders. Due to the inaccuracy of publicly available financial information, only DOE management was capable of providing effective oversight.

### *Inflated NHVR Budget Submission*

During the audit period, NHVR budgeted appropriations well in excess of its actual federal revenue. As a result, lawmakers and outside stakeholders reviewing NHVR's budget or subsequent statement of appropriations could have concluded NHVR had federal funding available that far exceeded its expenditures, and that the risk of any imminent budgetary crisis was low. In reality, NHVR was spending a significant portion of its current year federal award and increasingly depleting the carryover surplus from the prior year's grant. If NHVR had estimated its federal revenue accurately, the program's finances would have been exposed to traditional oversight controls within the State financial system, such as requesting approval for the transfer of funds. DOE management resolved this issue by using more realistic revenue estimates when developing its SFYs 2020-2021 budget request.

For years, NHVR's State budget submission inflated its federal revenue estimates relative to its actual federal revenue. Consequently, NHVR's statements of appropriation during the audit period were inaccurate and essentially misleading. Table 2 demonstrates the difference between estimated federal revenue and actual federal revenue for NHVR's VR Field Programs-Federal Accounting Unit, which accounted for the federal VR Grant to States during the audit period. As shown in Table 2, NHVR's SFY 2017 actual federal revenue was $13.0 million, but NHVR estimated its federal revenue in its State budget submission at $15.0 million. By inflating estimated federal revenue, NHVR's budget increased the appropriations available for it to spend beyond its expected federal revenue.

**Table 2**

**Estimated And Actual Federal Revenue For The VR-Field Programs-Federal Accounting Unit For SFYs 2017 Through 2020**

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| Estimated Federal Revenue[1,3] | $ 15,046,282 | $ 15,865,547 | $16,925,969 | $11,409,853 |
| Actual Federal Revenue[2, 3] | 12,998,786 | 12,334,341 | 7,841,245 | 7,805,764 |
| Net Difference | (2,047,496) | (3,531,206) | (9,084,724) | (3,604,089) |

Notes:
[1] Estimated federal revenue was inflated during the audit period and a more reasonable estimate was provided for SFY 2020.
[2] In SFYs 2019 and 2020, the amount of revenue drawdown on the federal award to pay for expenditures significantly decreased due to the OOS and various cost-cutting measures.
[3] Estimated and actual federal revenue includes SSA program income.

Source: LBA analysis of NHVR statements of appropriations.

Federal law allowed states to carry over unspent portions of a grant into the following FFY, if the state met its match requirements by September 30 of the year the grant was awarded. State law gave NHVR the authority to carry these federal funds between SFYs during the year-end closing process. Instead of exclusively using the year-end closing process to move federal revenue from one SFY into the next, NHVR reportedly increased its estimated federal revenue it was expecting

to receive in the State budget to include both carryover funds from a prior year and the current year grant award into its estimates. This practice essentially appropriated the same dollar twice by allowing NHVR to both: 1) carry over the federal dollar using the year-end closing process; and 2) directly appropriating in the State budget the same federal dollar expected to be carried over from the previous year. To an outside observer, this practice created the perception that more funds were available than actually were, and that NHVR had millions of federal dollars it could have accessed but chose not to spend.

***Lower Carryover Fund Balance Than Previously Identified***

In December 2017, DOE management became concerned when NHVR's carryover balances were projected to decrease at an unsustainable rate over the next few years. Upon further examination and a revision of carryover balances, DOE personnel found NHVR's December 2017 projection included significant errors, and historical and current carryover balances were less than originally reported. Table 3 shows the discrepancy between the carryover balance according to NHVR's December 2017 projection and the actual carryover including reallotment funding at the beginning of each FFY. Due to staff turnover and a long-standing lack of management oversight of NHVR financial operations prior to fall 2017, the DOE could not determine the exact cause of the error in the original assessment. However, we found the DOE's carryover balances revised in early calendar year 2018 appeared to reasonably reflect NHVR's actual carryover balance.

At the initial quarterly meeting in December 2017, NHVR's internal records showed it had a carryover balance of $7.8 million going into FFY 2018. However, shortly after the meeting, NHVR learned the carryover balance was only approximately $4.0 million, $3.8 million less than originally anticipated. Around the same time, NHVR had projected its SFY 2018 expenditures would produce an approximate $3.5 million deficit, which would significantly deplete carryover funds, in addition to the current year's grant, State match, and program income. NHVR concluded this deficit would not be sustainable if no immediate action was taken.

**Table 3**

**Projected Carryover Balance Of The VR Grants To States, FFYs 2013 Through 2021**

| Beginning Of FFY | December 2017 Projections[1] | Revised Projections (Including Reallotment Funds)[2] | Difference |
|---|---|---|---|
| 2013 | $ 8,292,256 | $ 7,872,341 | ($ 419,915) |
| 2014 | 7,403,180 | 6,288,059 | (1,115,121) |
| 2015 | 6,948,717 | 4,926,856 | (2,021,861) |
| 2016 | 7,863,536 | 4,004,610 | (3,858,926) |
| 2017[3] | 9,543,221 | 5,661,711 | (3,881,510) |
| 2018 | 7,865,273 | 4,041,392 | (3,823,881) |
| 2019 | 5,067,887 | 3,475,529 | (1,592,358) |
| 2020 | 3,165,105 | 9,298,927 | 6,133,822 |
| 2021 | 1,309,365 | N/A | N/A |

Notes:
[1] NHVR original projections for FFYs 2018 through 2021 were forecasted and FFYs 2013 through 2017 were likely based on a historical understanding of the financial position of NHVR. However, the difference between the December 2017 projection of the historical data and the revised figures was not discovered by DOE management until early in calendar year 2018.
[2] DOE did not pursue reallotment in FFYs 2016 and 2017, the two years prior to entering OOS.
[3] Revised carryover balances were on a steady decline from FFY 2013 to FFY 2016 but an irregular increase in FFY 2016 program income from the SSA resulted in an increase to the FFY 2017 carryover balance.

Source: LBA analysis of NHVR analyses and the statements of appropriations.

Table 4 shows NHVR's VR Grants to States funding sources and program expenditures for SFY 2017, and both projected and actual numbers for SFY 2018. In SFY 2017, NHVR's annual spending ran a deficit of $1.7 million, which NHVR funded through carryover from previous years' grants. While NHVR's SFY 2018 estimated deficit differed by $1.5 million from actual financial activity, at the time, NHVR made reasonable assumptions given the information available. Specifically:

- From October 1, 2017, to March 31, 2018, actual program income from the SSA charged to the FFY 2018 grant totaled $643,000, thus an NHVR estimate of $1.2 million appeared reasonable.
- Yearly expenditures of $18.2 million would be similar to previous years' spending.
- Actual expenditures of $17.3 million included cost reductions measures enacted prior to and during the OOS and the actual expenditures would have likely been higher if no action was taken during SFY 2018.

**Table 4**

**VR Grants To States Funding Sources And Expenditures, SFY 2017 Actual And SFY 2018 Estimated Versus Actual**

| Financial Activity[1] | 2017 (Actual) | 2018 (Estimated)[2] | 2018 (Actual)[2] |
|---|---|---|---|
| Federal Grant Award | $ 10,800,987 | $ 10,155,278 | $ 10,155,278 |
| Reallotment Award | 0 | 0 | 0 |
| General Funds | 3,335,078 | 3,335,098 | 3,335,098 |
| Program Income | 2,870,451 | 1,200,000 | 1,812,044 |
| **Total Current Funding** | 17,006,516 | 14,690,376 | 15,302,420 |
| **Expenditure** | $ 18,659,732 | $ 18,191,908 | $ 17,339,703 |
| **Surplus/(Deficit)[3]** | ($ 1,653,216) | ($ 3,501,532) | ($ 2,037,283) |

Notes:
[1] A financial analysis on an SFY basis shows annual spending patterns but cannot accurately predict carryover balance or the precise financial solvency of the program on an FFY basis.
[2] NHVR incurred an MOE penalty in SFY 2018, reducing its federal grant.
[3] NHVR was able to fund a yearly deficit because of carryover funds from the previous year.

Source: LBA analysis of NHVR documents and statements of appropriations.

**Actions Taken To Address Projected Shortfalls**

After realizing NHVR's financial situation was not sustainable in the long-term, and potentially in the short-term, NHVR:

- laid off or not held vacant 13 positions for an annual savings of approximately $920,000 and additional savings were realized by not filling positions after some employees resigned or retired;
- reduced expenditures for pre-employment transition services by utilizing in-house resources which reportedly saved an estimated $345,000 annually;
- consolidated two regional offices into one location and moving another to NHVR headquarters, for an estimated annual savings of $90,000;
- reduced the use of contractors and a consultant for an annual savings of approximately $130,000;
- temporarily reduced the use of out-of-state travel for a one-time saving of approximately $40,000;
- made efforts to increase the review and oversight of VR expenditures, sought administrative efficiencies, and required customer financial contribution to some services which had an indeterminable impact on spending;
- implemented an OOS which was likely the primary cause for the decreased spending on services for customers by $3.2 million between SFY 2018 and SFY 2019; and
- applied for federal reallotment two months after entering OOS, adding nearly $1.3 million to the FFY 2018 federal award and $500,000 to the FFY 2019 grant award.

According to DOE officials, the OOS was a shock to New Hampshire's VR system, which affected NHVR staff, service providers, and ultimately NHVR customers. Implementing an OOS and reducing staff not only stopped some immediate spending, but it slowed future spending because most new customers were put on a waitlist. NHVR began releasing customers off the waitlist in September 2018, four months after implementing an OOS.

**Lower Spending Produced Significantly Higher Carryover Balance In FFY 2020**

Over a year after reporting a fiscal crisis in FFY 2018, actions taken to address the fiscal shortfall resulted in NHVR carrying over $9.3 million in unspent federal funds in October 2019. While having millions of unspent dollars on hand a year after entering an OOS may appear counterintuitive, such a high carryover balance was likely a financial anomaly due to the challenges of adapting to the OOS and reducing program expenditures.

**NHVR Fiscal Processes Were In The Reactive Phase Of Maturity**

We utilized a maturity model framework to assess the development of NHVR's fiscal management practices during the audit period. A maturity model is a stage-based framework to evaluate a function's stage of development. While many different maturity models exist, each model commonly includes five levels of maturity that function as a continuum. Therefore, an organization was required to fully achieve each level of maturity before advancing to the next level. A maturity model is designed to assess progress but does not necessarily dictate a process or function should reach a high level of maturity to be effective. For instance, a high level of maturity may not be practical, cost-effective, or necessary to ensure an effective process. Table 5 depicts the maturity model framework we applied to NHVR's fiscal management processes. While NHVR was moving towards a repeatable fiscal process by the end of the audit period, for most of the audit period, NHVR's process was at the reactive level, the lowest level of system maturity.

**Table 5**

**Maturity Model Of Fiscal Management Processes**

| Levels Of Maturity | | Characteristics Of Fiscal Management Processes |
|---|---|---|
| **Level 1** | Reactive | Processes are informal and inconsistent. |
| **Level 2** | Repeatable | Processes are documented and repeatable with management understanding the overall process. |
| **Level 3** | Defined And Managed | Processes are complete, consistent, and metrics are assessed against defined standards. |
| **Level 4** | Sustained | Processes are frequently analyzed with data and formal assessments, and management implements improvement initiatives. |
| **Level 5** | Optimized | Processes are independently verified as best among peers and management experiments with innovative changes to the processes on an ongoing basis. |

Source: LBA analysis of Institute of Internal Auditors' literature on maturity models.

**Observation No. 2**

**Further Develop The Maturity Of Fiscal Processes**

NHVR's internal controls over its fiscal processes improved during the audit period but were still developing in maturity. Due to poor financial oversight and immature fiscal processes that existed for years prior to the audit period, DOE and NHVR management did not start to accurately understand NHVR's financial position until it was in the midst of an impending financial crisis in early calendar year 2018. This dire financial situation required NHVR to create ad hoc financial reports leading up to the decision to enter an OOS and develop new fiscal management processes to replace previous practices that had resulted in erroneous financial records and ineffective financial oversight. While NHVR began the process of documenting and enacting improved fiscal processes during the audit period, comprehensive written policies and procedures to help ensure newly established fiscal controls would be consistently repeatable and fully understood by all key stakeholders during the audit period were not fully developed and implemented.

**Reactive Fiscal Management**

Due to poor internal controls prior to calendar year 2018, DOE and NHVR management did not have accurate financial information on the program's operations until less than six months before entering an OOS. In the past, NHVR fiscal processes received minimal oversight and were not comprehensively documented and could not be repeated by staff newly assigned to oversee fiscal processes. Starting in October 2017, DOE management identified weaknesses in its fiscal processes and began to implement improvements, such as bringing DOE business and NHVR

program personnel into the development and monitoring phase of the budget and instituting segregation of duties pertaining to fiscal management and oversight. After enacting these improvements, DOE and NHVR management realized early in calendar year 2018 it did not have approximately $3.8 million in carryover revenue from the prior FFY to fund the program through FFY 2018. DOE and NHVR management's initial responses to discovering that internal controls did not produce accurate financial records were reactive since new fiscal monitoring processes and reports needed to be developed immediately to respond to a pending fiscal shortfall. This error created an immediate fiscal crisis and eventually resulted in NHVR instituting an OOS to immediately reduce expenditures to prevent overspending its budget. Although NHVR started to improve fiscal management processes in fall 2017, more mature and comprehensive fiscal management processes and practices in the past could have allowed NHVR to identify financial shortfalls earlier, act in a more timely manner to resolve impending fiscal challenges, and possibly diminish or delay the negative impacts of entering into an OOS.

**Moving Towards A Higher Maturity Level**

By the end of the audit period, NHVR controls were maturing towards a formalized process for developing and enacting its primary budget management tool, known as the "Form 11." After the audit period in October 2019, NHVR implemented the use this new formal budgetary process which provided consistency and formal review, indicating the process was in the early stages of a repeatable level of maturity. At this level, processes also should be documented, and steps should become standardized to achieve a consistent methodology. The fiscal process implemented after the audit period aligned NHVR's fiscal management activities with those the DOE instituted over its other federal grant programs, increasing the likelihood this process could be repeated and would contribute to DOE and NHVR management's overall understanding of budgetary practices. However, the process was not fully documented and defined during the audit period. For example, the role of one employee responsible for developing and monitoring the budget was documented, but NHVR had not developed documentation for the roles of management officials tasked with reviewing and overseeing the fiscal management of the VR Grants to States. Additional levels of maturity would require this newly enacted fiscal management process to be fully developed, have standards to base metrics upon, and undergo periodic formal assessments.

***Maturing Fiscal Processes Is An Ongoing Process***

Fully maturing fiscal processes during the audit period was difficult for the DOE since previous years of inadequate fiscal management required substantial improvements, redesign, and reimplementation. Additionally, fluctuations in NHVR's financial condition during the audit period likely made developing a stable fiscal process even more challenging. Although DOE and NHVR management improved fiscal management practices during the audit period, NHVR could benefit from additional steps to improve the overall maturity of these processes. For example, the "Form 11," NHVR's new budget management tool implemented after the audit period, did not fully integrate all financial components of NHVR's funding mix, such as reallotment funding dollars. In practice, NHVR management began pursuing reallotment after entering into the OOS. However, not integrating reallotment into the new primary budget tool jeopardized whether NHVR would continue to effectively maximize and consistently request reallotment, when necessary, in subsequent years after the audit period.

In addition to poor fiscal controls prior to January 2018 producing a $3.8 million error in internal financial records, NHVR did not consistently pursue federal funds through the reallotment process to mitigate declining federal grant awards in FFYs 2016 and 2017. Table 6 shows NHVR's initial federal grant award had generally been declining since 2012. However, NHVR did not increase its reallotment requests to offset the decline until FFY 2018. NHVR did not seek reallotment at all in FFYs 2016 and 2017, leaving a maximum potential revenue of $1.9 and $1.3 million uncollected, respectively. For example, in FFY 2016 NHVR spent $518,897 more in State funds than the minimum required to match the initial VR grant. A maximum of $1,917,238 could be requested through reallotment, but NHVR did not request any reallotment funding. While reallotment was historically a consistently available funding source when requested by NHVR, states were not guaranteed to be awarded funds during the reallotment process and the maximum potential reallotment was unlikely to be collected in full.

**Table 6**

**Potential Reallotment, Reallotment Requested, And Actual Reallotment Received, FFYs 2012 Through 2019**

| FFY | Initial Grant Award | Maximum Potential Reallotment[1] | Actual Requested Reallotment | Actual Reallotment Received | Total Grant, Including Reallotment |
|---|---|---|---|---|---|
| 2012 | $ 11,559,524 | $ 277,878 | $ 320,200 | $ 320,200 | $ 11,879,724 |
| 2013 | 11,302,384 | 2,525,738 | 300,000 | 300,000 | 11,602,384 |
| 2014 | 10,990,382 | 1,407,360 | 352,000 | 352,000 | 11,342,382 |
| 2015 | 11,099,461 | 2,733,875 | 311,865 | 311,865 | 11,411,326 |
| 2016 | 10,829,085 | 1,917,238 | 0 | 0 | 10,829,085 |
| 2017 | 10,800,987 | 1,304,679 | 0 | 0 | 10,800,987 |
| 2018 | 10,155,278 | 2,587,364 | 2,000,000 | 1,273,720 | 11,428,998 |
| 2019[2] | 10,925,983 | 1,236,949 | 500,000 | 500,000 | 11,425,983 |

Notes:
[1] The exact maximum potential reallotment may be unknown at the time of the request.
[2] A request of $500,000 may have been appropriate for FFY 2019 due to a significant decrease in NHVR expenses and a large carryover balance of unused federal award from the previous year.

Source: LBA analysis of NHVR reports.

**Recommendations:**

**We recommend DOE management continue its efforts to mature its NHVR fiscal management processes beyond the reactive status by ensuring:**

- **the selected NHVR grant planning, budgeting, and monitoring process is comprehensively documented and repeatable for current and future personnel involved in the process;**
- **those responsible for managing and overseeing the VR grant have clearly defined and documented roles;**

- **the fiscal management processes include metrics to evaluate and monitor the financial health and effectiveness of the program established in policy and procedures; and**
- **a documented formal assessment process takes place to incorporate feedback and new information into the budget development and monitoring processes and the information is used to improve procedures and policy, if needed.**

*NHVR Response:*

*NHVR concurs, in part with the recommendations. NHVR make the following remarks related to the auditor's observations:*

1. *Prior to October 2017, the financial management of the VR program was located in a separate bureau and managed by a business administrator that reported directly to the then Deputy Commissioner. Through reorganization, since December 2017, all business administrators report to the Chief Financial Officer and the VR Director has management oversight of all finances on a daily basis under the supervision of the Deputy Commissioner.*
2. *The audit report discusses "federal revenue" as two different ideas in different areas of the report. They refer to it as funding received from federal sources and they also refer to it when discussing appropriation levels, when discussing the budget process. These two definitions of federal revenue need to be clearly defined so that the reader understand what is being discussed. It matters greatly when understanding the complexity of the funding.*
3. *The audit report discusses adding reallotment funds into the Form 11 budgetary process. The concern from NHVR leadership is that reallotment is not something that can be budgeted for each year. It cannot be added in to any budget as a part of the budget as it may not be available. The program may not be able to exceed match requirements and thus not be eligible to request additional funds. Reallotment may not be available at all, meaning that all states were able to match their funds and no reallotment remains to be realloted.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The VR Director, assigned Business Administrator, the Deputy Commissioner and Commissioner review a comprehensive report of grant balances, unliquidated obligations (services provided awaiting payment), match status, maintenance of effort status, etc. on a weekly basis.*
- *Form 11 budgeting form is completed and reviewed every month to determine if the bureau is on target for all accounting unit budgets.*
- *VR leadership meet with the Business Administrator every other week to determine if the bureau has any fiscal items that need action (directed towards the State Legislative Budget Committee), questions on any accounts, or federal reporting questions as they come due.*

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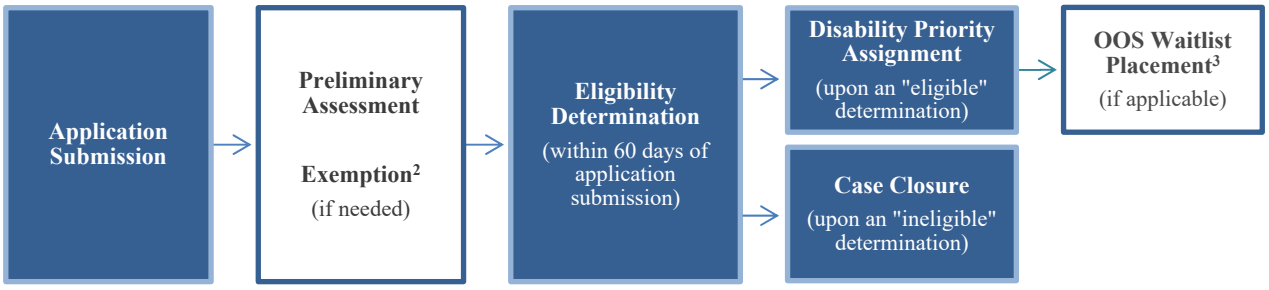
## CHAPTER 4: ELIGIBILITY

The New Hampshire Bureau of Vocational Rehabilitation (NHVR) was responsible for decisions affecting eligibility for vocational rehabilitation (VR) services. Management recognized eligibility as "the foundation" for developing customers' individualized plans for employment (IPE) and selecting appropriate services. Additionally, NHVR was required by federal law to assign customers to disability priority categories when under an order of selection (OOS). NHVR implemented an OOS in May 2018. Disability priority assignments prioritized customer access to services through a waitlist, and assured customers with the most significant disabilities received services first. Between July 2015 and May 6, 2018 (prior to the OOS), NHVR reportedly made 6,004 eligibility determinations, averaging 173 determinations per month. NHVR entered an OOS on May 7, 2018. Between May 7, 2018, and June 2019 (during the OOS), NHVR reportedly made 1,519 eligibility determinations, averaging 109 determinations per month.

An overview of the eligibility process is presented in Figure 4. Once an application was submitted, NHVR was required to determine eligibility within 60 days, or an exemption was required. Typically, the applicant and their assigned vocational rehabilitation counselor would meet for an intake appointment, initiating a preliminary assessment to determine eligibility and service priority. The assessment involved gathering and reviewing information, such as medical or educational records and supporting assessments, and evaluating them against eligibility requirements and disability priority criteria. The counselor then made a determination and, if the applicant was eligible, assigned them to a disability priority category. Some of these decisions required review and approval by a supervisor before becoming effective.

**Figure 4**

**Vocational Rehabilitation Eligibility Process[1]**




Notes:
[1] Main steps are in shaded boxes. Some steps may not occur, if unnecessary or not applicable.
[2] An exemption depended on whether a determination could be made in 60 days, or the severity of the applicant's disabilities.
[3] Placement on the waitlist depended on a customer's priority assignment and which categories were open for services.

Source: LBA analysis of federal and NHVR eligibility determination and disability priority assignment requirements.

Applicants had to meet all four requirements to be eligible to receive VR services:

1. Have A Physical Or Mental Impairment – Federal regulations defined an impairment as a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems; or b) any mental or psychological disorder. NHVR training materials defined an impairment as the area where an applicant's disability most significantly impacted long-term functioning. Impairments could be sensory and communicative, including blindness or deafness; physical, including dexterity or physical debilitation; or mental, including cognitive or psychosocial.
2. Have A Substantial Impediment To Employment – Federal regulations defined a substantial impediment to employment as a physical or mental impairment (in light of medical, psychological, vocational, educational, communication, and other related factors) that hindered an individual from preparing for, entering into, engaging in, advancing in, or retaining employment consistent with their abilities and capabilities.
3. Require VR Services – Federal regulations required VR services to be necessary for the applicant to prepare for, secure, retain, advance in, or regain employment, consistent with their unique strengths, resources, priorities, concerns, abilities, capabilities, interest, and informed choice. VR services included job search and job placement, vocational training, personal assistance, rehabilitation technology, and supported employment services.
4. Intend To Achieve An Employment Outcome – Completing an application was presumed to be sufficient evidence an applicant intended to achieve an employment outcome. As a result, applicants who were eligible based on the first three requirements were presumed eligible based on the fourth requirement, except for certain circumstances permissible under federal law.

Applicants determined eligible for services were assigned to one of three priority categories: most significant disability (MSD), significant disability (SD), and less significant disability (L-SD). Applicants who were determined to have a disability or be blind under the federal Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) programs were presumed eligible under the first and second requirements but had to meet all four requirements. These applicants were also required to be assigned to the SD category, at a minimum, but could be assigned to the MSD category with supporting documentation.

To ensure the efficiency, effectiveness, and compliance of eligibility processes, management was responsible for developing, implementing, monitoring, and continuously improving related management controls. When NHVR implemented the OOS, it reportedly implemented more stringent controls around eligibility determinations and disability priority assignments. However, we found eligibility determinations and disability priority assignments were not always in compliance with federal requirements and NHVR policy and procedures. Supervisory review did not identify compliance issues, including backdating and not meeting the time limit for determining eligibility. Extensions, which were allowable under certain circumstances, were not always consistent with federal regulations. Some cases were missing required documentation, calling some eligibility determinations and disability priority assignments into question. Few applicants and customers whose cases were closed as too severely disabled to benefit from services and would have needed a trial work experience, received one as federally required. Finally,

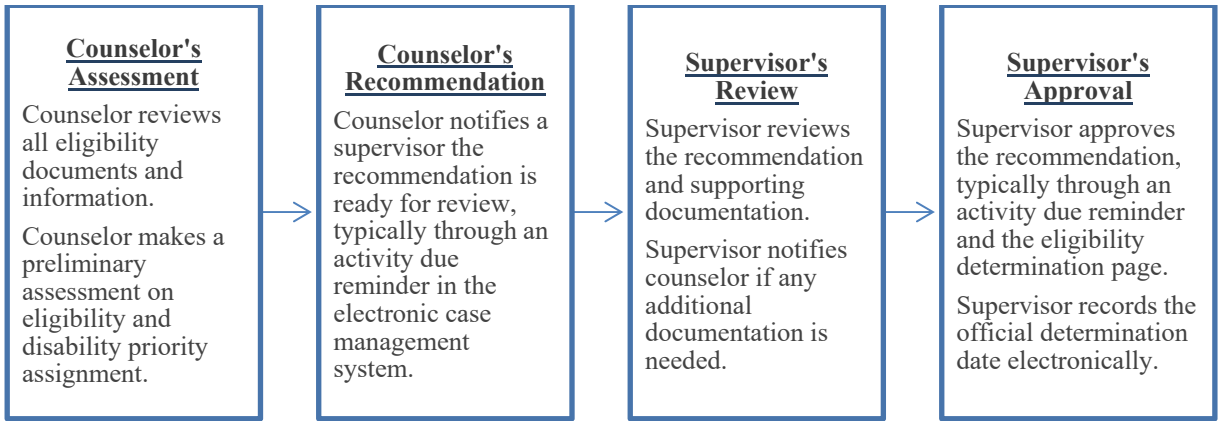
guidance documents were incomplete, and monitoring and enforcement of requirements were limited in effectiveness, despite the importance of having accurate and well-documented eligibility decisions and disability priority assignments.

**Eligibility Signature Authority And Supervisory Review**

NHVR management required counselors to have "signature authority" to make eligibility determinations and disability priority assignments. Counselors without signature authority could only "recommend" eligibility determinations and disability priority assignments and required supervisory review. Supervisory review included reviews from regional leaders (RL), vocational rehabilitation counselor (VRC) IIIs with signature authority, or the Field Services Administrator who had to approve recommendations before they became effective as shown in Figure 5. RLs generally reported reviewing the electronic case file, including data pages, case notes, and attached medical records. Some RLs also reported reviewing the hardcopy case file if needed. RLs assessed whether eligibility determinations and disability priority assignments were consistently supported by documentation, sufficiently explained, and reasonable.

**Figure 5**

**Supervisory Review And Approval Process For Counselors Without Eligibility Signature Authority**




Source: LBA analysis of NHVR's supervisory review and approval process for eligibility determinations and disability priority assignments.

Historically, the need for supervisory review and approval generally applied to VRC Is, who were not "qualified" counselors. Federal regulations required a qualified counselor make a determination that an applicant required services to be determined eligible. Federal law required NHVR to establish policies and procedures to ensure staff were appropriately and adequately prepared, including education requirements. NHVR required counselors hold a master's degree. Supplemental job descriptions for VRC IIs and VRC IIIs reflected this requirement. However, NHVR management indicated they were not always able to hire qualified counselors, and job descriptions for VRC Is required a bachelor's degree and a plan of action to qualify as a VRC II

within seven years. Job descriptions indicated VRC Is did "not have signature authority to complete eligibility determinations" and could only recommend decisions.

NHVR managers reported all or most VRC IIs and VRC IIIs held signature authority prior to the implementation of an OOS on May 7, 2018. In June 2017, at least 17 of 39 counselors (44 percent) did not have signature authority. With the implementation of the OOS, some counselors left or were laid off and all remaining counselors' eligibility signature authority was reportedly rescinded. Management reportedly established a process for VRC IIIs to regain their signature authority, which began in October 2018 on a case-by-case basis. In June 2019, 31 of 32 counselors (97 percent) did not have signature authority.

**Observation No. 3**

## Improve Supervisory Review Over The Eligibility Process

NHVR management attempted to ensure compliant and consistent eligibility decisions were made for each applicant by granting eligibility signature authority to some counselors, while requiring supervisory review and approval for counselors without eligibility signature authority. However, NHVR's policies, procedures, and training materials did not provide guidance about these processes. Controls were not effectively designed, implemented, or monitored, and management did not ensure accountability. As a result, some eligibility decisions were noncompliant with some federal or NHVR requirements, processes could have been more efficient, and supervisors did not always identify or address issues in the eligibility process.

### Monitoring Of Signature Authority Was Limited

Even though signature authority and supervisory review and approval were NHVR's primary controls over eligibility decisions, management did not comprehensively monitor signature authority or determine whether supervisory review and approval were effective. Fifteen of 25 counselors responding to our survey (60 percent) reported that management did not always ensure policies and procedures were consistently applied. When asked in which areas management did not always ensure policies and procedures were consistently applied, three of the 15 counselors (20 percent) identified signature authority and supervisory review. We found counselors without signature authority were making and approving eligibility determinations. Supervisors did not use a standardized process when reviewing eligibility decisions, and their review did not always identify issues with the eligibility process.

Due to inadequate monitoring of which counselors had signature authority and monitoring of those with signature authority, management was unable to holistically enforce accountability with eligibility requirements and disability priority criteria. Additionally, while there was no process to revoke signature authority of counselors whose decisions were inconsistent with federal and program requirements, a manager reported such a process was being considered for implementation in calendar year 2020. Without monitoring and enforcement, management would have been unable to determine whether existing controls were adequate or whether more robust, or different, controls were needed.

***Counselors Without Signature Authority Made And Approved Eligibility Decisions***

NHVR controlled eligibility signature authority through its electronic case management system, by allowing only counselors with authority to finalize the "eligibility determination" data page. To assess compliance with signature authority requirements, we reviewed: 1) cases with eligibility determinations made between July 2015 and June 2019 from our file review of complete case files, and 2) all cases with eligibility determinations made in June 2017, June 2018, and June 2019. We were unable to assess decisions made by VRC IIs or VRC IIIs prior to the OOS, as management did not document which counselors had authority during that time. We assessed only decisions for cases assigned to VRC Is prior to the OOS, as well as decisions for cases assigned to all counselors during the OOS. We found signature authority did not always serve as an effective control over eligibility decisions.

- Some Counselors Without Authority Made Their Own Eligibility Decisions – Some counselors who, according to NHVR's records, did not have signature authority at the time, made determinations and disability priority assignments. These counselors finalized the "eligibility determination" data page themselves, rather than only *recommending* these decisions for review and approval, which effectively bypassed NHVR controls. Prior to the OOS, one of 83 cases (one percent) had decisions made by a VRC I. During the OOS, 16 of 255 cases (six percent) had decisions made by VRC Is, VRC IIs, or VRC IIIs who did not have signature authority at the time the decision was made.
- Some Counselors Without Authority Approved Others' Eligibility Decisions – Some counselors without signature authority reviewed and *approved* others' eligibility recommendations. During the OOS, 17 of 255 decisions (seven percent) were approved by VRC IIIs who, according to NHVR records, did not have authority at the time the approval was made.

In October 2020, NHVR management reported VRC IIIs' authority was not rescinded in the case management system to allow them to review and approve VRC Is' eligibility recommendations in their supervisory capacity supporting the RL. This understanding was not documented, and we were unable to confirm this process, as it contradicted information previously provided by other staff. NHVR staff including management, RLs, and counselors reported that immediately following the implementation of the OOS, eligibility signature authority was rescinded for *all* counselors. Specifically, four RLs we interviewed between August and September 2019, reported they reviewed eligibility determinations for *all* counselors in their regional office. RLs also reported VRC IIIs could not review other counselors' recommendations until the VRC III's eligibility signature authority was restored. This was supported by documentation provided by NHVR in September 2019 showing when each counselor's authority was restored.

Decisions made by VRC Is were not effective, and it was unclear whether decisions made or approved by VRC IIs or VRC IIIs without signature authority were effective. Ineffectively implemented controls also introduced the potential that inconsistent or noncompliant decisions could be made by counselors without authority.

***Decisions Made By Counselors With Signature Authority Prior To The OOS Contained Issues***

Prior to the OOS, VRC IIs and VRC IIIs with signature authority had autonomy to make their own eligibility decisions. However, there were no processes to monitor whether eligibility decisions made by these counselors were in accordance with federal and NHVR requirements, nor was there a process to revoke signature authority for counselors whose eligibility determinations were inconsistent with these requirements. As a result, we identified noncompliance with eligibility requirements and inconsistent disability priority assignments in eight of nine cases (89 percent) assigned to VRC IIs and VRC IIIs that did not undergo supervisory review prior to the OOS. Noncompliance and other issues we identified in these eight cases included:

- An extension form was not signed as required and did not appear to be for an exceptional and unforeseen circumstance beyond the control of NHVR, as we discuss in Observations No. 7 and No. 8.
- Counselors did not always document the applicant's serious functional limitations, recorded fewer serious functional limitations than required to support the priority category assigned, or recorded fewer services to support the priority category assigned, as we discuss in Observation No. 9.
- When documenting eligible cases, counselors did not always use current medical documentation to support eligibility decisions, did not always verify social security benefits, did not always document substantial impediments to employment or that VR services were needed to address the impediments, as we discuss in Observation No. 11.

For example, in one case, eligibility documentation was incomplete, as we discuss in Observations No. 9 and No. 11. Documentation in the file did not support that a qualified person had determined the applicant had all the impairments or any of the impediments to employment recorded in the case management system. There was no discussion in the case file as to why specific VR services would be needed by the applicant. Additionally, while the counselor assigned the applicant to the MSD category, there was no medical documentation supporting any of the recorded functional limitations.

***Decisions Made By Counselors With Restored Authority During The OOS Contained Issues***

VRC IIIs were able to have their eligibility signature authority restored during the OOS, after a supervisor assessment. Presumably, restoration of authority signaled a VRC III understood eligibility requirements and produced consistent recommendations. We identified two cases assigned to a VRC III with signature authority during the OOS in our sample. However, these cases did not contain all documentation necessary to support all four eligibility requirements, as we discuss in Observation No. 11, or to support the priority category assigned, as we discuss in Observation No. 9.

***Supervisory Review Did Not Always Identify Issues With The Eligibility Process***

When supervisory reviews occurred, supervisors did not always identify or address issues with eligibility determinations and disability priority assignments.

- Documentation Required For Making Eligible And Ineligible Determinations Was Not Always Complete – We found 23 of 24 cases prior to the OOS (96 percent) and 41 of 42 cases during the OOS (98 percent) did not meet at least one federal documentation requirement. As we discuss in Observation No. 11, counselors were required to use current medical documentation, verify social security benefits, document the applicant's impairment, document substantial impediments to employment and that VR services were needed to address the impediments. Additionally, as we discuss in Observation No. 12, counselors were required to document the determination the customer was ineligible, consult with applicants before finding them ineligible, provide notification, and follow-up with cases closed because the disability was too severe to benefit from services. Supervisors needed this information to thoroughly review eligibility recommendations and confirm compliance with documentation requirements. For example, in one case during the OOS, the file contained no documentation of an impairment or impediment to employment, but the supervisor approved the eligibility determination.
- Inconsistent Disability Priority Assignments – We found nine of 23 eligible cases prior to the OOS (39 percent) and 14 of 40 eligible cases during the OOS (35 percent) appeared to have been assigned to a different disability priority category than supported by case documentation as we discuss in Observation No. 9. Inconsistent assignments affected some customers' ability to receive services timely during the OOS. In one case, a customer was categorized as MSD, with a severe impairment seriously limiting four functional capacities, requiring three VR services over 16 months. However, documentation in the file supported only one limitation, which would have categorized the customer in the SD category.
- Inefficiency Of The Eligibility Process – Supervisory review did not identify or address counselor inefficiencies in the eligibility process, resulting in determinations that were not made as soon as possible, as we discuss in Observation No. 5, or were noncompliant with the 60-day time limit, as we discuss in Observation No. 6. Inefficiency resulted in longer wait times for some applicants and may have delayed the ability of some eligible customers to obtain VR services.

**Supervisory Review Was Inconsistently Documented**

NHVR provided no guidance on how to document supervisory review of eligibility decisions. One central office manager reported supervisor feedback could be provided through an "activity due" reminder, an email, in person, or by phone. The manager indicated it was not always desirable to document feedback in the case file. However:

- federal regulations required NHVR to include documentation supporting determinations of an applicant's eligibility or ineligibility for VR services in each case file, and
- State law required the Commissioner to "make and maintain records containing adequate and proper documentation of the… decisions… of the agency...."

To document eligibility decisions, supervisors should have recorded the results of their review and any subsequent changes to eligibility recommendations. However, this information was not always in the case file. As a result, it was unclear whether supervisors agreed with a recommendation or whether review resulted in any changes to counselors' recommendations.

**Limited Guidance On Signature Authority And Supervisory Review Processes**

Signature authority and supervisory review requirements were not documented, and roles, responsibilities, and performance expectations were not clearly communicated. Upon implementation of the OOS, staff were reportedly notified signature authority was revoked by NHVR management orally, and not in writing. Eleven of 25 counselors responding to our survey (44 percent) reported that policies and procedures were not always clear and understandable. When asked in which areas policies and procedures were not always clear and understandable, three of 11 counselors (27 percent) identified signature authority and supervisory review. At best, unclear guidance contributed to confusion and inefficiency. At worst, unclear guidance contributed to noncompliance with federal regulations, such as when supervisors backdated some eligibility determinations.

Additionally, the process to restore signature authority was informal and unclear. Following the implementation of the OOS, NHVR management permitted only VRC IIIs to have their eligibility signature authority restored. Supervisors reported that RLs decided whether to restore authority. RLs submitted their decision to the Field Services Administrator who approved the decision and initiated restoration of authority in the case management system. However, there was no guidance on the process to be used by RLs, such as the number of prior decisions that should be reviewed, or minimum requirements VRC IIIs must meet to have their signature authority restored. As a result, counselors in different regional offices could be subject to different restoration processes and levels of scrutiny. Additionally, there was no guidance on what information should be submitted to support an RL's decision to restore authority. As a result, the central office had minimal oversight of the process.

**Recommendations:**

**We recommend NHVR management improve eligibility signature authority and supervisory review and approval processes by:**

- **tracking who has signature authority and when authority is rescinded or restored;**
- **formally assigning appropriate signature authority and supervisory review responsibility to counselors, supervisors, and managers;**
- **developing, implementing, and refining written requirements for supervisory review, including guidance on what should be considered when reviewing counselors' eligibility recommendations and disability priority assignments;**
- **ensuring eligibility signature authority and supervisory review processes are clearly communicated to staff;**
- **developing training materials on eligibility signature authority and supervisory review processes and incorporating into training sessions;**
- **identifying data and information necessary for monitoring compliance with eligibility signature authority and supervisory review requirements;**
- **developing, implementing, and refining processes to routinely collect, monitor, and analyze compliance data and information; and**

- **routinely assessing staff compliance with signature authority and supervisory review requirements, analyzing information to identify trends and potential issues, and timely remediating deficiencies identified.**

*NHVR Response:*

*NHVR concurs, in part with the recommendations. NHVR make the following remarks related to the auditor's observations:*

1. *Evaluation of signature authority for a period prior to December 2017, and entering an order of selection, modified authority after the initial phases of the order of selection had passed and in the current environment presents a complex and dynamic situation. Even with this complexity, the bureau is confident in its primary control, namely that only those authorized with signature authority in the system are capable of transaction approval. Thus although complex, the close monitoring of system signature authority authorization is the mechanism the bureau used to determine, under the changing circumstances, employees authorized. Individuals, other than those given signature authority, cannot finalize or approve eligibility determinations. Signature authority is identified in the case management system. As the system is designed, those without authority would be unable to make and approve these determinations. At any time in the system, the agency can determine who has appropriate authority to complete the eligibility process. While the only agency record of authorized signatories is maintained in the change records in the system, and the bureau did not maintain separate record of changes, an individual without rights would not have been able to perform the action within the case management system.*
2. *VRC I's do not have the ability to make independent eligibility determinations and this would be impossible as staff rights are controlled by our case management system. The cases cited were actually case closures that were given an incorrect closure reason. The incorrect closure reason of "disability too severe" was used when participants requested case closure because they did not believe they would be able to pursue employment due to their current health status. This reason should not have been used as it is only used when someone is determined ineligible after going through trial work experiences to determine if they could benefit from services intended to result in an employment outcome. The agency is aware of these incorrect closure codes, and we have already provided training and have eliminated this concern.*
3. *The agency had previously identified the weakness in supervisory review of ineligibility determinations as these could be closed through the closure data page and by-pass the eligibility determination page. The agency has since put into place different processes to assure supervisory review including an ineligibility date field on the eligibility determination page that requires approval authority to date. The audit team cited 16 of 255 cases decisions were made by VRC I's when NHVR was only able to confirm 2 of 255 and those 2 of 255 were the incorrect closure reasons listed above that resulted in an ineligibility determination.*
4. *VRIII's continued to review eligibility determinations made by VRI's and II's during the Order of Selection. Their rights were not rescinded as the auditors. Our case management system has approval parameters based on job title. RCIII's have the ability to review eligibilities of those counselors who do not have those rights.*

5. *In April, 2020 guidance provided to the field regarding eligibility determinations includes "RCII's can make eligibility decisions, however with the implementation of the Order of Selection process, the agency has temporarily removed their rights. If an RCII has not had their rights restored, they will send their AD's to the RL's a minimum of 5 working days prior to the 60-day time frame and the eligibility date is still the date of the RL review." The agency has implemented the following in order to correct the cause of this observation. Between July and September of 2020, all Regional Leaders and RC III's took part in a consensus building process to develop objective and consistent methods to review eligibility determinations and disability priority categorization. Training materials were created in September, 2020, and the entire counseling staff was trained on how to thoroughly and professionally document eligibility decisions and priority categorizations. These training materials are available on the Yes LMS learning management platform as a resource for counselors and Regional Leaders. In addition, Regional Leaders have a guide to refer to with specific questions and examples of proper documentation that is used to allow for consistent and objective decision making.*
6. *In January 2020, NHVR began to track signatory authority start and end dates, so that a list of staff who has that authority within a given time frame could be provided in the future, if necessary. The agency will review this process and assess need for additional processes or changes to track signature authority status of each counselor beyond what occurs now which is communication between Regional Leaders and the Field Service Administrator regarding recommendation for changes in signature authority after a promotion or performance concern.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau will evaluate the effectiveness of the process implemented to track authorized signatories outside of the system and make modifications as needed.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**NHVR's internal controls do not always function as intended, which is why we recommend NHVR monitor compliance with signature authority. Monitoring will help detect improperly identified signature authority in the case management system, or errors with the case management system controls.**

**In Remark 1, NHVR acknowledges it did not track signature authority. Additionally, there was no formal process to determine when and how signature authority should be restored. Without these formal processes, NHVR management could not verify internal controls were working as designed nor could they ensure signature authority was provided appropriately. We note while the electronic case management system was purportedly programmed to only**

**allow individuals with signature authority to finalize activities, our review found counselors, whom NHVR identified in a document provided to us in September 2019 as not having signature authority, finalized activities in 17 cases. In 15 of these cases, counselors never had signature authority, or had not yet received their authority back by September 2019. In the other two cases: 1) the determination was made in June 2018, while the counselor received authority in July 2019; and 2) the determination was made in July 2018, while the counselor received authority in October 2018.**

**In Remark 2, NHVR attributes some of our findings to cases that were given inaccurate closure reasons. We identified six cases where VRC Is made eligibility determinations, only two of which the applicants were determined ineligible. These cases received no supervisory review or approval. Effective internal controls should ensure that *all* eligibility determinations on the caseloads of VRC Is – whether eligible or ineligible – are reviewed by a supervisor. The fact that these cases were inaccurately closed does not negate our finding of an internal control weakness.**

**NHVR's response in Remark 3 is inaccurate. The Observation states, "Prior to the OOS, one of 83 cases (one percent) had decisions made by a VRC I. During the OOS, 16 of 255 cases (six percent) had decisions made by VRC Is, VRC IIs, or VRC IIIs who did not have signature authority at the time the decision was made." We identified six cases where VRC Is made eligibility determinations. In four of the six cases, applicants were determined eligible. In these cases, the VRC I dated the "eligibility determination" data page, thereby finalizing eligibility. As of December 2020, the electronic case management system showed only a VRC I having dated the "eligibility determination" data page. No documentation was provided by NHVR to demonstrate that staff with signature authority finalized these determinations.**

**NHVR notes in Remark 4, VRC IIIs' rights were not rescinded as they had "the ability to review eligibilities of those counselors who do not have those rights." We did not find documentation VRC IIIs should have retained signature authority following implementation of the OOS and this understanding was not documented. Additionally, we were unable to confirm this process, as it contradicted information previously reported by NHVR managers, RLs, and counselors who reported that signature authority was rescinded for *all* counselors immediately following the implementation of the OOS. This was supported by documentation provided by NHVR in September 2019 showing when each counselor's authority, including VRC IIIs, was restored. Additionally, we question the effectiveness of an internal control that purportedly permitted counselors who were unable to make *their own* eligibility determinations to review and approve the eligibility recommendations of other counselors.**

### Eligibility Determination Timeliness

According to federal regulations, NHVR was responsible for all decisions affecting eligibility for VR services. These decisions included the date on which the eligibility determination was made. NHVR management had long-standing performance expectations for counselors to make

eligibility determinations in a "reasonable" amount of time or "as soon as possible" after application, and within the federal 60-day time limit. An applicant's official eligibility determination date was recorded on the "eligibility determination" data page in NHVR's electronic case management system. The *NHVR Counselor Desk Reference* (*Desk Reference*) permitted counselors and RLs to "backdate" eligibility determination dates in the electronic case management system by up to 14 days on their own, or for longer periods with central office approval.

We found backdating was used extensively and unaudited data on eligibility determination dates from NHVR's case management system was not reliable. Due to the frequency with which backdating was used, we were unable to verify overall compliance with the 60-day time limit, or timeliness of eligibility determinations generally. Additionally, even with backdating, NHVR did not always complete eligibility determinations within the 60-day time limit. NHVR eligibility determination data inflated compliance rates, although we were unable to determine by how much. Inaccurate data showing a higher compliance rate could have affected decision-making by NHVR management such as by making the improvement of controls over compliance rates a lower priority. Additionally inaccurate data would have affected the accuracy of compliance rates reported to the Rehabilitation Services Administration, NHVR's federal oversight agency, by making NHVR appear more compliant than it was with the 60-day time limit.

**Observation No. 4**

**Address Backdated Eligibility Determination Dates**

NHVR managers and staff routinely backdated eligibility determination dates, which compromised information available for decision-making. Backdating made some eligibility determinations appear compliant with the federal 60-day time limit and reduced the amount of time available to develop an IPE within 90 days for some customers.

**Data Integrity And Oversight Was Undermined By Unreliable Eligibility Dates**

Central office managers were aware backdating occurred, and backdated eligibility determination dates when they conducted supervisory review and approval. The *Desk Reference* required staff to submit a request to the central office "with a detailed description on why the date change needs to occur" for backdating beyond 14 days. However, the *Desk Referen*ce did not require any explanation if backdating occurred within 14 days. One manager reported backdating to avoid "penalizing" applicants if supervisory review could not be conducted on the date requested by the counselor. On the whole, the practice was unquestioned and occurred agency-wide.

In one case of backdating during the OOS, the counselor requested supervisory review of their eligibility recommendation 69 days after application submission, nine days past the 60-day time limit. The supervisor initially reviewed the recommendation 73 days after application submission, and requested the counselor provide additional documentation to support their eligibility recommendation. The supervisor's approval did not occur until 80 days after application submission, 20 days past the time limit. However, the supervisor backdated the official eligibility determination date to 59 days after application submission, which was before the counselor even

submitted the case for review. In another case, a counselor requested backdating "ASAP in order to stay off [the] naughty list," referring to the weekly case monitoring report.

Counselors and supervisors generally did not document the reasons why backdating was needed. To assess the extent of backdating and its appropriateness, we analyzed 96 eligibility determinations made between July 2015 and June 2019 from: 1) our file review case records, 2) our review of two samples of electronic case files with eligibility determinations made within the 60-day time limit, and 3) our review of a sample of electronic case files with determinations made after the 60-day time limit. Of the cases we reviewed, we found:

- Backdating Was Widespread – NHVR management intended backdating to be used infrequently, but eligibility determination was backdated in 49 of 96 cases (51 percent).
- Managers And Staff At All Levels Used Backdating – Of the 49 cases, backdating was used by central office managers in 16 cases (33 percent), RLs in 24 cases (49 percent), VRC IIIs in five cases (ten percent), and VRC Is or VRC IIs in four cases (eight percent).
- The Use Of Backdating Increased During The OOS – We found backdating in 12 of 35 cases (34 percent) with eligibility determinations made prior to the OOS, and 37 of 62 cases (60 percent) with eligibility determinations made during the OOS.
- Backdating Made Some Eligibility Dates Appear Compliant With 60-day Time Limit – Counselors requested eligibility determinations be backdated to appear compliant with timeliness requirements and due to fear of appearing on the weekly case monitoring report as delinquent. Two cases prior to the OOS and 14 cases during the OOS had eligibility determinations made after the 60-day time limit, but 15 of the 16 (94 percent) appeared compliant after backdating. In one case, 93 days after the application was submitted, the counselor requested the supervisor backdate the eligibility determination to 57 days after the application was submitted.
- Backdating Resulted In Official Determination Dates Different From Actual Approval Dates – Supervisors typically backdated eligibility determinations to the date of counselors' recommendations instead of using the date of their approval. Ten of 21 decisions reviewed and approved by a supervisor (48 percent) prior to the OOS were backdated, while 30 of 50 decisions reviewed and approved by a supervisor (60 percent) during the OOS were backdated.
- Backdating Affected Some Official Determination Dates By Two Weeks Or More – We found three cases prior to the OOS backdated by 21 to 25 days, and two cases during the OOS backdated by 14 to 21 days.

**Negative Impact On IPE Development**

Backdating eligibility determination dates negatively affected the timely development of some IPEs. The eligibility determination date was the start of the federal 90-day time limit to develop an IPE. When counselors made an eligibility recommendation to a supervisor, an applicant's eligibility determination had not yet been finalized. The applicant could only become a customer after the supervisor with signature authority reviewed and approved the eligibility determination. By backdating the eligibility determination date, counselors began IPE development later and had

less time to complete an IPE before the 90-day time limit. Counselors could request an extension to the 90-day time limit, but this created unnecessary delays for customers working towards their employment goal.

In one case, the supervisor reviewed and approved the counselor's eligibility recommendation 66 days after application submission, six days past the 60-day time limit. However, the supervisor backdated the official eligibility determination date to 15 days before the 60-day time limit. The start of IPE development was delayed, since IPE development was limited by federal regulations to customers. By the time the counselor began working on the IPE, almost two-thirds of the 90-day time limit, or 56 days, had elapsed. Slightly more than one-third of the 90-day time limit, or 36 days, would have elapsed if the eligibility determination had not been backdated.

**Appropriateness Of Backdating Was Questionable**

State law required the Commissioner to "make and maintain records containing adequate and proper documentation of the…decisions…of the agency…." A record included any document or electronic record made in connection with the transaction of official business. For eligibility decisions, this included the "eligibility determination" data page and official eligibility determination date.

The *Desk Reference* did not acknowledge State records requirements, although it cautioned that staff "should not rely on backdating as a normal way of doing business." One RL indicated backdating could be used when a determination had been made but not yet entered into the case management system, such as if counselors were meeting with applicants outside the office and did not have access to the system. However, NHVR policy, procedure, and training materials did not identify in which situations backdating would be appropriate or inappropriate. Additionally, management had no processes in place to be able to identify and assess the appropriateness of backdating, and counselors and supervisors generally did not identify why they were backdating.

**Recommendations:**

**We recommend NHVR seek and obtain guidance from the Rehabilitation Services Administration to assess whether backdating official eligibility determination dates is permissible, and if so, under what circumstances. If there are circumstances under which backdating is permissible, then the Commissioner and NHVR management must properly control the use of backdating and ensure compliance with federal requirements and applicable State laws on records management by:**

- **developing, implementing, and refining written requirements on recording official eligibility determination dates;**
- **revising, implementing, and refining written criteria for situations when backdating eligibility determination dates may be appropriate;**
- **developing, implementing, and refining written processes for staff to utilize and request backdating of eligibility determination dates, including establishing clear timeframes for when backdating may be requested, by whom, and what information**

**is needed to request backdating, including a process for requesting backdating outside of established timeframes; and**

- **developing, implementing, and refining processes to assess the validity and accuracy of official eligibility determination dates and to address inaccurate date in a timely and formal manner.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR backdating procedure was developed to account for actions being completed in the field or when staff were not able to access and enter data into the system until a later date. Recent technology now allows for more timely entry of data and as such NHVR had provided updated guidance to staff regarding the use of backdating.*
2. *The bureau acknowledges that controls were put in place, as the auditors observe, through the weekly Case Monitoring Report, designed to ensure a high level of customer service and meet federal timelines. While the bureau also acknowledges that there are legitimate uses of backdating, it will not permit inappropriate use of the practice.*
3. *There is no federal prohibition of backdating. Appropriate use of backdating is an acceptable practice used by VR agencies across the country.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *In April, 2020, guidance was provided to the field regarding the appropriate use of backdating. This guidance is stored on the agency's Intranet. Guidance states "NHVR allows up to 14 days for backdating within the case management system, AWARE, for the purposes of providing VR staff sufficient time to enter required data. Backdating was made available as many counselors are required to travel to meet with participants and immediate data entry is not always feasible. Backdating shall not be used as a means to meet compliance criteria for Eligibility Determination."*
- *Guidance was provided to the field in April, 2020, regarding processes for ensuring eligibilities are reviewed and completed in a timely manner. Counselors must review their Activity Dues (AD) in AWARE frequently paying close attention to Agency generated AD's for eligibilities (appears at day 40). If the case is at the 40-day mark and no medical documentation has been received, the counselor or assigned support staff should: - Reach out to medical facilities and the participant to explore the status of medical records (Notate the contact in case notes) - Discuss with the participant the need to develop an Extension (Signed copy in File) Prior to the 60-day mark - If records have been received; determine eligibility immediately and send AD to supervisor (If an RCI/RCII who does not have rights) Regional Leaders (RL)/RCIII's must monitor AD's sent for approval on a daily basis. They are also required to monitor Agency generated AD's for the office, paying close attention to those that impact compliance for eligibility determinations. As all RCI's and most RCII's require supervisor approval for eligibilities, the following dating practice will be followed: - RCI's do not have approval rights, therefore they must submit an AD to the*

*RL at least 5 working days prior to the 60-day mark. The actual date of the eligibility will reflect the date that the RL has reviewed and approved the eligibility. - RCII's can make eligibility decisions, however with the implementation of the Order of Selection process, the agency has temporarily removed their rights. If an RCII has not had their rights restored, they will send their AD's to the RL's a minimum of 5 working days prior to the 60-day time frame and the eligibility date is still the date of the RL review.*

- *The bureau implemented in April 2020 revised eligibility procedures to ensure they are reviewed and completed in a timely manner.*
- *The bureau will implement additional guidance beyond that which was already provided around the appropriate use of backdating and the disciplinary measures that will be implemented for inappropriate use.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**Contrary to NHVR's assertion in Remark 2, the weekly case monitoring report is not an internal control designed to detect or monitor the use of backdating. We did not find internal controls designed or implemented for this purpose. As such, NHVR was unable to determine whether the use of backdating by managers, supervisors, and counselors was appropriate.**

**As we discuss in one example in the Observation, a counselor requested supervisory review nine days past the 60-day time limit, and the supervisor provided final approval 20 days past the time limit but backdated the official eligibility date to one day prior to the time limit. This demonstrates an inappropriate use of backdating, resulting in the appearance of meeting compliance time limits. NHVR appears to acknowledge the inappropriateness of this use of backdating in this response and in its response to Observation No. 6, as the guidance it provided in April 2020 indicates the date on which RLs review recommendations from counselors without signature authority constitutes the eligibility determination date.**

**Observation No. 5**

**Ensure Eligibility Determinations Are Made As Soon As Possible**

According to the Government Accountability Office, in setting the organization's tone, management must reinforce the commitment to improve operations, not just maintain a minimum level of performance necessary to comply with applicable laws and regulations. Federal law and NHVR's *Policy Manual* required eligibility be determined "within a reasonable period of time, not to exceed 60 days." The *Desk Reference* further specified NHVR "needs to assure that an eligibility determination is made as soon as possible, but no later than sixty (60) days." Training materials provided more definitive guidance, stating "the eligibility determination ***shall be*** made as soon as possible, but no later than sixty (60) days." [emphasis added]

In practice the eligibility process focused solely on making an eligibility determination within 60 days, not whether the determination was made as soon as possible. This resulted in longer wait times for some applicants before an eligibility determination and may have delayed some customers from obtaining VR services and progress towards an employment outcome sooner.

**Eligibility Determinations Took Longer To Make**

We analyzed unaudited data from NHVR's electronic case management system on all eligibility determinations made between July 2015 and June 2019. However, some eligibility determination dates appeared inaccurate due to NHVR's use of backdating. Accordingly, we qualify our use of, and our conclusions resting upon, NHVR eligibility determination date data.

- Eligibility Determinations Took Longer To Make During The OOS – On average, determinations made prior to the OOS took 34 days, while determinations made during the OOS took 51 days, a 50 percent increase.
- More Eligibility Determinations Were Made At The End Of The 60-Day Time Limit – The proportion of eligibility determinations made between 55 and 60 days after application submission increased from 12 percent prior to the OOS, to 30 percent during the OOS.

NHVR's ability to make eligibility determinations sooner may have been affected by a reduction in the number of counselors leading up to, and shortly after entering, the OOS. To mitigate the effect of staff reductions, two regional offices temporarily used former counselors to assist with the intake process.

**Eligibility Determinations Could Have Been Made Sooner**

To better understand the increase in time taken to make eligibility determinations during the OOS, we reviewed a sample of 14 eligibility determinations made within the 60-day time limit and looked for determinations that could have been made "sooner," meaning the case file recorded receipt of all information used to make the determination earlier than either the date the counselor made the recommendation or the official determination date. We found six of the 14 eligibility determinations (43 percent) could have been made sooner, including one that could have been made up to 53 days sooner. We could not verify whether eligibility determinations could have been made sooner in six cases (43 percent) because counselors did not always document when eligibility record requests were sent out, if follow-up was conducted on outstanding requests, or when necessary records and information were ultimately received.

**No Monitoring Of Whether Eligibility Determinations Could Have Been Made Sooner**

NHVR management did not design or implement controls specifically to monitor whether staff made eligibility determinations in a "reasonable" amount of time or "as soon as possible" after application.

- Existing Controls Focused On Compliance – "Activity due" reminders, weekly case monitoring reports, and NHVR's monthly internal audit process, which required RLs to

review two cases from their regional office per month, focused solely on compliance with the 60-day time limit, not on ensuring determinations were made as soon as possible.

- Supervisory Review Did Not Ensure Determinations Were Made As Soon As Possible – Supervisory review was not designed to monitor performance expectations. We found when supervisors did provide written feedback on eligibility recommendations, feedback did not address whether determinations were made as soon as possible.

**No Guidance On How To Ensure Eligibility Determinations Were Made As Soon As Possible**

Policies, procedures, and training did not identify specific internal performance goals or address how staff should ensure determinations were made as soon as possible. NHVR had no guidance on what to consider a "reasonable" amount of time, or how soon "as soon as possible" was. There was also no guidance on how to make eligibility determinations as soon as possible, including how to best utilize support staff during the eligibility process. Support staff in some regional offices sent out record requests and conducted follow up, reportedly allowing counselors to spend more time on tasks such as developing eligibility recommendations or determinations. The lack of guidance likely contributed to some eligibility determinations taking longer than necessary.

**Recommendations:**

**We recommend NHVR management better ensure eligibility determinations are made as soon as possible by:**

- **developing, implementing, and refining written guidance on internal performance targets;**
- **developing, implementing, and refining written guidance on obtaining necessary documentation, including medical records, in a timely manner;**
- **developing, implementing, and refining written guidance on counselor and support staff roles during the eligibility process; and**
- **identifying data and information necessary for monitoring compliance with internal targets and developing, implementing, and refining processes to routinely collect, monitor, and analyze compliance data and information.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *In some respects, the audit report compares apples to oranges when it makes the comparison of days to eligibility determination prior to and in the order of selection. Prior to the order of selection, all disability levels were being served. In the order of selection, initially only the Most Significantly Disabled (MSD) customers were eligible for services. While one might imagine that the determination might be easier, the nature of the disabilities for these individuals is such that there is more reliance on complex medical assessments. Those medical assessments, which are required documentation for eligibility determination, take longer to receive, resulting in longer eligibility determination periods.*

2. *Outside the order of selection, the bureau averaged 34 days for eligibility determinations. Under the order of selection our staffing resources were stretched. Determining eligibility as soon as possible needs to take into account records being received and the thorough analysis of those records and other information gathered by the qualified professional to make appropriate eligibility determinations. As identified in Observation 6, the bureau completed eligibility determinations within the 60-day time frame or with an extension 98% or the time prior to entering an order of selection and 97% of the time under the order. Prior the order of selection, the agency maintained an average of 34 days for this action. Identifying that it took longer to do eligibility determinations when the bureau entered and is working under an Order of Selection is not unexpected. When the bureau entered the Order we also experienced a reduction in staff who were available to complete eligibility determinations. Additional responsibilities as a result of the order and releasing individuals also created a constraint on staff time and resources. Completing eligibility determinations as soon as possible should take into account staffing availability and resources. It is unclear what parameters the auditors used to determine that a determination took longer than necessary without including these factors.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The agency works to complete eligibility determinations in a timely manner, and will continue to do so. As identified in Observation 6, the agency completed eligibility determinations within the 60-day time frame or with an extension 98% or the time prior to entering an order of selection and 97% of the time under the order. Prior to the order of selection, the agency maintained an average of 34 days for this action. Identifying that it took longer to do eligibility determinations when the Agency entered and is working under an Order of Selection is not unexpected. When the Agency entered the Order we also experienced a reduction in staff who were available to complete eligibility determinations. Additional responsibilities as a result of the order and releasing individuals also created a constraint on staff time and resources. Completing eligibility determinations as soon as possible should take into account staffing availability and resources. It is unclear what parameters the auditors used to determine that a determination took longer than necessary without including these factors.*
- *Counselors and supervisors have access to tools, including the activity due layout and reports to identify upcoming eligibility determinations. These appear to be effective tools as the agency maintains a 97%, 60 day or extension rate. The other tools mentioned are management tools that are used to identify trends and systemic issues.*
- *The bureau provided guidance to staff in May of 2020 which outlines expectations for processes related to eligibility documentation. If the counselor believes that there is additional medical information that would support a higher level of priority or assist in plan development, they should not hold off the eligibility determination waiting for additional documentation.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully*

*implemented by December 2021.*

**LBA Rejoinder:**

**Information on length of time to eligibility determination is provided in the Observation for context. Our findings indicated that poor case management resulted in determinations taking longer than they otherwise could have. The results of our review are at odds with NHVR's statement in Remark 1 that "medical assessments, which are required documentation for eligibility determination, take longer to receive, resulting in longer eligibility determination periods." As NHVR conducted no similar review of its own, it is difficult to say how NHVR can substantiate this statement. As stated in the Observation, we found cases where eligibility could have been determined up to 41 or 53 days sooner. In two cases, medical records were attached in the electronic case management system six days and 19 days after the application was filed, respectively. The case record showed no additional eligibility-related activity occurred. However, eligibility was not determined until 59 days and 60 days after application, respectively.**

**NHVR's Remark 2 is misleading. As noted throughout this chapter, NHVR eligibility determination data inflated compliance rates due to unreliable data affected by backdating, although, as stated, we were unable to determine by how much. Unreliable data similarly affected our ability to know how long it took to determine eligibility for the entire population. In a report encompassing FFYs 2016 through 2018, and released in late 2020, the Rehabilitation Services Administration, NHVR's federal oversight agency, also found issues with eligibility dates in its review of NHVR. Federal reviewers noted that 25 percent of case records they reviewed did not contain documentation verifying the date of eligibility determination. They also reported 15 percent of case records contained inconsistent dates between hard copy records, the electronic case management, and federal reports.**

**While NHVR states in Remark 2 that it is unclear what parameters our analysis used to determine that a determination took longer than necessary, as explicitly stated in the Observation, we "looked for determinations that could have been made 'sooner,' meaning the case file recorded receipt of all information used to make the determination earlier than either the date the counselor made the recommendation or the 'official' determination date."**

**Observation No. 6**

**Improve Data Accuracy And Compliance With Federal 60-Day Time Limit**

The federal 60-day time limit was intended to ensure NHVR made timely determinations about applicants' eligibility for VR services. However, we identified noncompliance with the 60-day time limit in three prior audits from SFY 2000, FFY 2013, and FFY 2015. Although managers and supervisors reported implementing more stringent controls following the implementation of the OOS, noncompliance continued through our current audit, and compliance monitoring and staff guidance were limited in effectiveness. Additionally, we found eligibility determination dates were often compromised due to backdating, and noncompliance rates were higher than NHVR data indicated.

**Prior Audit Findings Remained Unresolved**

NHVR was aware of noncompliance with the 60-day time limit, dating back two decades. Our *Department Of Education Financial And Compliance Audit Report For The Year Ended June 30, 2000* identified four of 56 cases that were not completed within 60 days. We recommended the Department of Education (DOE) implement procedures to ensure it met federal eligibility compliance requirements. Additionally, the *Single Audit Of Federal Financial Assistance Programs For The Year Ended June 30, 2013* identified one of 40 cases did not meet the 60-day time limit, and the *Single Audit For The Year Ended June 30, 2015* found noncompliance with the 60-day time limit in four of 40 cases. Both single audits recommended NHVR management establish controls and procedures over eligibility processes to more frequently identify and correct noncompliance, as well as identify when the 60-day time limit was approaching. The DOE concurred and indicated it would establish oversight procedures, monitor compliance, ensure compliance with time limits, and timely correct noncompliance. In FFY 2015, the DOE reported corrective actions had been completed, which included a new case management system. In FFY 2017, NHVR also implemented weekly case monitoring reports. However, we found these controls did not fully address the prior audit findings. Unaudited NHVR data indicated noncompliance rates remained similar through June 2019.

**Eligibility Determinations Made After 60-Days Increased During The OOS**

To assess compliance with the federal 60-day time limit, we reviewed unaudited data from NHVR's case management system on all eligibility determinations made between July 2015 and June 2019. While some eligibility determination dates appeared inaccurate because of backdating and some extensions used by NHVR staff were not always valid, NHVR data showed:

- Prior to the OOS, 5,511 of 6,004 determinations (92 percent) were made within the 60-day time limit and 369 (six percent) were made after 60 days with an exemption recorded in the case management system. Additionally, 124 (two percent) were noncompliant, made after the time limit without an exemption. On average, noncompliant determinations were made in 86 days. Some determinations took as long as 475 days.
- During the OOS, 1,312 of 1,519 determinations (86 percent) were made within the 60-day time limit and 165 (11 percent) were made after 60 days with an exemption. Additionally, 42 (three percent) were noncompliant. On average, noncompliant determinations were made in 75 days. Some determinations took as long as 127 days.

**Compliance Monitoring Was Limited**

NHVR processes to monitor compliance with the 60-day time limit for eligibility determinations were either ineffective or reactive, identifying noncompliance only after it had occurred. Additionally, management did not timely or consistently address noncompliance and did not ensure staff were compliant with federal requirements. Specifically, we found:

- Weekly Case Reports Did Not Ensure Noncompliance Was Addressed Timely – NHVR generated weekly case monitoring reports to identify and address noncompliant eligibility determinations. Cases were included on the report once an eligibility determination already

exceeded the 60-day limit without obtaining an exemption. We subjectively reviewed 12 cases appearing on weekly case monitoring reports between September 2017 and June 2019 and found 11 cases appeared on multiple reports without being resolved. The 12 cases appeared on an average of six weekly reports. On average, these cases appeared on reports 114 days after application submission, or 54 days past the 60-day time limit. In one case during the OOS, there was no documented activity by the counselor from application submission until the case's seventh appearance on a case monitoring report 114 days later. There was no documentation in the electronic case file that the supervisor contacted the counselor to address the noncompliance.

- Noncompliant Cases Did Not Appear On Case Reports Timely – We also found two of the 12 determinations (17 percent) did not appear on a weekly case monitoring report until 82 and 98 days after application submission, or 22 days and 38 days past the 60-day time limit, respectively. If the reports included these cases once they first exceeded the time limit, management would have been able to identify noncompliance weeks sooner.
- "Activity Due" Reminders And Reports Were Limited In Effectiveness – NHVR staff reportedly monitored upcoming time limits through the case management system's "activity due" feature. An "activity due" reminder was automatically generated 14 days before the 60-day time limit, as a reminder to the counselor. "activity due" reports could be generated for a counselor's entire caseload or by regional office, but there was no guidance on how frequently staff should generate and review these reports, and monitoring appeared ineffective. Some RLs also reported delegating monitoring to support staff.
- Internal Audit Process Did Not Allow Opportunities To Correct Noncompliance – NHVR had a monthly audit process, where the RL reviewed two active cases from each regional office. RLs were required to identify whether an eligibility determination had been made within the 60-day time limit, or whether an exemption had been obtained. However, the review happened after determinations had already been made, leaving no opportunity to correct the deficiency. Additionally, a very small number of cases were reviewed and management reported the information was not yet used for programmatic improvement.

**Guidance On Eligibility Determination Compliance Was Limited**

Policies, procedures, and training were consistent when discussing the 60-day time limit for eligibility determinations. However, guidance in other areas was unclear or inadequate, which contributed to noncompliance.

- Guidance On Eligibility Determination Dates Was Contrary To Requirements – When a supervisor reviewed a VRC I's recommendation, NHVR procedure was to date eligibility determinations with the date of the eligibility case note. However, this guidance was contrary to federal requirements that a "qualified" counselor make the determination and to NHVR's signature authority requirements that a VRC I could only recommend, not make, an eligibility determination. There was no guidance on how to date eligibility determinations for other counselors without signature authority.
- No Guidance On The Timeline For Supervisory Review – NHVR had no guidance on supervisory review, including when a counselor should develop an eligibility

recommendation and request supervisory review, or how many days a supervisor should take to review and approve a recommendation, to ensure adequate review and time limit compliance.

**Recommendations:**

**We recommend NHVR management ensure compliance with the federal time limit for making eligibility determinations by:**

- **developing, implementing, and refining written requirements for timelines on supervisory review and approval of eligibility determinations;**
- **routinely measuring staff compliance with federal and program requirements on meeting time limits and analyze information to identify trends and potential issues with compliance; and**
- **remediating deficiencies among individual counselors, regional offices, or agency-wide, as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau does not agree that 'NHVR processes to monitor compliance with the 60-day time limit for eligibility determinations were either ineffective or reactive, identifying noncompliance only after it had occurred." As identified in the observation, the agency completed eligibility determinations within the 60-day time frame or with an extension 98% of the time prior to entering an order of selection and 97% of the time under the order. Counselors and supervisors have tools to identify and manage the work to achieve and maintain this level of compliance. These tools include on-demand work-flow reports of determinations coming due in the next 14-days and weekly monitoring reports for determinations past due.*
2. *Where necessary, the ability to utilize extensions is a management practice to provide opportunity for additional oversight of reasons why the eligibility determination is being delayed. It provides opportunity for supervisory assistance if needed to identify issues and complete the eligibility as timely as possible. Multiple eligibility are extensions not prohibited in our regulations. Multiple extensions may be appropriate under certain circumstances and would be used to document the reasons and agreements to the extensions.*
3. *The audit report characterizes the RL post-determination audit of determinations for compliance as too late since the determination had already been made. This is a detective control deliberately implemented after the determination to monitor the effectiveness of the previously identified controls, including the 60-day report and the 14-day report.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *Requiring at least weekly use by all counselors of the activity due reports.*
- *Per guidance received in April, 2020, Regional Leaders (RL)/RCIII's must monitor AD's sent for approval on a daily basis. They are also required to monitor bureau generated AD's for the office, paying close attention to those that impact compliance for eligibility determinations.*
- *As all RCI's and most RCII's require supervisor approval for eligibilities, the following dating practice will be followed: - RCI's do not have approval rights, therefore they must submit an AD to the RL at least 5 working days prior to the 60-day mark. The actual date of the eligibility will reflect the date that the RL has reviewed and approved the eligibility.*
- *RCII's can make eligibility decisions, however with the implementation of the Order of Selection process, the bureau temporarily removed their rights. If an RCII has not had their rights restored, they will send their AD's to the RL's a minimum of 5 working days prior to the 60-day time frame and the eligibility date is still the date of the RL review.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**NHVR's Remark 1 is misleading. As noted throughout this chapter, NHVR eligibility determination data inflated compliance rates due to unreliable data affected by backdating, although, as stated, we were unable to determine by how much. Additionally, the Rehabilitation Services Administration also identified issues with NHVR's eligibility determination dates, which would have affected compliance rates. Federal reviewers cited five of 20 cases they reviewed (25 percent) lacked required documentation verifying the date of eligibility determination. They also found that eligibility date information contained in the hardcopy file, the electronic case management system, and reported in federal performance reports did not match in three of 20 cases (15 percent).**

**NHVR notes in Remark 3 that the internal audit process "is a detective control deliberately implemented after the determination to monitor the effectiveness of the previously identified controls…" NHVR's internal audit process cannot be used to correct issues with eligibility determination dates or timeliness, as the eligibility determination has already been finalized by the time the review happens. NHVR's response does not indicate it will be using information collected from the internal audit process to incorporate improvements, rendering this process ineffective as an internal control.**

**Exemptions To Eligibility Time Limits**

Federal regulations provide exemptions to the 60-day time limit for: exceptional and unforeseen circumstances, or if a customer required trial work to determine whether they could benefit from services. The most common exemption used was for "exceptional and unforeseen circumstances beyond the control of [NHVR] that preclude making an eligibility determination within 60 days."

Regulations also allowed an exemption if an extended evaluation was needed, but this provision was eliminated in July 2017. Federal law required NHVR and the applicant to agree to a specific extension of time if an exemption to the 60-day time limit was needed. We found extensions were not always valid because they did not contain the applicant's signature, appeared to be completed before the application was submitted, or were completed after the 60-day time limit had passed. Additionally, the use of some exemptions did not appear to be limited to reasons permitted under federal regulations.

**Observation No. 7**

**Ensure Eligibility Determination Extensions Are Valid**

Extension requirements were intended to ensure applicants were aware of both the exemption from the 60-day time limit to determine their eligibility, and the additional time the eligibility determination process might take. However, we found some extensions were invalid, expired before an eligibility determination was made, or were anomalous and inefficient. Issues with extensions resulted in extensions that were noncompliant with federal and program requirements, and eligibility determinations that were noncompliant with the federal 60-day time limit. Unreliable and inaccurate data affects management decision-making and the accuracy of compliance rates reported to the Rehabilitation Services Administration by making NHVR appear more compliant than it was with extension requirements.

**Some Extensions Were Invalid Or Expired Before Required Actions Were Taken**

While federal law did not explicitly require an applicant's signature on an extension, federal instructions clarifying reporting requirements issued in 2017 indicated extensions should be signed by the applicant and counselor. Additionally, guidance provided by the Rehabilitation Services Administration in a monitoring report to one state in 2018 indicated if a VR agency required an applicant to indicate agreement by signing an extension form, the signature should be obtained for the extension to be considered valid. NHVR's *Desk Reference* required the applicant and the counselor to sign an *Eligibility Determination Extension* form showing agreement to a specific extension of time. The *File Review Form*, which was included in each hardcopy case file, also specifically required an extension form be "completed (signed and dated) in the file with [*Applicant*] and [*Counselor*] *signature*" [emphasis original] if an eligibility determination was made more than 60 days after application submission. However, requirements were inconsistently followed:

- Some extension forms did not contain the applicant's signature, were completed before application submission, or were completed after the 60-day time limit had passed, rendering these extensions invalid.
- Some extensions expired by the time an eligibility determination was made, or by the time a subsequent extension was "completed," although it was unclear actions taken during expired extensions were valid or compliant.

***Extension Forms Did Not Always Include The Applicant's Signature***

NHVR's case management system did not have a standardized and centralized way to document applicants had signed extension forms. Additionally, an official extension start date represented the date when a counselor entered the extension into the system, whether or not there was a completed extension form. Consequently, we were unable to verify overall compliance with signature requirements, although our review of seven cases with extensions and eligibility determinations made between July 2015 and June 2019 indicated NHVR eligibility determination extension data inflated compliance rates. The seven cases had a total of ten extensions. Among the ten extensions:

- four (40 percent) had an extension form, but were only signed by the counselor; and
- four (40 percent) were not documented on an extension form and therefore unsigned by both the counselor and the applicant.

Management reported it was sometimes difficult to obtain applicant signatures on extension forms. NHVR procedure allowed counselors to complete an extension *without* obtaining the customer's signature, which appeared contradictory to federal guidance and other NHVR requirements. The *Desk Reference* indicated that if the extension form was not signed, the counselor should: 1) write a case note documenting a conversation with the applicant agreeing to an extension, and 2) include a copy of the letter and extension form sent to the applicant to obtain their signature in the case file. This guidance appeared to be infrequently followed. Among the eight extensions without an applicant signature:

- two (25 percent) had a case note documenting the applicant's agreement with the extension,
- one (13 percent) documented a letter was sent to the applicant for their signature, and
- none (0 percent) contained both a case note and documentation of a letter.

***Extensions Were Not Always Completed When Appropriate***

We reviewed unaudited data from NHVR's case management system on eligibility determinations made between July 2015 and June 2019 and found:

- Prior to the OOS, 119 of 395 eligibility extensions (30 percent) were completed more than 60 days after application submission. On average, extensions were completed 76 days after application submission. Some extensions took as long as 228 days.
- During the OOS, 88 of 167 eligibility extensions (53 percent) were completed more than 60 days after application submission. On average, extensions were completed 72 days after application submission. Some extensions took as long as 149 days.

We also found one extension appeared to be completed three days before the official application date. The counselor indicated in a case note that NHVR had not received a signed application and could not determine eligibility without it.

### *Some Extensions Expired Before An Eligibility Determination Was Made*

We reviewed unaudited data from NHVR's case management system and found:

- Prior to the OOS, 90 of 395 eligibility determinations with at least one extension (23 percent) were made under an expired extension. Eligibility determinations were made an average of 57 days, and as long as 357 days, after extensions expired.
- During the OOS, 56 of 167 eligibility determinations with at least one extension (34 percent) were made under an expired extension. Eligibility determinations were made an average of 56 days, and as long as 167 days, after extensions expired.

### Some Cases Had Multiple Extensions

Federal law required NHVR and the applicant to "agree to ***a*** specific extension of time" [emphasis added] prior to an exemption from the 60-day time limit. This same requirement was specified in NHVR's administrative rules. However, in practice, NHVR permitted *multiple* extensions when a determination could not be made within the required timeframe. Since federal regulations only referenced a single extension of time, it was unclear subsequent extensions were valid. Additionally, the case management system tracked official extension dates only for *initial* extensions, not for any *subsequent* extensions.

NHVR's case management system did not have a standardized and centralized way to monitor whether cases had multiple extensions. Consequently, we were unable to identify the total number of cases with multiple extensions between July 2015 and June 2019. We reviewed seven cases with extensions from our file review and an additional sample of ten cases with extensions. We found four of 17 cases (24 percent) had multiple extensions, including one case with two extensions, two cases with three extensions, and one case with four extensions, for a total of four initial and eight subsequent extensions.

### *Some Subsequent Extensions Expired Before An Eligibility Determination Was Made*

Due to limitations with monitoring subsequent extensions, we analyzed the same 17 cases and found:

- In eight cases (47 percent), eligibility determinations were made before the extension expired. This included two cases with subsequent extensions for which the electronic case management system showed determinations had been noncompliant, as they were made under initial extensions that were expired for 64 and 130 days, respectively.
- In nine cases (53 percent), eligibility determinations were made after the extension expired. This included two cases with subsequent extensions for which the electronic case management system showed determinations had been made under initial extensions that were expired for 135 and 148 days, respectively. Determinations in these cases were actually made 15 and eight days after the last extensions expired, respectively.

### *Some Extensions Were Expired By The Time Subsequent Extensions Started*

Since federal law and regulations required NHVR and the applicant to "agree to ***a*** specific extension of time," [emphasis added] there was no federal guidance on subsequent extensions. Although NHVR relied upon subsequent extensions, it provided no guidance beyond documenting the applicant's agreement with the extension.

The case management system did not have a standardized and centralized way for counselors to document the start date of subsequent extensions completed after an initial extension. The case management system continued to display the initial extension's start and end dates as the official dates. The start date of subsequent extensions could be determined only if the extension form was signed and dated by both the applicant and counselor. There was no standardized and centralized way to determine whether subsequent extensions started while a prior extension was in effect or after the prior extension had already expired. Consequently, we were unable to determine the total number of subsequent extensions made after prior extensions already expired. We reviewed the one case with multiple extensions from our file review. We found the initial extension had been expired for five weeks before the counselor completed the second extension form and the third extension had been expired for six weeks.

## Timeliness And Anomalies Contributed To Longer, Inefficient Processes In Some Cases

Federal law, federal regulations, and NHVR's administrative rules did not specify requirements or provide guidance on eligibility determination extension timeliness. Due to limitations in NHVR's case management system with monitoring subsequent extensions, we were unable to determine or analyze the length of all subsequent extensions. However, we found some extensions may have been unnecessary or were for longer than NHVR reportedly allowed, while some extension dates did not appear rational in the context of eligibility and extension requirements.

### *Some Extensions Were For Longer Periods Of Time Than Reportedly Allowed*

The case management system was reportedly programmed to limit the initial extension end date to no more than 120 days after application submission. We reviewed unaudited data from NHVR's electronic case management system and found:

- Prior to the OOS, 116 of 395 initial extensions (29 percent) had an end date between 121 and 180 days after application submission.
- During the OOS, none of 167 initial extensions had an end date more than 120 days after application submission.

The NHVR Director indicated an extension could be for as long as needed, while supervisors reported each extension could be for up to 60 days. Training materials specified extensions should not exceed 60 days, although the length depended on the reason for the delay. We reviewed unaudited data from NHVR's case management system and found:

- Prior to the OOS, 195 of 395 initial extensions (49 percent) were for more than 60 days. One extension took as many as 145 days to complete.

- During the OOS, 47 of 167 initial extensions (28 percent) were for more than 60 days. One took as many as 84 days to complete.

***Some Extension Dates Were Anomalous***

During our analysis, we identified 18 out of 562 initial extensions (three percent) where official extension dates were not rational. In all 18 cases, there were no case notes mentioning the extension, and "eligibility extension" data pages did not provide discussion of relevant information, such as start dates or extension length, needed to confirm data accuracy.

- Some Extensions Appeared To Have Expired Before They Started – Six extensions had end dates ranging from eight to 50 days prior to their start dates. Three cases were prior to the OOS, and three were during the OOS.
- Some Extensions Were For No Time – Ten extensions had the same start and end date. All cases were prior to the OOS.
- Some Extensions Expired Within The Time Limit To Make A Determination – Two extensions had end dates eight days and 43 days after application submission, respectively. One case was prior to the OOS, and one was during the OOS.

***Extension Timeliness Goals Were Unclearly Met***

NHVR required eligibility determinations with extensions be made "as quickly as possible." Extensions generally resulted in longer wait times for applicants before an eligibility determination was made, although management did not establish performance goals or define what "as quickly as possible" meant. We reviewed unaudited data from NHVR's case management system and found eligibility determinations with extensions took three to four times longer, on average, to make than those without extensions.

- Prior to the OOS, determinations with extensions took an average of 107 days, and as long as 477 days.
- During the OOS, determinations with extensions took an average of 120 days, and as long as 287 days.

**Additional Data Accuracy Issues**

We found data accuracy issues, which compromised information available for decision-making and made some extensions appear compliant with requirements.

- Extensions May Have Been Backdated – The *Desk Reference* permitted eligibility determination extensions to be backdated, and staff were required to submit a request "with a detailed description on why the date change needs to occur." We found one case contained an explicit request to the central office to backdate an extension in the electronic case file. There was no indication as to why backdating was needed and no apparent agreement from the applicant's guardian for the extension. However, the start date of the backdated extension coincided with the end date of the prior extension. We were unable to

determine whether other extensions had been backdated, as the case management system did not have the same controls around extension dates as it did around eligibility determination dates.

- One Case File Appeared To Be Modified In Response To Audit Fieldwork – One hardcopy case file contained an extension purportedly agreed to by the customer in August 2018. However, the extension form was printed from the electronic case management system on the day we requested the file for review in October 2019 and was only signed by the counselor. The form was backdated to August 2018. There was no documentation of the applicant's agreement with the extension in the case file.

**Compliance Monitoring Was Limited In Effectiveness**

NHVR processes to monitor compliance with extension requirements and timeliness were limited in effectiveness or reactive, identifying noncompliance only after it had occurred. Additionally, there were few formal mechanisms in place to monitor timeliness or duration of extensions. NHVR did not monitor when extensions were "completed," whether start dates were within the 60-day time limit or while another extension was in effect, how long extensions were for, or whether eligibility determinations were made before extension end dates. Finally, management did not timely or consistently address noncompliance and did not ensure staff were compliant with requirements.

***Weekly Case Monitoring Reports Were Not Effectively Used To Resolve Noncompliance***

NHVR reportedly used weekly case monitoring reports to identify and address expired eligibility extensions. Cases were included on the report once an initial extension reached its end date without an eligibility determination. However, weekly case monitoring reports were not effectively used to ensure extensions were followed up on. We subjectively reviewed 13 cases appearing on weekly case monitoring reports between September 2017 and June 2019 and found:

- Case Reports Could Not Ensure Noncompliance Was Addressed Timely – All 13 cases appeared on multiple reports without being resolved. The 13 cases appeared on an average of 21 weekly reports before a subsequent extension was completed, an eligibility determination was made, or the case was closed. On average, we found these cases appeared on reports 233 days past the initial extension end date, or 293 days past the 60-day time limit. In one case during the OOS, there was no documentation of external eligibility determination activities from application submission until the case's 40th appearance on a weekly case monitoring report, 406 days later, even though the initial intake case note indicated the counselor would be sending a release for medical information to the applicant's doctor. There was no documentation in the electronic case file that a supervisor contacted the counselor to address the noncompliance.
- Noncompliant Cases Did Not Appear On Weekly Case Monitoring Reports Timely Or At All – One of the 13 cases (eight percent) did not appear on a weekly case monitoring report until 41 days after the initial extension had expired. Another case from our review of 97 case records had four extensions. This case did not appear on the five weekly reports generated between expiration of its initial extension and the start of its second extension.

If the reports included these cases when the extensions first expired, management would have been able to identify noncompliance nearly five or six weeks sooner.

- Subsequent Extensions Were Reportedly Omitted From The Weekly Case Monitoring Report – Since the case management system did not standardize recording of start and end dates for subsequent extensions, these extensions were reportedly excluded from the weekly case monitoring reports. Instead, a central office staff member tracked these extensions separately and monitored them for expiration. However, this process appeared to be ineffective. We found one case from our file review with four extensions appeared on one weekly report released between the expiration of its third extension and the start of its fourth extension. The extension end date displayed by the report was for the case's first eligibility extension, not its third extension. Additionally, as we discuss above, we identified subsequent extensions that had expired before another extension or an eligibility determination could be made.

***Internal Review Processes Were Not Used To Correct Noncompliance***

NHVR developed processes intended, in part, to aid in its compliance with federal requirements. However, these processes did not appear to be effective in identifying and addressing whether extensions were compliant with requirements. Additionally, management did not track or analyze data and information on areas of noncompliance identified through these internal processes to focus counselor training or otherwise improve performance.

- *File Review Form* – The form required the counselor to initial a checklist and note the date an extension was completed. A supervisor generally reviewed the checklist prior to case closure. However, the review happened after an eligibility determination had already been made, leaving no opportunity to proactively correct noncompliance. Additionally, it appeared the checklist was not used to reactively address noncompliance. Among the eight extensions without an applicant signature identified through our file review, seven (88 percent) belonged to cases that had been closed prior to our review.
- Internal Audit Process – NHVR had a monthly audit process, where RLs each reviewed two active cases from their own regional office. RLs were required to identify whether an eligibility determination had been made within the 60-day time limit, and if not, whether an extension had been signed. However, the review happened after determinations had already been made, leaving no opportunity to correct the deficiency. Additionally, a very small number of cases were reviewed and management reported the information was not yet used for programmatic improvement.

Additionally, issues with official extension start dates may affect future compliance reporting. The Rehabilitative Services Administration implemented a new reporting requirement, effective July 2020, for VR agencies to report whether the applicant and counselor mutually agreed upon an extension of time within 60 days of application submission. The federal oversight agency required that official extension start dates "must be verifiable through supporting documentation." NHVR did not begin documenting start dates in the case management system until after the audit period, in response to the new requirement. Central office staff reported official start dates were populated using the date the "extension" data page was created in the electronic case management system.

However, as our file review found, official extension start dates typically represented the date counselors entered extensions into the electronic case management system, whether or not applicant agreement was documented by a completed extension form.

**Guidance On Extensions Was Unclear And Not Always Followed**

NHVR did not have clear guidance on the use of extensions. For example, during the audit period, there was no guidance on whether extensions should be reviewed by a supervisor. Consequently, central office managers and supervisors variously reported:

- initial and subsequent extensions were subject to eligibility signature authority and corresponding supervisory review requirements;
- an initial extension could be completed without supervisory review, while others indicated an initial extension *always* required supervisory review; and
- a subsequent extension could be completed without supervisory review, while others indicated subsequent extension *always* required RL review.

Unclear and inadequate guidance likely contributed to noncompliance and untimely extensions.

- Administrative Rules Did Not Accurately Or Comprehensively Describe The Extension Process – The *Eligibility Determination Extension* form was not adopted in rules, nor did rules describe the requirements of the extension process, contributing to ad hoc rulemaking.
- Guidance On Multiple Extensions Appeared Contradictory – While the *Desk Reference* permitted multiple extensions, training materials indicated that if extensions were needed for more than 60 days, counselors should consider closing those cases and re-opening them at a more appropriate time.
- Training Materials Contradicted Federal Law On Whether Eligibility Determinations Made Under Extensions Were Compliant – NHVR training materials specified that even when cases had extensions, the Rehabilitation Services Administration still considered eligibility determinations to be "late," or noncompliant with the 60-day time limit. This guidance was contrary to federal law and regulations which allowed for eligibility determinations to be made beyond 60 days under specific circumstances. Determinations made after 60 days would only be noncompliant if made without a valid extension.
- Rules And Policy On Applicant Agreement Were Contrary To Practice – Administrative rules and policy specified that if NHVR and the applicant could not come to agreement on an extension, NHVR would make an eligibility determination based on the available information. However, our file review found eight of ten extensions (80 percent) did not have an applicant's signature indicating agreement.
- Procedure Outlined Incomplete Supervisory Review Process – The *Desk Reference* was updated in October 2019 and specified subsequent extensions required RL review and processing through the central office. However, guidance still did not specify whether initial extensions required supervisory review or what central office processing entailed.
- Performance Goals Were Undefined – NHVR required eligibility determinations with extensions be made "as quickly as possible." However, "as quickly as possible" was

undefined, and limited guidance was provided to counselors how to ensure eligibility determinations with extensions were made as quickly as possible.

- No Guidance On Determining Official Extension Start Dates – There was no guidance on how counselors should determine the official extension start date entered into the case management system. However, practice appeared to be to use the date the counselor had determined an extension was needed, whether or not the extension form had been printed and signed by the counselor or signed by the applicant. This practice appeared contradictory to federal guidance on other start dates, such as for the IPE.

**Recommendations:**

**We recommend NHVR management ensure backdating of official eligibility determination extensions aligns with its assessment of whether backdating is generally permissible, as recommended in Observation No. 4.**

**We also recommend NHVR management seek and obtain guidance from the Rehabilitation Services Administration to determine whether multiple extensions may be completed for each "exceptional and unforeseen circumstances" exemption, and if so, whether subsequent extensions are valid if made after a prior extension had expired. If multiple extensions are permissible, NHVR management should properly control the use of multiple extensions and ensure compliance with federal requirements by developing, implementing, and refining written guidance on the use of multiple extensions. Guidance should include how multiple extensions should be documented in the hardcopy and electronic case files and how it should be monitored by the counselor, RL, and central office management to ensure information is accurate, complete, and in compliance with all requirements.**

**We also recommend NHVR management improve compliance with federal and internal extension requirements by:**

- **developing, implementing, and refining written guidance on internal performance targets;**
- **developing, implementing, and refining written guidance on obtaining necessary documentation, including applicant signatures, in a timely manner;**
- **ensuring administrative rules, policies, and procedures clearly and comprehensively describe the extension process;**
- **refining training materials to fully align with federal and internal requirements and incorporating into training sessions;**
- **identifying data and information necessary for monitoring extension requirements and timeliness of extensions and eligibility determinations made under extensions, and developing, implementing, and refining processes to routinely collect, verify, monitor, and analyze compliance data and information;**
- **routinely measuring staff compliance and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and equitable manner and refining performance expectations and processes as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR consulted with Rehabilitation Services Administration regarding multiple extensions and confirmed that they are allowable and a practice that is used throughout the country as a means to document reasons why an eligibility determination cannot be made.*
2. *There is no federal requirement for a signature on these extensions. Per section 102 of The Rehabilitation Act:*

   *TIMEFRAME FOR MAKING AN ELIGIBILITY DETERMINATION.—The designated State unit shall determine whether an individual is eligible for vocational rehabilitation services under this title within a reasonable period of time, not to exceed 60 days, after the individual has submitted an application for the services unless—*

   *(A) exceptional and unforeseen circumstances beyond the control of the designated State unit preclude making an eligibility determination within 60 days and the designated State unit and the individual agree to a specific extension of time; or*

   *(B) the designated State unit is exploring an individual's abilities, capabilities, and capacity to perform in work situations under paragraph (2)(B).*
3. *The statement in the report that "NHVR's Desk Reference required the applicant and the counselor to sign an Eligibility Determination Extension form showing agreement to a specific extension of time" is not accurate. The actual language is:*

   ***Completed Eligibility Determination Extension** form is in file with counselor and participant signature. If unable to get signatures, documentation that there was a conversation with the participant and they have agreed to the extension (case note) AND copy of letter sent to the participant with the extension form to gain the signature.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau agrees that there needs to be a more formalized process to ensure that agreement to extensions and efforts to obtain signatures are documented. We will provide this guidance to the field by June, 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to NHVR's Remarks 2 and 3, the Observation states there is no explicit signature requirement in federal law. However, the Observation also notes federal reporting requirements indicate extensions should be signed by the applicant and counselor. As we**

**note in the Observation, we found noncompliance with this requirement. NHVR procedures also allowed alternate methods of documenting customer agreement if a signature could not be obtained. We also did not find consistent documentation of customer agreement in the case record when a signature could not be obtained.**

**Observation No. 8**

## Ensure The Use Of Exemptions For "Exceptional And Unforeseen Circumstances" Is Consistent With Federal Regulations

To ensure timely determinations for all applicants and thorough eligibility assessments for applicants with the most severe disabilities, federal regulations permitted exemptions from the federal 60-day time limit for eligibility determinations only under certain circumstances. However, NHVR used exemptions that were supposed to be only for "exceptional and unforeseen circumstances" beyond its control, for reasons that did not appear to be consistent with federal regulations. Inconsistent use resulted in longer wait times for some applicants before an eligibility determination was made and may have delayed the ability of some customers to obtain VR services and progress towards an employment outcome.

### "Exceptional And Unforeseen Circumstances" Exemptions Used Often

NHVR training materials indicated eligibility determination exemptions "**should NOT be used frequently!**" [emphasis original] and supervisors reported exemptions were uncommon, although the frequency with which exemptions should be expected was never established. We reviewed unaudited data from NHVR's case management system on all eligibility determinations made between July 2015 and June 2019. Exemptions were used with increasing frequency following the implementation of the OOS in May 2018.

- Prior to the OOS, 397 of 6,004 eligibility determinations (seven percent) had an exemption.
- During the OOS, 167 of 1,519 eligibility determinations (11 percent) had an exemption.

Between July 2015 and June 2019, almost all exemptions – 562 of 564 – appeared to be for "exceptional and unforeseen" circumstances. However, we were unable to verify whether all 562 exemptions were used consistent with federal regulations. The case management system could generate a list of cases with an exemption. However, it could not provide, in a standardized and concise manner, the reason why the exemption was used. Management would have needed to review each case individually to determine why an exemption was used.

### Exemptions Did Not Always Appear To Be Consistent With Federal Regulations

To determine whether some exemptions appeared consistent with federal regulations, we analyzed seven cases with exemptions between July 2015 and June 2019 from our file review of 97 case records. Counselors did not always thoroughly document the eligibility process and related decisions in the case file, and inadequate documentation made it difficult to know whether all exemptions were truly for "exceptional and unforeseen" circumstances beyond the control of NHVR. However, most of the exemptions we reviewed appeared to be used contrary to federal

requirements. If exemptions were used appropriately, it is likely some eligibility determinations could have been made sooner, potentially enabling some applicants to access services and progress towards an employment outcome sooner.

### *Some Circumstances Appeared To Be Within The Control Of NHVR*

Three of seven exemptions (43 percent) we reviewed appeared to result from circumstances within NHVR's control, such as inadequate case management. In one case during the OOS, the counselor indicated an exemption was needed because the counselor was on vacation when the 60-day time limit for eligibility determination passed. However, the initial intake interview did not occur until 51 days after application submission, and there was no documentation the counselor asked a supervisor to complete the eligibility determination while out on planned leave. If the supervisor or another counselor with eligibility signature authority had made the eligibility determination while the counselor assigned to the case was out on planned leave, an extension would have been unnecessary, and the applicant could have been found eligible sooner. In another case, which occurred prior to the OOS, the counselor indicated an exemption was needed because they had been recently assigned the case and were unable to contact the applicant. There were three staff assigned to the case at various points: the original counselor, who handled the initial intake and application submission; a supervisor; and the new counselor, assigned to the case 20 days prior to indicating an exemption was needed. There was no documentation of attempted contact with the applicant between the intake and the exemption, 113 days later.

### *Some Circumstances Did Not Appear To Be "Exceptional And Unforeseen"*

Five of seven exemptions (71 percent) appeared to result from circumstances that were not uncommon and unexpected, such as waiting for existing eligibility documentation to be provided or a lack of communication with the applicant. In one case prior to the OOS, the counselor indicated an exemption was needed because they sent a release and had left messages with the provider requesting records but received no response. However, the counselor's first documented attempt at obtaining medical documentation occurred 52 days after the application was submitted when the counselor noted they left messages with the provider. If the counselor had sought these records sooner, an exemption may have been unnecessary, and the applicant, who was found eligible, could potentially have received VR services sooner. In one case during the OOS, the counselor indicated an exemption was needed because they were waiting for eligibility documentation from the applicant's guardian. However, there was no documentation of attempted contact between the initial intake, 35 days after application submission, and the exemption, 19 days later.

## Guidance On When To Use Exemption Was Not Comprehensive And Contrary To Requirements

Neither federal regulations nor NHVR rules defined "exceptional and unforeseen circumstances" beyond NHVR's control. Limited guidance on, and supervisory understanding of, this exemption did not always appear to align with common definitions of "exceptional" and "unforeseen." NHVR training materials specified this exemption would generally only be needed when there was "a

delay" in obtaining required eligibility documentation or if there were "limited sources" that could provide eligibility documentation. Supervisors also reported this exemption was used when:

- counselors were obtaining additional eligibility documentation through new evaluations,
- applicants were non-responsive to requests for documentation or release forms, or
- applicants were undergoing hospitalization or treatment.

Of 25 counselors responding to our survey, three (12 percent) indicated management did not always ensure eligibility exemption policies and procedures were consistently applied, and four (16 percent) indicated training on eligibility exemptions did not always provide needed information. Unclear guidance likely contributed to use of exemptions that was inconsistent with federal regulations and led to ineffective monitoring.

NHVR had limited monitoring of whether exemptions were consistent with federal regulations. The supervisory review process for counselors without eligibility signature authority did not include eligibility determination exemptions, and only some exemptions were reportedly reviewed by supervisors. Additionally, while the monthly internal audit process required RLs to ensure exemptions had a clearly demonstrated reason, there were substantial limitations with the internal audits. Finally, since NHVR's case management system did not collect information in a centralized and standardized way, management could not monitor and analyze the appropriateness of all exemptions reportedly used for exceptional and unforeseen circumstances without reviewing each case individually.

**Recommendations:**

**We recommend NHVR management ensure exemptions are consistent with federal regulations by:**

- **defining "exceptional and unforeseen circumstances" beyond the control of NHVR in administrative rules and providing adequate guidance through policy and procedure on when this exemption may be appropriate;**
- **fully aligning training materials with federal and internal requirements on the use of exemptions and incorporating requirements into training sessions;**
- **identifying data and information necessary for monitoring frequency and appropriateness of exemptions, as well as developing, implementing, and continually improving processes to routinely collect, monitor, and analyze compliance data and information;**
- **routinely measuring staff compliance and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The auditor report injects a degree of speculation, inappropriate for this type of work. This occurs, for example, when the report states, "If the supervisor or another counselor with eligibility signature authority had made the eligibility determination while the counselor assigned to the case was out on planned leave." It is unclear why the client took 51 days from the date of intake to the first meeting. The bureau clients have a variety of disabilities that can make it difficult to make contact and difficult to arrange meetings. Often times the customers develop personal relationships with counselors and may not even be open to meeting with someone else. Clients frequently begin the process and medical issues/treatments stemming from their disabilities disrupt the process timelines. The bureau, of course wants to provide good timely services, but auditor descriptions do not always accurately reflect the nature of a personalized service.*
2. *"Exceptional and unforeseen circumstances" are broadly defined in federal statute as a reflection that this personal service provided to unique individuals with unique disabilities will require flexibility to effectively provide support.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau agrees that, while the use of eligibility extensions is rare and when they do occur it is for appropriate reasons, further guidance can be developed. This guidance will be developed and disseminated to the field by June, 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to NHVR's Remark 1, we note there are many reasons why applicants may have difficulty engaging in the vocational rehabilitation process. However, without documentation through case notes or other records in the case file, it is impossible for management to evaluate the appropriateness of delays in the eligibility determination process, as NHVR acknowledges. Performance auditors are obligated to report information on the situation that exists at an agency, the factors responsible for internal control weaknesses, and the effect or potential effect of those weaknesses, which is used to develop meaningful recommendations for corrective action.**

**Contrary to NHVR's assertion in Remark 2, as noted in the Observation, neither federal law nor regulations provided a definition of "exceptional and unforeseen circumstances beyond the control of the [VR agency that] preclude making an eligibility determination within 60 days." While NHVR states it uses this exemption to ensure flexibility when determining eligibility, none of the cases we reviewed demonstrated exemptions used in this manner.**

**Disability Priority Assignments**

Federal law required VR agencies under an OOS to assign priority categories to eligible applicants to determine their priority for service and to assure individuals with the most significant disabilities would be selected first to receive VR services. NHVR policy indicated counselors should assess disability priority at the time of eligibility, regardless of whether NHVR was in an OOS. Federal law provided VR agencies with some flexibility when establishing disability priority criteria.

NHVR had three disability priority categories: most significant disability (MSD), significant disability (SD), and less significant disability (L-SD). Assignment to a specific priority category depended on several criteria. An applicant had to:

1. have a physical or mental disability causing substantial functional limitation,
2. have a severe physical or mental impairment seriously limiting functional capacities in terms of an employment outcome, and
3. be expected to require VR services over a period of time.

Federal law and regulations identified a number of conditions, such as autism, blindness, epilepsy, mental illness, or multiple sclerosis, that could result in disabilities causing serious functional limitations. Federal law and regulations identified examples of functional capacities that could be affected by a disability, such as mobility, communication, and self-care. The *Desk Reference* defined a "serious" limitation of functional capacity as a loss or restriction "of one's capacity to perform to the degree that the individual requires VR services or accommodations, not typically provided to others, in order for the individual to work." VR services were services necessary to assist with rehabilitation, such as job search and job placement, vocational training, personal assistance, rehabilitation technology, assistive technology, or guidance and counseling.

Training materials cautioned that a medical condition was not a disability if it was controlled through medication or other means, and similarly cautioned that functional limitations were not always serious. NHVR's *Policy Manual* specified there "must be clear evidence, demonstration, or documentation of the limitations imposed by the disability." Training materials specified counselors only record disabilities "**significant enough**" and limitations serious enough to affect an employment outcome. [emphasis original]

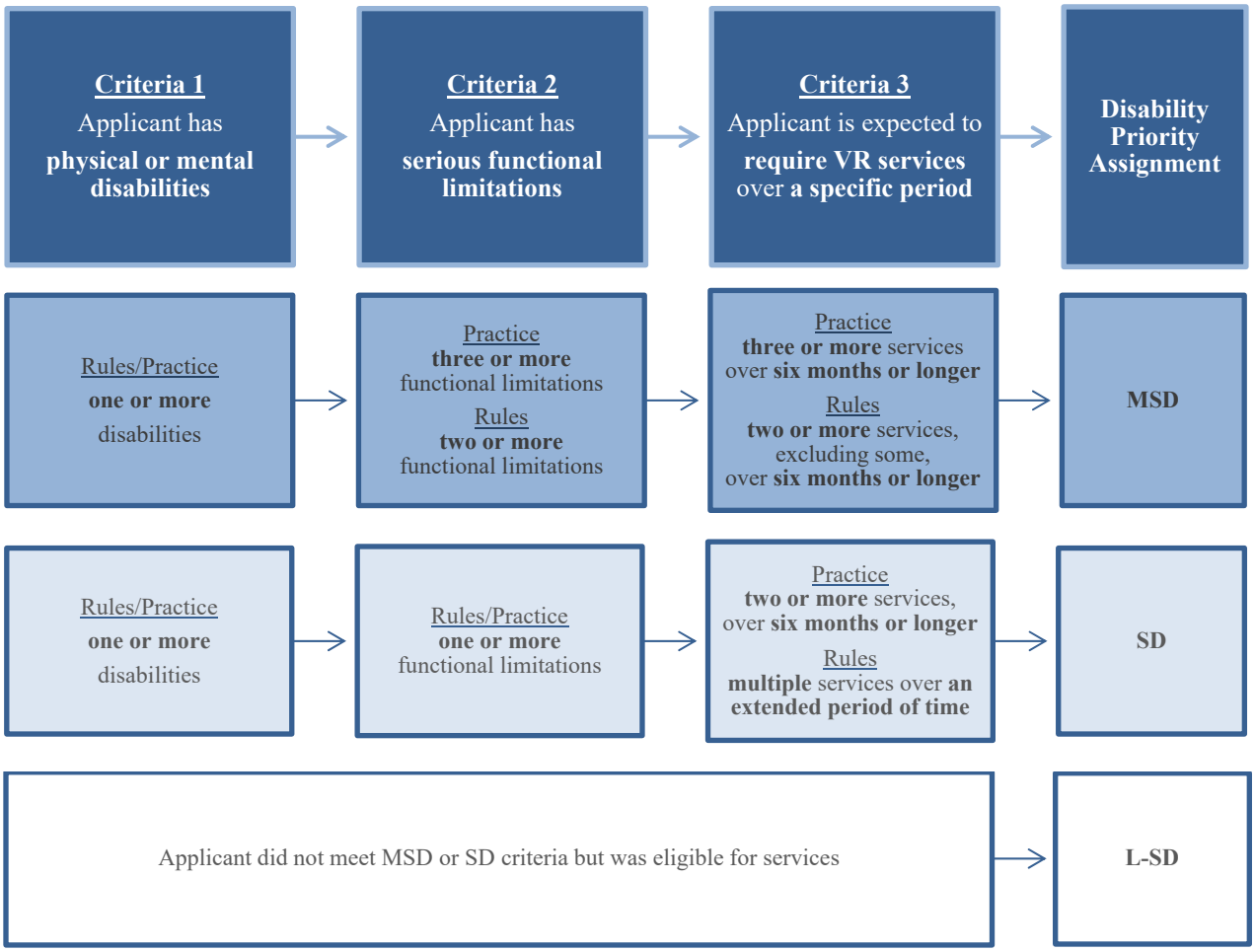
NHVR's *Desk Reference* and training materials required disabilities and serious functional limitations be verified through medical records, and training materials specified disabilities be diagnosed and evaluated by professionals qualified to practice in the field of the disability. Federal law specified that, to the maximum extent appropriate, NHVR should use information that was existing and current, as of the eligibility determination date. If existing information did not describe an applicant's current functioning or was unavailable, insufficient, or inappropriate, NHVR was permitted to assess additional data obtained by providing certain services.

Federal law established SD criteria, required MSD criteria at least meet SD criteria, and provided VR agencies with discretion to establish additional criteria and categories. NHVR administrative rules adopted federal SD criteria and defined additional MSD criteria, although disability priority assignments made after the implementation of the OOS reflected some criteria adopted in practice

but not in rules, as shown in Figure 6. Federal law specified that applicants determined to have a disability or be blind under SSDI or SSI were considered to be at least SD. If additional documentation supported classification to MSD, then NHVR could assign a customer receiving SSI or SSDI to MSD.

**Figure 6**

**NHVR Disability Priority Criteria**




Note: Rules-based criteria were used by NHVR prior to implementation of the OOS. Following implementation of the OOS, NHVR assignment of priority categories in practice differed from some rules-based criteria still in effect.

Source: LBA analysis of federal and NHVR disability priority criteria.

**Observation No. 9**

**Improve Consistency Of Disability Priority Assignments**

Consistent and accurate disability priority assignments could have allowed NHVR management to ensure compliance with federal requirements and provided information for resource management

and use. However, we found priority assignments did not always appear to be consistent or compliant with federal and NHVR requirements, including during the OOS. Some customers appeared to be placed on the waitlist or waited longer due to a disability priority assignment that was not consistent with the documentation in the customer's record, affecting the customer's ability to receive services sooner. Managers and supervisors reported that assignments were less important, less consistent, or received less emphasis prior to the implementation of an OOS partly because prior to an OOS, NHVR did not need to implement a waitlist for services and customers were served immediately. Since NHVR entered an OOS, management reported implementing more stringent controls, including having a supervisor review all disability priority assignments, and more emphasis was placed on accurate priority assignments. Inconsistent assignments also affected data used by management for decision-making, including projecting when NHVR could potentially exit the OOS.

**Some Disability Priority Assignments Did Not Appear To Be Consistent With Federal And NHVR Requirements**

To determine whether eligible customers had been assigned to the disability priority category consistent with the documentation in their case record, we analyzed 63 cases where applicants were found eligible between July 2015 and July 2019, from our file review of 97 cases. We found the disability priority assignments recorded in the electronic case management system were not always supported by the documentation found in the case file, contributing to noncompliant and inconsistent assignments, as shown in Table 7. Some inconsistent priority assignments were made during the OOS, at a time when NHVR management reported more stringent controls had been implemented. We found:

- Seven of 23 cases prior to the OOS (30 percent) and 14 of 40 cases during the OOS (35 percent) were assigned to higher priority categories than supported by the documentation found in the file. During the OOS, customers assigned to a higher priority category would have received services without being placed on the waitlist or would have been released off the waitlist sooner.
- Two of 23 cases prior to the OOS (nine percent) from our file review were assigned to lower priority categories than supported by the documentation found in the file. During the OOS, customers assigned to a lower priority category would have waited longer on the waitlist.

Federal law limited some services to only MSD customers. In the sample of cases discussed above where NHVR categorized customers as MSD without sufficient supporting documentation, we did not find those customers received these limited services. However, any customer who had been miscategorized as MSD could potentially have received services limited to only those customers. Conversely, customers with documentation supporting an MSD categorization but placed by NHVR into a lower priority category would not have been able to receive these limited services.

**Table 7**

**Disability Priority Assignments Made By NHVR, Compared To Assignments Supported By Case Documentation**

| | | | Disability Priority Assignment Supported By Case Documentation[1] | | |
|---|---|---|---|---|---|
| | | | **MSD** | **SD** | **L-SD** |
| **Disability Priority Assigned By NHVR** | **MSD** | **Pre-OOS** | 8 | **1** | **3** |
| | | **During OOS[2]** | 24 | **4** | **10** |
| | **SD** | **Pre-OOS** | **2** | 6 | **3** |
| | | **During OOS[2]** | 0 | 1 | 0 |
| | **L-SD** | **Pre-OOS** | 0 | 0 | 0 |
| | | **During OOS[2]** | 0 | 0 | 1 |

Notes:
[1] Lighter shaded cells represent cases NHVR assigned to a lower disability priority category than supported by documentation in the case record. Darker shaded cells represent cases assigned to a higher disability priority category than supported by documentation in the case record.
[2] We used the number of functional limitations required by NHVR practice during the OOS, as reflected in the *Policy Manual*, to assess the priority category assignments.

Source: LBA analysis based on federal requirements, NHVR administrative rules, NHVR *Policy Manual*, and information from NHVR case files.

We also found one customer receiving federal benefits was inaccurately assigned. NHVR verified applicants received SSDI or SSI benefits in 11 cases, eight of which were assigned as MSD. One case (13 percent) appeared to lack documentation supporting the assignment. Federal law specified that applicants who were determined to have a disability or be blind under SSDI or SSI were considered to be at least SD. If additional documentation supported classification to MSD, then NHVR could assign a customer receiving SSI or SSDI to MSD. Without such documentation, customers should have been assigned as SD, as required by federal law.

Additionally, among the 52 cases in which NHVR did not verify the applicant had SSA benefits, we found:

- Some Customers Were Inaccurately Assigned Without Documentation Of A Disability – Four MSD cases (eight percent) did not appear to contain documentation of any disability. Without such documentation, customers should have been assigned L-SD, as required by NHVR policy.
- Some Customers Were Inaccurately Assigned Without Documentation Of A Limitation – Twelve MSD cases (23 percent) and two SD cases (4 percent) did not appear to contain

documentation of any limitation. Without such documentation, customers should have been assigned L-SD, as required by NHVR policy.

- Some Customers Were Assigned With Fewer Limitations Than Required – Four MSD cases (eight percent) did not appear to contain documentation supporting more than one limitation. Without such documentation, customers should have been assigned no higher than SD, as required by federal law.
- Some Customers Were Assigned With Fewer Estimated Services Than Required – One SD case (two percent) recorded on the "disability priority" page that the customer would require a total of four services but only selected one specific service out of the list as being needed on the "eligibility determination" page, and one MSD case (2 percent) recorded the customer would need two services but only selected one service. Without documentation supporting the need for more than one service, customers should have been assigned no higher than L-SD, as required by NHVR policy.

**Compliance Monitoring Was Limited**

Compliance monitoring was limited and generally ineffective. Four of 25 counselors responding to our survey (16 percent) reported that management sometimes or rarely ensure policies and procedures were consistently applied. When asked in which areas management did not always ensure policies and procedures were consistently applied, four of 15 counselors responding to our survey (27 percent) identified disability priority, another potential indicator of ineffective monitoring. We also identified one case during the OOS where a supervisor requested the central office correct an assignment to MSD in the case management system, at the time of the eligibility determination. However, it did not appear that the central office made the change when originally requested, as a second supervisor reviewed the case seven months later and again requested the central office correct the assignment, immediately prior to a release from the waitlist.

There was potential overreliance on ineffective monitoring mechanisms, such as supervisory review and training. Managers and supervisors often specifically cited training as a method to ensure consistency of priority category assignments, and the NHVR Director emphasized the importance of training to make sure counselors were applying criteria consistently. However, we identified deficiencies with training, as we discuss in Observation No. 44.

- "Disability Priority" Data Page Was Not Always Updated When New Information Was Received – The case management system automatically assigned customers to disability priority categories. However, the automated calculator relied upon information from the "disability priority" data page, which was often completed around the initial intake and did not always appear to be updated after receipt of medical records.
- Some Data Pages In The Case Management System Contained Conflicting Information – We identified discrepancies between information on limitations and estimated services recorded on the "disability priority" and "eligibility determination" data pages in 15 of 32 eligible cases during the OOS (47 percent). In one case during the OOS, the "disability priority" data page, which was completed in December 2018, listed the applicant as having eight functional limitations. However, the "eligibility determination" data page, which was completed in February 2019, did not list two of them.

- *File Review Form* Did Not Allow Opportunities To Correct Noncompliance – The form required the counselor to initial a checklist and indicate whether the disability priority category was appropriate. The RL for each regional office reviewed the checklist for cases in their regional office prior to closure. If the review happened near case closure, there was no opportunity to correct noncompliance with documentation requirements for disability priority assignments.
- No Monitoring Of "Public Safety Officers" – NHVR administrative rules established three disability priority groups. Priority group 2 included customers categorized as SD and public safety officers disabled in the line of duty who were not included with customers categorized as MSD in Priority group 1. However, NHVR did not specifically document whether applicants were disabled public safety officers through the application form, the *Personal Information Form*, or the initial intake interview. Without this information, management would have been unable to ensure compliance with its own rules.

**Recommendations:**

**We recommend NHVR management develop a more robust process for ensuring disability priority assignments are compliant and consistent by:**

- **assessing the effectiveness of the current process of requiring RLs review disability priority assignments completed by their own staff;**
- **determining how to incorporate routine review or audits of cases by other regional leaders or managers in a timeframe that would allow modifications to the disability priority assignment, if needed; and**
- **addressing noncompliance in a timely, formal, and consistent manner.**

**We also recommend NHVR improve its monitoring of disability priority assignments by:**

- **identifying data and information necessary for monitoring compliance with disability priority assignment requirements and developing, implementing, and refining processes to routinely collect, monitor, and analyze compliance data and information;**
- **routinely assessing staff compliance, analyzing information to identify trends and potential issues with compliance, and remediating deficiencies with management controls as identified; and**
- **developing training to address areas of noncompliance.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *We disagree with the auditors' conclusions regarding Disability Priority assignments. Eligibility determination and disability priority assignments involve complex skills in interpreting data and eliciting information from people. It involves analyzing all information received and then making decisions on next steps based on that analysis. Critical to this analysis is speaking with applicants for VR services during a thorough*

*initial interview. Eligibility and Disability Priority assignment decisions are only to be made by qualified personnel, and Rehabilitation Counselors and their supervisors are such qualified personnel. Without proper training, education and experience, the integrity of the results of trying to make those decisions is highly questionable.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau agrees that more robust training on Eligibility and Disability Priority assignments is beneficial and it will be developed and implemented by June, 2021. Between July and September of 2020, all Regional Leaders and RC III's took part in a consensus building process to develop objective and consistent methods to reviews eligibility determinations and disability priority categorization. Training materials were created in September, 2020, and the entire counseling staff was trained on how to thoroughly and professionally document eligibility decisions and priority categorizations. These training materials are available on the YESLMS learning management platform as a resource for counseling and RL staff. In addition, Regional Leaders have a guide to refer to with specific questions and examples of proper documentation that is used to allow for consistent and objective decision making.*
- *The bureau will also incorporate eligibility determination into the RL file audit process, including follow up training where such audit processes reveal inconsistencies in the determinations.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

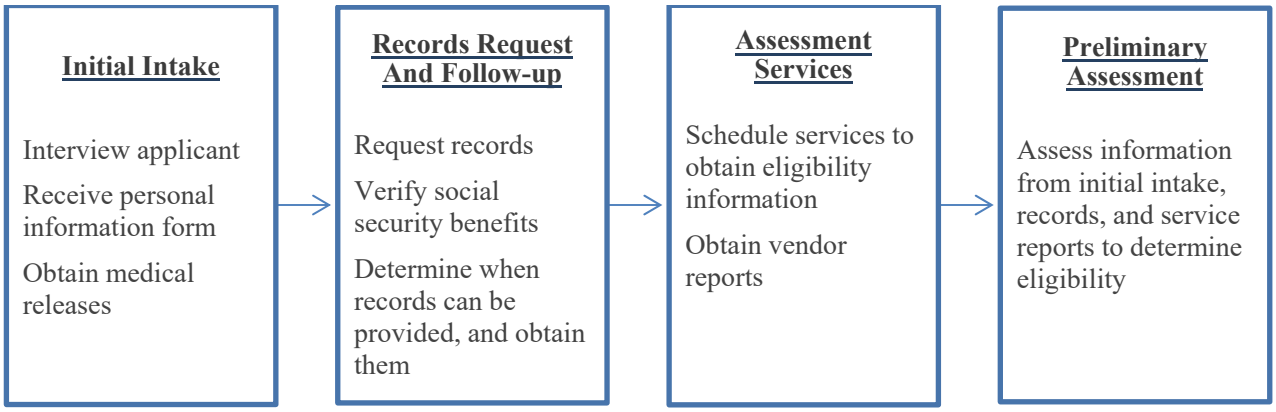
**While NHVR may disagree with our conclusions, it provided no supporting documentation verifying all required information was present in the case record. We reviewed the complete record for each case, including all documentation in the hardcopy file and in the electronic case management system. We provided NHVR with a list in March 2020 of cases with disability priority assignments that we could not verify. NHVR responded in September 2020 demonstrating NHVR staff reviewed only information in the case management system and acknowledged that several of our assessments were accurate based solely on that information. We provided NHVR with an additional list in October 2020 detailing specific information we identified as needing verification to support the disability priority category. No additional documentation was provided by NHVR.**

**Documenting Eligibility And Disability Priority**

Federal law required eligibility determinations be based on a review and assessment of existing information and, to the extent necessary, assessment activities to obtain additional information if necessary. If existing information did not describe the current functioning of the applicant or was unavailable, insufficient, or inappropriate to make an eligibility determination, NHVR could assess additional information. This additional information could include trial work experiences, assistive technology devices and services, personal assistance services, or other support services such as functional capacity evaluations. The initial intake interview began the process of gathering information about an applicant and identifying assessment needs, as shown in Figure 7.

**Figure 7**

**Eligibility Assessment Process**




Note: Some steps may not occur at all, or may occur in a different order than shown.

Source: LBA analysis of federal and program eligibility determination requirements.

Federal law required priority assignments be based upon: 1) a review of existing information, which federal regulations specified should be the information used to make an eligibility determination, and 2) if necessary, the provision of appropriate assessment activities to obtain necessary information to make an assignment. We found NHVR did not always retain adequate documentation to support its eligibility determinations.

- Supporting Documentation – Federal regulations required NHVR to include documentation supporting determinations of an applicant's eligibility or ineligibility for VR services in each case file.
- Availability Of Documentation – Federal law specified that, to the maximum extent appropriate, NHVR should use information to determine eligibility that was existing and current, as of the date of the determination. If existing information did not describe the current functioning of the applicant or was unavailable, insufficient, or inappropriate to make a determination, NHVR was permitted to assess additional data resulting from the provision of VR services.

- Notification Of Determination To Applicants – When operating under an OOS, NHVR was required to provide notification to eligible applicants. NHVR was also required to notify applicants of an ineligible determination, regardless of whether NHVR was under an OOS.

Federal guidance and the *Desk Reference* indicated that the use of an electronic case management system did not remove the requirement to maintain either hard copies or scanned copies of required supporting documentation in a case file, as an electronic case management system was merely a data entry process that was susceptible to data entry errors.

**Observation No. 10**

## Improve Guidance On Eligibility Documentation And Requirements

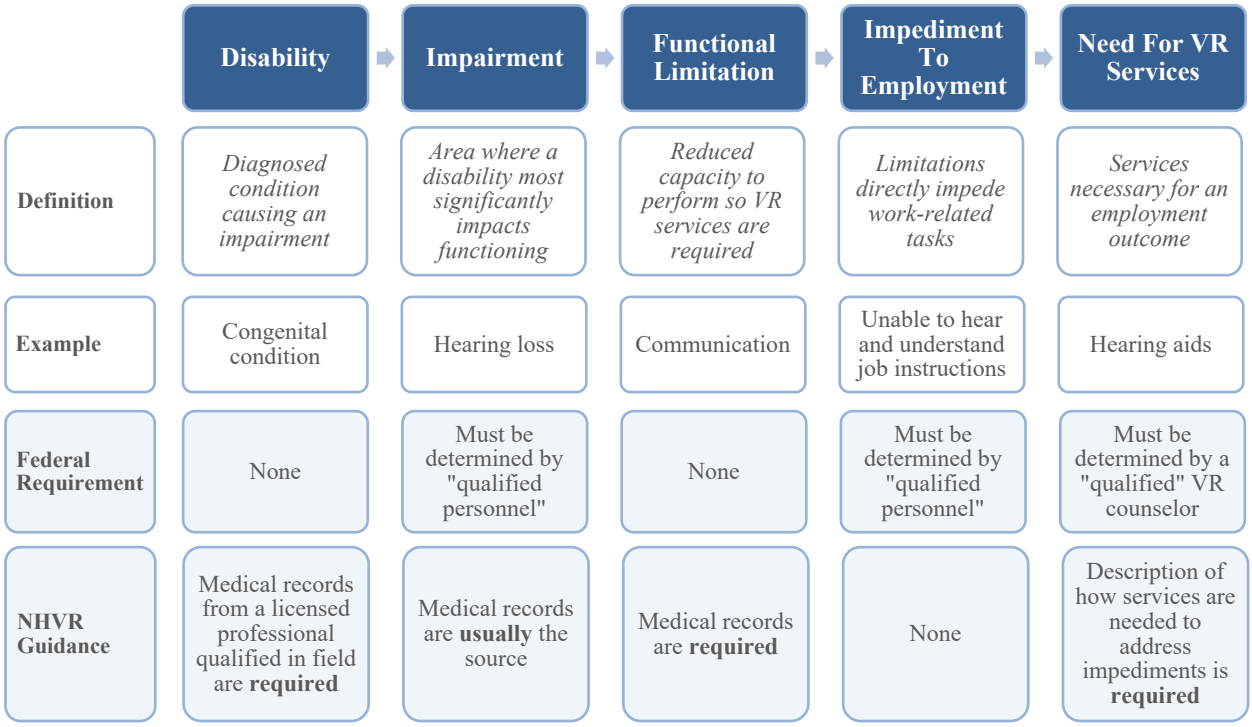
Federal law required applicants meet four requirements to be found eligible for VR services and, during an OOS, be assigned based on three criteria to a disability priority category to assure individuals with the most significant disabilities were selected first for the provision of services. Additionally, federal regulations required NHVR to include documentation supporting an applicant's eligibility determination and disability priority assignment in each case file. However, NHVR did not establish administrative rules to further define federal requirements and its internal guidance in these areas was not comprehensive and at times unclear, causing staff confusion and likely contributing to inconsistent decisions and inadequate documentation.

### Unclear Guidance On Need For Medical Records To Verify Requirements And Criteria

The *Desk Reference* indicated medical or psychological records were needed to determine eligibility and assign customers to a disability priority category. However, guidance on the need for medical records to support individual requirements and criteria appeared to be unclear or inadequately communicated. Supervisors and managers had inconsistent views that, at times, conflicted with one another or guidance. Additionally, guidance appeared to make unclear distinctions between which requirements and criteria needed to be documented through medical records and which did not, as shown in Figure 8.

**Figure 8**

**Relationship Between Eligibility Requirements And Disability Priority Criteria**




Source: LBA analysis of federal and NHVR requirements and guidance.

***Unclear Guidance On Who Is Qualified To Determine Specific Eligibility Requirements***

Federal eligibility regulations, 34 CFR 361.42(a)(1), required:

> *(i) A determination by* qualified personnel *that the applicant has a physical or mental impairment;*
> *(ii) A determination by* qualified personnel *that the applicant's physical or mental impairment constitutes or results in a substantial impediment to employment for the applicant; and*
> *(iii) A determination by a* qualified vocational rehabilitation counselor employed by the designated State unit *that the applicant requires vocational rehabilitation services to prepare for, secure, retain, advance in, or regain employment…* [emphasis added]

Neither federal law nor regulations defined the term qualified personnel. Federal law defined "qualified vocational rehabilitation counselors" as counselors trained and prepared in accordance with state personnel standards. We discuss inadequacies in NHVR personnel standards in Observation No. 43. In distinguishing what "qualified personnel" and what a "qualified vocational rehabilitation counselor" were each responsible for, federal eligibility regulations appeared to

make a distinction that "qualified personnel" and a "qualified vocational rehabilitation counselor" employed by the state VR agency were not the same people.

NHVR administrative rules, policy, and procedures did not define "qualified personnel." NHVR training materials potentially introduced additional confusion by using a different term and indicating that a "rehabilitation professional" could determine whether a substantial impediment existed, without defining who a "rehabilitation professional" was. Additionally, the term "qualified rehabilitation counselor" was not defined in NHVR's administrative rules, policy, and procedures. Two central office managers reported "qualified personnel" and "qualified vocational rehabilitation counselors" could be the same people. However, one of these managers also reported eligibility documentation should come from someone who is qualified to make a diagnosis, which would appear to exclude counselors based on NHVR requirements.

***Unclear Guidance On How Specific Eligibility Requirements Should Be Documented***

Rules, policies, and procedures did not specify what documentation was needed to verify an *impairment*, although training materials indicated counselors "usually" gathered information on specific impairments from medical records. Three supervisors indicated medical records should document impairments or confirm self-reported information.

Rules, policies, procedures, and training materials did not specify what documentation was needed to verify an *impediment*. Supervisors and managers reported inconsistent information about how an impediment should be documented. Four supervisors and one manager reported medical records should document impediments or confirm self-reported information, while one supervisor reported impediments only needed to be self-reported.

***Unclear Guidance On Documentation Of Disability Priority Criteria***

Although federal law and regulations did not specify exactly how disability priority criteria should be documented, the *Desk Reference* and training materials required disabilities be verified through medical records, which six supervisors and two managers confirmed. However, training materials potentially introduced confusion by indicating qualified personnel – federal terminology specific to determining impairments and impediments for eligibility – should document disabilities. According to training materials, qualified personnel included: 1) medical doctors, psychologists, psychiatrists, and other professionals licensed or certified by the State to diagnose in the field related to the disability; 2) determinations made by the SSA; and 3) documentation used by school systems to identify disabilities.

Additionally, the *Policy Manual* required "clear evidence, demonstration, or documentation" of functional limitations, which the *Desk Reference* specified could be through counselor observations "in conjunction with supporting medical information." Training materials also specified limitations be documented through medical records, which two supervisors and one manager confirmed. However, three supervisors and one manager reported staff could make an assignment based on either visible or self-reported limitations.

**Inadequate Guidance On Disability Priority Criteria**

Federal law established SD criteria, required MSD criteria at least meet SD criteria, and provided VR agencies with discretion to establish additional criteria and categories. NHVR administrative rules adopted federal SD criteria and defined additional MSD criteria. However, policies, procedures, and training provided unclear guidance on what the criteria were, such as calculating number of estimated services, or conflicted with requirements and one another, such as administrative rules on assigning MSD conflicting with federal law. Additionally, we found that while some NHVR training materials distinguished between disabilities and impairments, and impediments and functional limitations, other guidance appeared to use terms interchangeably.

Counselors responding to our survey identified related concerns and reported disability priority processes were either unclear in rules (three of 25, or 12 percent), policy and procedures (four of 25, or 16 percent), or inadequately covered in training (five of 25, or 20 percent). Some supervisors and managers also reported inaccurate understanding of federal requirements, administrative rules, or practice prior to and during the OOS. For example, one manager and one supervisor reported there had been no change in the disability priority criteria, even though the MSD criteria were changed by NHVR without updating administrative rules.

***Unclear Guidance On "Severe Physical Or Mental Impairment"***

In order to make a disability priority assignment, federal law required NHVR to determine whether applicants had a "severe physical or mental impairment." Neither federal law nor regulations defined a severe impairment, and the term was also undefined in administrative rules, policies, procedures, and training materials. Training materials during the OOS potentially introduced confusion by using different terminology and specified that a severe *disability* meant the customer had one or more disabilities specified in federal law, received social security benefits as the result of a disability, or had another disability that caused comparable substantial functional limitation.

***Contradictory Guidance On Calculating An Estimated Number Of Services***

NHVR administrative rules specified MSD criteria included having a customer who was expected to require two or more VR services, *in addition to* counselor-provided services of guidance, counseling, service coordination, and job placement. However, this rule appeared to conflict with federal law, which defined VR services as any services described in an IPE necessary to assist a customer in rehabilitation, *including* guidance and counseling and job-related services.

Potentially contributing to confusion, internal guidance further differed from administrative rules.

- The *VR Portion Of WIOA State Plan For The State Of New Hampshire (State Plan)* specified, as of April 2018, an MSD customer was expected to require three or more *primary* services. Training materials from the OOS defined "primary services" as "major services… necessary to prepare" a customer for employment, including guidance and counseling, training, treatment, and job placement. Training materials distinguished between "primary" services and "support" services. "Support" services were "provided in conjunction with a primary service" and included maintenance, transportation, physical or occupational therapy, and occupational licenses or related tools and equipment. However,

this guidance also appeared to conflict with federal law. The definition of VR services in federal law included services such as maintenance, transportation, and occupational licenses, which were excluded from revised NHVR guidance. Additionally, some training materials also indicated the change to "primary" services applied to the SD category, which directly conflicted with federal law indicating an SD customer was expected to require multiple *VR* services.

- Additions to the *Policy Manual* on May 7, 2018, indicated an MSD customer was expected to require three or more *VR* services, which constituted ad hoc rulemaking. However, if properly adopted in rules, the use of *VR* services for criteria appeared to be generally consistent with federal law.
- Training materials during the OOS also potentially introduced confusion by using different terminology and referring to both "primary services" and "required services" without clearly stating whether these were the same services.

### *Ad Hoc Guidance On MSD Definition Contradicted Administrative Rules*

NHVR administrative rules specified MSD criteria included having *two* or more serious limitations affecting an employment outcome and expecting to require *two* or more VR services over six months or longer. The *State Plan* specified, as of April 2018, an MSD customer had *three* or more limitations and needed *three* or more services, which was echoed in additions to the *Policy Manual* on May 7, 2018, although policy continued to also cite the rules-based criteria. The electronic case management system reportedly assigned customers as MSD if they had *four* or more limitations and needed *three* or more services since May 5, 2018.

### *Ad Hoc Guidance On SD Definition Contradicted Federal Law*

Federal law specified SD criteria included having *one* or more serious limitation affecting an employment outcome, but since May 5, 2018, the case management system reportedly assigned customers as SD if they had *two* or more limitations. Additionally, federal law required an SD customer be expected to require multiple VR services over an extended period of time. NHVR administrative rules included an outdated citation to the federal definition, without defining "multiple" or "extended." Neither policy nor procedure defined either term, although training materials specified SD criteria included two or more services over a period of six or more months.

## Guidance On Updating Disability Priority Assignments Was Not Comprehensive

One supervisor reported while updates to initial disability priority assignments were rare, at least one update was occurring each month. However, the exact process counselors must follow when seeking an update was inadequately documented in policy and undocumented in procedures or training materials. The *Policy Manual* outlined two circumstances when a customer's priority assignment could be updated: misclassification by NHVR, or a change in circumstances requiring assignment to a higher category. Two supervisors reported the process included either:

- writing a case note explaining the need for the change, obtaining approval from the RL and the Field Services Administrator, then having central office staff make the change in the electronic case management system; or

- completing an *Eligibility And Disability Priority Worksheet*, providing it to the Field Services Administrator for approval, and then having the Field Services Administrator make the change in the case management system.

**Minimal Guidance On Documenting That Employed Applicants Needed VR Services**

To be eligible for services, federal law required that the applicant need VR services to prepare for, secure, retain, advance in, or regain employment. While rules, policies, and procedures did not provide guidance on how counselors should ensure applicants who were employed actually needed services, training materials indicated an applicant could be eligible for services if they sought advancement or if their job was in jeopardy, endangered health or safety, was unsteady, or resulted in underemployment. However, no guidance was provided to counselors as to how to document or assess whether these criteria were met. Four cases with eligibility determinations made prior to the OOS and eight cases with determinations made during the OOS from our file review involved customers who were employed at the time of application, including:

- one customer determined eligible prior to the OOS, reported during IPE development they felt they could continue to work without NHVR services and wanted to close their case;
- two customers prior to the OOS and one customer during the OOS were looking for new jobs, but the reasons were unclear;
- one customer during the OOS who self-reported their job would be in jeopardy without NHVR services; and
- one customer during the OOS who self-reported needing a new job due to their disability.

We did identify two customers during the OOS who provided letters from their employers indicating their jobs were in jeopardy without NHVR services. However, providing sufficient justification for the need for VR services was important for all employed customers, particularly during the OOS, as customers who were in danger of losing their job could receive a waiver from the waitlist and obtain services sooner.

**Minimal Guidance On Seeking Additional Information For Eligibility Determinations**

Federal regulations specified if existing information did not describe the current functioning of the applicant or were unavailable, insufficient, or inappropriate to make an eligibility determination, counselors could request certain services, such as neurological exams, to provide information necessary for eligibility. However, neither federal regulations nor NHVR administrative rules, policy, procedure, or training materials defined what "unavailable," "insufficient," or "inappropriate" meant.

NHVR training materials also indicated "choosing not to purchase [a] superfluous medical evaluation saves time and effort for the individual and saves [the counselor] time and the agency money as well." However, guidance did not explain how to determine when an additional medical evaluation would be "superfluous." Unclear guidance on obtaining additional information could potentially result in unintended outcomes. However, not conducting needed evaluations could cost NHVR more in the long run. It could also hinder progress towards an employment outcome if customers did not receive appropriate services to address their impairments and impediments.

**Minimal Guidance On Social Security Recipients**

The *Policy Manual* specified counselors needed documentation of SSI or SSDI benefits, which included a benefits award letter, before presuming recipients eligible for services. Some training materials emphasized it was NHVR's responsibility to obtain verification. However, other training materials potentially introduced confusion by noting counselors should presume applicants to be eligible as soon as the applicant *stated* they received benefits because of a disabling condition. There was no guidance on whether counselors should verify benefits were still being received at the time of application, such as if an award letter was dated several months or more prior to the application date.

Training materials specified that verification of benefits satisfied eligibility requirements, and counselors did not need to obtain additional information, including medical records, or conduct additional testing to make an eligibility determination, unless a trial work experience was necessary. Training materials did note counselors would want to obtain medical records "for planning purposes and to fully understand [customers'] functional limitations and impediments to employment and service planning." Federal laws required an applicant determined eligible for SSI or SSDI be categorized as at least SD. Medical documentation was needed to support an MSD categorization but not an SD categorization for these customers. Additional medical documentation during the eligibility process may not have been needed for customers who would have been unlikely to be placed in the higher category. However, we found counselors most often sought additional medical records for all customers during the eligibility process, rather than waiting for the IPE development process, potentially preventing eligibility determinations for some SD customers from being made sooner.

**Other Identified Issues**

We also identified the following issues with eligibility documentation and requirements, including:

- No Guidance On How To Utilize Medical Records And Social Security Verification From Prior Cases – Some customers applied for and received NHVR services multiple times over several years. Neither rules, policy, procedures, nor training materials addressed the use of records from prior cases. Federal regulations required each case file to contain documentation supporting an eligibility determination and disability priority assignment. However, we found some cases appeared to rely on records from prior closed cases, without including a copy of these records in the active file. Additionally, the NHVR Director reported counselors must determine eligibility for each new case, as a customer's situation, including their disabilities, may have changed since they last received services.
- Conflicting Guidance On *Eligibility And Disability Priority Worksheet* In Case Files – Training materials from during the OOS inconsistently indicated: 1) worksheets were to be placed in the hardcopy case file but had no requirement to scan a copy into the electronic case file, 2) were to be scanned into the electronic case file, or 3) were to be scanned into the electronic case file only if the pre-OOS "disability priority" data page had been used. A supervisor reported staff in one regional office were unsure whether the worksheet needed to be included in the case file but decided inclusion was not needed.

**Recommendations:**

**We recommend NHVR management ensure guidance on eligibility requirements, disability priority criteria, and related documentation are accurate and comprehensive. When reviewing guidance for completeness and accuracy, NHVR management should ensure administrative rules, policy, procedure, and training materials accurately and clearly reflect federal law and regulations and provide guidance and definitions externally consistent with federal requirements and internally consistent with one another.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The change in criteria for client categorization between MSD and SD as a result of the order of selection was implemented to enable the bureau to create clear delineation among MSD and SD clients so that those clients with the most severe disabilities, and most in need of NHVR services, could continue to receive priority even in the order of selection. This change was agreed to by the Rehabilitation Services Administration. NHVR concurs that emergency rulemaking should have been immediately implemented for this change.*
2. *The audit report correctly states that, "…choosing not to purchase [a] superfluous medical evaluation saves time and effort for the individual and saves [the counselor] time and the agency money as well." The report goes on to speculate that by not thoroughly defining superfluous, it "… could cost NHVR more in the long run. It could also hinder progress towards an employment outcome." While the bureau appreciates the importance of making complete and accurate determinations, it believes the term superfluous is sufficiently clear for training purposes and finds the hypothetical of the auditors of what "could" happen to be non-factual and speculative.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau will review, update and align administrative rules, and policy. This work is continuing currently with timeline to completion being July 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 2, performance auditors are obligated to report information on the situation that exists at an agency, the factors contributing to internal control weaknesses, and the effect or potential effect of those weaknesses, which is used to develop meaningful recommendations for corrective action.**

**Observation No. 11**

## Ensure Documentation Fully Supports Eligible Determinations

By having NHVR staff document eligibility determinations and disability priority assignments, management could ensure counselors made compliant and consistent decisions, and that only applicants who met all four eligibility requirements were prioritized in the correct category to receive services. However, we found required documentation was not always included in case files, and incomplete or inaccurate documentation could have negatively affected eligibility decisions or IPE development and contributed to inaccurate performance reporting.

### Prior Findings Of Noncompliance Remained Unresolved

Our *Department of Education Financial And Compliance Audit Report For The Year Ended June 30, 2000* found noncompliance with requirements to document disabilities. We recommended the DOE implement procedures to ensure compliance and the DOE concurred. During their May 2019 onsite monitoring of NHVR, federal oversight agency staff noted eligibility letters were not always in case files and indicated documentation was sometimes difficult to find. We also identified noncompliance with documentation requirements during our current audit.

Additionally, in its FFY 2004 monitoring report, NHVR's federal oversight agency identified noncompliance with presumption of eligibility for SSDI and SSI recipients. According to its FFY 2010 monitoring report, the Rehabilitation Services Administration reported NHVR had resolved this issue at that time. However, we found guidance on presumption of eligibility was unclear during the audit period.

### Some Eligible Cases Did Not Contain Required Documentation

Federal regulations required NHVR to include documentation supporting an applicant's eligibility determination and disability priority assignment in each case file. NHVR's electronic case management system did not have a standardized and centralized way to monitor whether eligible cases had the required documentation. Consequently, we were unable to identify overall compliance with documentation requirements. Instead, we analyzed 63 cases from our file review of 97 cases where the applicant was found eligible between July 2015 and July 2019.

#### *Inconsistent Documentation Of Eligibility Requirements*

Without documentation the applicant met all four eligibility requirements, NHVR should have obtained additional documentation or found the applicant ineligible. However, 18 of 23 cases prior to the OOS (78 percent) and 28 of 40 cases during the OOS (70 percent) appeared to lack documentation of at least one requirement at the time the eligibility determination was made.

- Some Older Cases Did Not Contain An Application – Federal regulations specified applications were to be signed by the applicant. Among the 31 cases with determinations made prior to July 2015, we found four (13 percent), which were closed between April 2017 and January 2019, lacked applications. Additionally, one (three percent), which was

active until April 2020, did not contain a signed application. We did not identify issues with applications for eligibility determinations made during or after July 2015.

- Some Cases Did Not Contain Documentation Of Social Security Benefits – NHVR required documentation an applicant was receiving SSI or SSDI benefits prior to making a determination, such as through a benefits award letter. We found four of seven cases prior to the OOS (57 percent) and seven of 15 cases during the OOS (47 percent) did not contain verification, even though applicants were recorded as recipients. However, none of these cases contained documentation supporting all four eligibility requirements.

We excluded three cases prior to the OOS and eight cases during the OOS for which NHVR verified SSA benefits from the following analyses.

- Some Cases Did Not Contain Documentation Of Any Impairment – Training materials specified impairments were usually identified through medical records. However, we found one of 20 cases prior to the OOS (five percent) and four of 32 cases during the OOS (13 percent) appeared to lack medical or other documentation. This included three cases where NHVR noted the applicant was receiving SSA benefits, but we did not find evidence in the case record the benefits were verified.
- Some Cases Did Not Contain Documentation Of A *Substantial* Impediment – Training materials specified there must be a demonstration specific limitations imposed by disabilities directly impeded applicants from performing specific job tasks, functioning in a job environment, or becoming involved in job preparation activities. However, we found four of 20 cases prior to the OOS (20 percent) and 11 of 32 cases during the OOS (34 percent) appeared to lack documentation. This included five cases where NHVR noted the applicant was receiving SSA benefits, but we did not find evidence in the case record the benefits were verified.
- Many Cases Did Not Contain Documentation VR Services Were Needed – The *Disability Handbook* cautioned this requirement was "sometimes overlooked." NHVR's case management system, implemented in July 2015, indicated counselors were to "describe" how services would reduce, eliminate, or accommodate impediments. NHVR's August 2017 training materials reaffirmed this requirement and specified counselors must "**EXPLAIN** or show the logical development or relationship of how services will reduce, eliminate or accommodate the individual's impediment" and discuss "how these are **NEEDED** services that will assist the individual in securing or maintaining employment." [emphasis original] However, we found 18 of 20 cases prior to the OOS (90 percent) and 27 of 32 cases during the OOS (84 percent) appeared to lack any description in the hardcopy file or "case notes," "assessment," or "eligibility" data pages in the case management system. This included 11 cases NHVR noted the applicant was receiving SSA benefits, but we did not find evidence in the case record the benefits were verified.

***Inconsistent Documentation Of Disability Priority Criteria***

Without documentation of all three disability priority criteria, NHVR should have obtained additional documentation or assigned eligible applicants to the L-SD category. However, 18 of 23 SD and MSD cases prior to the OOS (78 percent) and 27 of 39 SD and MSD cases during the OOS

(69 percent) appeared to lack documentation of at least one criterion at the time the initial disability priority assignment was made. We found some cases did not contain verification of social security benefits, as we discuss above. Three SD cases with verified benefits were excluded from the following analyses.

- Some Cases Did Not Contain Documentation Of Any Disability – The *Desk Reference* required disabilities be verified through medical records. However, we found one of 20 cases prior to the OOS (five percent) and three of 39 cases during the OOS (eight percent) appeared to lack medical documentation. In one case during the OOS, the medical documentation contained in the file was a ten-year-old consultation report from immediately after the applicant's car accident which specified follow-up was needed to confirm the extent of the applicant's injuries.
- Some Cases Did Not Contain Documentation Of A Serious Limitation To Employment – Policy specified there "must be clear evidence, demonstration, or documentation of the limitations imposed by the disability." The *Desk Reference* emphasized "counselor observations alone **are not** adequate to support the determination of a serious functional loss, but should be used **in conjunction with** supporting medical information." [emphasis original] Training materials indicated limitations should be documented in medical records. Training materials cautioned limitations were not always serious and required counselors to ensure employment was affected before finding someone eligible. However, we found four of 20 cases prior to the OOS (20 percent) and ten of 39 cases during the OOS (26 percent) appeared to lack documentation of *any* functional limitation. Additionally, among cases with documentation of a limitation, we found 14 of 16 cases prior to the OOS (88 percent) and 16 of 29 cases during the OOS (55 percent) appeared to lack adequate documentation of a *serious* functional limitation.

**Other Issues With Missing Or Inadequate Eligibility Documentation**

We identified additional noncompliance and other documentation issues through our file review.

- Some Hardcopy Case Files Were Missing – At the time we requested them, two of the hardcopy case files were missing entirely, while a third was substantially missing. NHVR eventually located one of the files that was entirely missing 11 months after we requested it for review. For these three cases, eligibility documentation had not been scanned into the electronic case file. Without the hardcopy files, we were unable to audit the eligibility determinations and disability priority assignments in these cases.
- Information Used To Determine Eligibility Was Not Always Current – Federal law specified to the maximum extent appropriate, NHVR should use information that was existing and current, as of the eligibility determination. If existing information did not describe the applicant's current functioning or was unavailable, insufficient, or inappropriate, NHVR was permitted by federal regulations to obtain necessary additional information. Training materials also indicated records should be current, especially if a disability was progressive or unstable. However, we found three of 23 cases prior to the OOS (13 percent) and four of 40 cases during the OOS (10 percent) used dated information. In one case during the OOS, a 20-year old applicant's assignment was based on nine-year old medical records recommending an evaluation of their disability every year or two to

monitor progress. Additionally, one case prior to the OOS (four percent) and two cases during the OOS (five percent) used medical documentation that could have potentially been outdated or conflicted with other information. For example, in one case, the most recent medical documentation was two years old; however, the medical history indicated the applicant's condition did not appear to be stable for the past six years.

- Interim Steps In The Eligibility Process Were Not Always Adequately Documented – The *Desk Reference* and training materials contained various requirements to document interim steps and information used to make eligibility determinations and disability priority assignments. For example, the *Desk Reference* required counselors to document the initial interview, that medical and psychological records were requested, follow-up on requested records, case notes documenting steps and activities needed to gather eligibility documentation, case notes on missed appointments, and the preliminary assessment through the "comprehensive assessment" data page. However, we found case notes, data pages, and attachments did not always address these requirements. NHVR management acknowledged case notes were not always comprehensive.
- Notification To Some Eligible Customers During The OOS Was Missing Or Delayed – When operating under an OOS, federal regulations dating back to at least July 2010 required VR agencies to provide written notification to eligible applicants of their disability priority assignment, at the time of eligibility determination. However, among 40 cases with eligibility determinations during the OOS, we found:
    - seven (18 percent) did not contain written notification of eligibility,
    - nine (23 percent) did not contain written notification of disability priority, and
    - three (eight percent) contained notification which was delayed between one and three months.
- Notification To Some Eligible Customers Prior To The OOS Was Inconsistent – While it was not required to provide written notification, NHVR made disability priority assignments prior to implementing an OOS and provided notification to some, but not all, customers. Written notification could have helped management with monitoring because these decisions affected some customers' ability to receive certain services. Among the 23 cases with eligibility determinations prior to the OOS, we found:
    - 17 (74 percent) did not contain written notification of eligibility,
    - 19 (83 percent) did not contain written notification of disability priority, and
    - one (four percent) contained notification which was delayed for one month.

**Compliance Monitoring Was Limited In Effectiveness**

NHVR processes to monitor compliance with eligibility requirements and disability priority assignments were either limited in effectiveness, such as supervisory review, or reactive, identifying noncompliance only after it had occurred. Through the *File Review Form*, counselors were required to verify medical, psychological, SSI or SSDI, and other relevant documents used to make eligibility decisions were in the case file. Generally, an RL was required to sign off once the file was closed. During a monthly internal audit, RLs were required to verify that disability documentation in the case file matched the disability information in the case management system. Neither of these processes would have likely resulted in an opportunity to correct the deficiencies.

Additionally, management did not timely or consistently address noncompliance and did not ensure staff were compliant with federal requirements.

**Recommendations:**

**We recommend NHVR management develop a process to ensure adequate documentation of eligibility determinations are contained in the files. As part of the process, NHVR should:**

- **identify data and information necessary for monitoring compliance with federal and NHVR eligibility documentation requirements and develop, implement, and refine processes to routinely collect, monitor, and analyze compliance data and information;**
- **routinely measure staff compliance with requirements and assessing information to identify trends and potential issues with compliance; and**
- **remediate deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refine processes as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The audit report points out that, in "June 30, 2000 [the auditors] found noncompliance with requirements to document disabilities." The bureau assumes responsibility for any lack of responsiveness to the June 30, 2000 audit, but observes that the audit function itself is part of the overall system of internal control. To be effective, as such, would necessitate that there is timely and appropriate follow-up and support of bureaus working to implement the audit recommendations, which does not seem to be the case for this cited audit.*
2. *The audit report states that, the "Rehabilitation Services Administration reported NHVR had resolved this issue ... However, we found guidance on presumption of eligibility was unclear." The bureau is uncertain how to respond to the reflections of the auditors that they found the guidance unclear. The bureau responded to a 2004 audit finding by the Rehabilitation Services Administration. The Rehabilitation Services Administration, upon follow-up concluded that the bureau had appropriately responded to the finding in 2010. The auditor's finding that the guidance is unclear is insufficiently actionable by the bureau, creating ambiguity as to the response sought.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR fully concurs that documentation of eligibility determinations must follow stated procedure. The bureau is contracting with a quality assurance contractor to develop a full quality assurance program to make the needed improvements. The bureau, however, also finds the incongruence between the work of the auditors and the work of the Rehabilitation Services Administration to be difficult to reconcile. The Rehabilitation*

*Services Administration also performed an audit of eligibility determination during this period. This audit consisted on a review of 40 files by a qualified VR professional from the state of Maryland. That audit found significantly different results in its review of documentation in all files evaluated to support the determination.*

**LBA Rejoinder:**

**In reference to Remark 1, federal internal control standards specify it is management's responsibility to complete and document corrective actions to remediate internal control deficiencies on a timely basis, including resolving audit findings. The LBA Audit Division does not work for the DOE and is not part of NHVR's routine system of internal controls. The LBA Audit Division's function is to identify areas for improvement; it remains DOE management's responsibility to ensure findings and recommendations are addressed timely.**

**In reference to Remark 2, we note that an agency's control environment and internal controls are not static. Although the Rehabilitation Services Administration identified the issue of presumptive eligibility for applicants receiving SSI or SSDI as resolved in 2010, that does not preclude relevant controls from future weaknesses, which we identified. We recommended developing a process to ensure NHVR maintained adequate documentation of eligibility determinations. As part of this process, NHVR could review its guidance related to presumptive eligibility, and ensure all relevant requirements, procedures, and practices are comprehensively documented for staff and applicants.**

**Further, NHVR's response is disingenuous, as the federal Rehabilitation Services Administration had a different focus during its monitoring process than our audit. As clearly stated in the Rehabilitation Services Administration's *Monitoring and Technical Assistance Guidance*, issued in FFY 2018 and in FFY 2019, the case review is used only "to ensure the documentation in the service record is accurate, complete, and supports the data entered into" federal reports. In contrast to the Rehabilitation Services Administration's case review, our case review encompassed a wide range of documentation required to support an eligible determination, issues with which are presented in this Observation, including verification of the four eligibility requirements and the three disability priority criteria.**

**During its review of NHVR, the Rehabilitation Services Administration found issues with eligibility dates. Federal reviewers noted that 25 percent of case records they reviewed did not contain documentation verifying the date of eligibility determination. They also reported 15 percent of case records contained inconsistent dates between hard copy records, the electronic case management, and federal reports. Additionally, federal reviewers found issues with application dates, noting that five percent of case records they reviewed did not contain documentation verifying the application date. They also reported 10 percent of case records contained inconsistent dates between hard copy records, the electronic case management, and federal reports.**

### Determining Applicants And Customers Were Ineligible For Services

If an applicant did not meet all four eligibility requirements, NHVR had to determine the applicant was ineligible for services. Additionally, NHVR could determine customers who had initially been found eligible were subsequently ineligible. Federal law required NHVR to:

- make an ineligible determination only after providing an opportunity for full consultation with the applicant or customer, and
- inform the applicant or customer in writing of the ineligible determination, including the reasons for the determination and the "clear and convincing evidence" that formed the basis for the determination.

Federal law required NHVR use trial work experiences prior to determining an applicant was ineligible because they could not benefit from VR services in terms of an employment outcome due to the severity of their disability. We found NHVR did not always properly document when applicants were determined to be ineligible, nor did it ensure applicants were able to access trial work experiences when required.

### Observation No. 12

### Ensure Case Records Contain Documentation Required For Ineligible Determinations

NHVR staff were required to document determinations of applicant ineligibility, allowing management to ensure counselors made compliant and consistent decisions, and that only applicants who met all four eligibility requirements received services. However, we found required documentation was not always included in case files. Incomplete or inaccurate documentation could have negatively affected eligibility determinations.

### Some Ineligible Cases Did Not Contain Required Documentation

To determine whether requirements were met, we analyzed eight cases closed due to ineligibility between July 2015 and July 2019 from our file review of 97 case records.

- Some Cases Did Not Contain Documentation Customers Were Ineligible For Services – Federal regulations required NHVR to include documentation in case files supporting determinations that customers were ineligible for services because they did not meet at least one of the four eligibility requirements. We found seven cases (88 percent) lacked required documentation.
- Some Cases Did Not Contain Documentation Of Full Consultation – Federal law required NHVR to make an ineligible determination only after providing the customer with an opportunity for full consultation, and the *Desk Reference* required documentation be included in the case file. We found three cases (38 percent) lacked documentation of a consultation.
- Some Cases Did Not Contain Notification Of Ineligibility – Federal law required NHVR to provide notification in writing of the ineligible determination, including the reasons for

ineligibility and the "clear and convincing evidence that form[ed] the basis for the determination." The *Desk Reference* required the case file include documentation the letter was sent by certified mail and documentation of its receipt. We found four cases (50 percent) lacked documentation of ineligibility notification, five cases (63 percent) lacked notification of the reasons for ineligibility, and eight cases (100 percent) lacked documentation the notification was sent or received through certified mail.

- Cases Closed Due To Severe Disability Did Not Contain Required Follow-up – Federal law required NHVR to review any ineligible determination based on the finding an applicant or customer was too severely disabled: 1) within 12 months of the determination, and 2) annually thereafter, if requested by the applicant or customer. In our file review, four of the eight cases (50 percent) were closed due to severe disability. We found all four cases lacked documentation that customers were informed of the review process at the time of the ineligible determination and of a review within 12 months of the determination.

**Management Did Not Appear To Monitor Ineligible Determinations**

We were unable to identify explicit monitoring of ineligible determinations. Although eligibility signature authority and supervisory review processes presumably encompassed ineligible determinations, we found counselors without signature authority made their own determinations of ineligibility, without receiving supervisory review and approval. Our file review identified one ineligible determination on a VRC I's caseload prior to the OOS, and two on another counselor's caseload during the OOS. None of these determinations had been approved by a supervisor as required. Completion of the "eligibility determination" data page should have reportedly triggered review, but we found it had not been completed for any of the three cases.

**Recommendations:**

**We recommend NHVR management ensure case records contained documentation required to support ineligible determinations by:**

- **identifying data and information necessary for monitoring ineligible determinations and associated documentation requirements;**
- **developing, implementing, and refining processes to routinely collect, verify, and monitor compliance data and information;**
- **routinely assessing staff compliance and analyzing information to identify trends and potential issues with compliance;**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed; and**
- **refining training materials to fully align with federal and program requirements and incorporating into training sessions.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As noted in response to Observation No 3, the cases cited in this report were not ineligibility decisions, but closure that were given an incorrect closure code. As noted, this has already been addressed and corrected within the agency and training has been provided to staff to prevent this from happening in the future.*

**LBA Rejoinder:**

**Effective internal controls should ensure that *all* cases with ineligible determinations contain required documentation. That these cases were inaccurately closed does not negate our finding of an internal control weakness.**

**Observation No. 13**

## Ensure Use Of Trial Work Experiences Is Consistent With Federal Requirements

According to federal regulations, trial work experiences were required before applicants could be found too severely disabled to benefit from VR services in terms of an employment outcome. Trial work experiences were used to determine whether there was sufficient evidence an applicant with a severe disability could benefit from services, or whether the applicant's disability was too severe to allow them to benefit. They also provided a source of information for counselors to make eligibility determinations and identify which services a customer needed. However, trial work experiences were not conducted or documented as required and could likely be better used to identify applicants who could have been too severely disabled to benefit from VR services. Increased use of trial work experience would increase compliance with federal requirements and could potentially save applicants and NHVR time and resources.

### Some Cases Closed Because The Customer's Disability Was Too Severe Did Not Contain Required Documentation

Federal regulations required case files to include documentation supporting the need for trial work, the trial work plan, and periodic assessments carried out during trial work. We reviewed unaudited data from NHVR's electronic case management system on all cases closed between July 2015 and June 2019. We found the electronic case management system recorded 89 of 7,951 cases prior to the OOS (one percent) and one case of 1,841 during the OOS as closed because the applicant or customer's disability was determined too severe to benefit from services. Among the 90 cases:

- 87 cases (97 percent) did not document a trial work experience had occurred, and
- three cases (three percent) contained documentation in the case notes of a situational assessment, a service through which NHVR could provide trial work experiences.

Among the three cases with documentation of a situational assessment:

- one case, also included in our file review, included most but not all of the required documents in the hardcopy and electronic case files;
- one case appeared to include all required documentation in the electronic case file; and

- we were unable to verify the compliance of the third case since the required documentation was not included in the electronic case file and we did not review the hardcopy file.

**Lack Of Monitoring May Have Contributed To Noncompliance**

We were unable to identify explicit monitoring of trial work experience requirements during the audit period. NHVR management could have potentially used supervisory review of eligibility determinations for oversight of initial ineligible determinations due to severity of an applicant's disability. But, as we discuss in Observation No. 3, supervisory review was inadequate.

**Incomplete Guidance Contributed To Noncompliance**

NHVR administrative rules, policy, procedures, and training materials provided inadequate guidance on trial work experience processes.

- No Guidance On How To Document That Trial Work Could Not Be Provided – Federal law required trial work be conducted prior to finding a customer ineligible due to the severity of their disability. Two central office managers reported NHVR typically did not conduct trial work experiences, or provided a limited experience, due to employer willingness and the severity of customers' disabilities. Both managers indicated limitations with providing trial work should be explained in the case file. It was unclear whether documenting the reason for not providing a trial work experience was adequate to ensure compliance with federal law, and there was no federal or NHVR guidance to this effect. We did not find relevant case notes in the 87 cases recorded in the case management system as closed because the customer was too severely disabled to benefit from services.
- No Guidance On How To Determine Variety Or Duration – Federal regulations required trial work conducted prior to finding a customer ineligible due to the severity of their disability "must be of sufficient variety and over a sufficient period of time." One central office manager reported the number needed was subjective. However, NHVR provided no guidance to counselors on *how* to determine whether they had provided a sufficient variety of experiences over a sufficient period of time.
- No Guidance On Supervisory Approval – NHVR training materials indicated if a customer needed to participate in multiple situational assessments, a supervisor was required to review the case before services could be authorized. However, there was no guidance on the review process, such as how counselors should request a review, how long review should take once requested, or what was needed for a supervisor to approve the request.
- Unclear Guidance On Trial Work Experiences And Situational Assessments – One central office manager reported NHVR did not conduct trial work experiences and instead used situational assessments, which were a similar service. Policy and some training materials referred solely to "trial work experiences," while other training materials noted situational assessments could be used as trial work experiences.
- Case Management System Not Effectively Used To Identify Cases With Trial Work – The case management system had a standardized and centralized way to document which customers had a trial work experience through the "trial work experiences" data page.

However, counselors did not use this data page to record when situational assessments were used to conduct trial work experiences, which could have hindered NHVR's ability to collect data. To identify cases using trial work experience, management needed to review each case individually.

- No Rules On Requirements Affecting Customers, Vendors, Or Employers – NHVR administrative rules did not incorporate requirements such as the need for the customer to sign and certify the *Trial Work Experiences Plan*; the need for the customer, vendor, and employer to sign the *Situational Assessment Agreement*; or the need for the customer to agree to an extension of time if a trial work experience delayed the eligibility determination or development of an IPE.

**Trial Work Experiences Could Potentially Have Been Used More Broadly**

Federal law permitted the use of trial work experiences *not only* to determine eligibility, but *also* to determine VR needs. NHVR policy required applicants to be assigned to either the SD or MSD categories prior to a trial work experience. During our file review, we identified one case where a situational assessment was conducted after the customer was determined eligible, had been assigned to the SD category, but an IPE had already been developed. The situational assessment, which appeared to be used to identify the customer's VR needs, reportedly identified the customer's strengths and specific difficulties the customer was having, which the counselor noted would be addressed through specific VR services.

NHVR did not have a formal process to identify whether customers could benefit from a trial work experience. The number of serious functional limitations and estimated services could have provided information to the counselor a trial work experience may have been beneficial. For customers with many serious limitations and service needs, a trial work experience could have provided information such as whether a customer required additional services specific to their needs, the employment goal was aligned with their abilities and capabilities, or a customer was too disabled to benefit from services. We identified some customers with a high number of serious functional limitations or estimated services, some of whom may have benefitted from a trial work experience. From 97 cases in our file review, we found:

- 40 cases (41 percent) recorded the customer as having at least four of eight functional limitations;
- 45 cases (46 percent) recorded the customer as needing at least an estimated four of seven services prior to the OOS or eight services during the OOS; and
- 31 cases (32 percent) recorded at least four functional limitations and at least four services needed.

In one of the 31 cases, the customer applied for VR services during the OOS, and was determined eligible and assigned to the MSD category. An IPE was developed six weeks later, with an employment goal of bagging associate because it "matches" the customer's "interests, abilities, and strengths" and was "a good choice" given the customer's "abilities and disability." The counselor completed a comprehensive assessment, indicating the customer would be able to perform the job. NHVR did not conduct a trial work experience for this customer. However,

NHVR received a job development progress report two months later from the vendor working with the customer, which reported:

- it was "unlikely [the customer] could keep the pace of a bagging associate" and expressing concern the customer "could sufficiently fill bags,"
- they would "continue to work to set up scenarios to determine the level of independence [the customer] is able to obtain while on a job site,"
- they had arranged to have the customer work in a retail environment to determine the customer's capabilities, and
- it was unlikely the customer would be able to maintain employment without a job coach, given difficulty completing tasks.

The case remained open at least for a year, with no additional information on progress towards an employment outcome.

**Recommendations:**

**We recommend NHVR obtain guidance from the federal Rehabilitation Services Administration to determine how to ensure compliance with federal requirements to conduct trial work experience when NHVR is unable to find employers willing to provide them.**

**We also recommend NHVR management improve compliance with trial work experience requirements by:**

- **ensuring administrative rules incorporate trial work experience processes and all trial work requirements binding on customers, vendors, and employers;**
- **ensuring administrative rules and guidance in policy, procedures, and training materials is comprehensive and aligns with federal requirements, including improving guidance on when to use trial work experiences;**
- **fully aligning training materials with federal and State program requirements on the use of trial work experiences and incorporating requirements into training sessions; and**
- **developing policies and procedures to ensure cases that will be closed as ineligible due to disability severity contain all required documentation of a trial work experience prior to closure.**

**We also recommend NHVR management improve its monitoring of trial work experiences, including federal and program requirements, by:**

- **identifying data and information necessary for monitoring use of trial work experiences;**
- **developing, implementing, and continually improving processes to routinely collect, monitor, and analyze compliance data and information;**
- **routinely measuring staff compliance and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed.**

**Finally, we recommend NHVR consider whether trial work experience could be expanded to other customers to assess VR service needs, as permitted by federal regulations.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As cited in Observations 3 and 12, the records interpreted in this report as being categorized "ineligible" were, in fact, not. This was a closing code error as previously explained and training has occurred to correct this and that training has been successful.*
2. *Situational Assessments are a type of vocational evaluation conducted to assess work behaviors, interpersonal skills and job-related skill levels for purposes of establishing eligibility or developing the Individualized Employment Plan. Situational assessments may take place in community-based settings, including real life work and transitional employment settings, or in facility-based settings, such as community rehabilitation program facilities. The cases cited by the auditors were situational assessments being used for the purpose of informing the development of the IPE, not as trial work experiences to assess ability to benefit in terms of an employment outcome.*
3. *When Trial Work is needed as a result of an ineligibility decision, a Trial Work Page is used in our case management system and the participant is moved to status App-T to indicate TW. Currently, we have zero cases in App-T. In federal fiscal year 2020, 7 of 1317 closures were closed ineligible which is less than one percent; 0.5%. Ineligibility determinations are very uncommon and the majority, if not all of the cases cited in this report, were not ineligibility decisions, but closures that should have had a different closure code.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The agency is currently working on aligning rules, policies, procedures and regulations and timeline for completion is July 2021*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, effective internal controls should ensure that *all* cases closed because the applicant or customer was too severely disabled to benefit from services contain required documentation upon closure. That these cases were inaccurately closed does not negate our finding of an internal control weakness.**

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## CHAPTER 5: INDIVIDUALIZED PLAN FOR EMPLOYMENT DEVELOPMENT AND SERVICES

An individualized plan for employment (IPE) was a written document prepared on agency forms describing the customer's employment outcome or goal and the services necessary to achieve the chosen goal. Prior to calendar year 2014, federal regulations stipulated the IPE was to be developed and implemented in a "timely manner," leaving discretion to states to determine a standard for timely IPE development. Following the passage of the *Workforce Innovation and Opportunity Act* (WIOA), which became effective in July 2014, state vocational rehabilitation (VR) agencies were required to adopt the standard of developing IPEs within 90 days of an eligibility determination and implement a process to allow an exemption through an extension when necessary. The *Rehabilitation Act of 1973* and regulations incorporated the 90-day standard and exemption in December 2015 and July 2017, respectively. The extension was required to include a specific date for IPE development that was agreed to and signed by the customer and counselor. IPEs were required to include the following mandatory components to be considered federally compliant:

- Employment Outcome – description of the specific employment outcome, chosen by the customer, consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the customer and consistent with the general goal of competitive integrated employment.
- Services – description of the specific VR services needed to achieve the employment outcome.
- Timelines – for the achievement of the employment outcome and initiation of services.
- Service Providers – description of the entity chosen by the customer to provide the services and methods used to procure such services.
- Evaluation Criteria – description of the criteria used to evaluate progress toward achievement of the employment outcome.
- VR Agency Responsibilities – terms, conditions, and information describing the responsibilities of the state VR agency.
- Customer Responsibilities – responsibilities of the individual in relation to participation in paying for costs of services and obtaining comparable benefits.
- Other Entities' Responsibilities – responsibilities of other entities as the result of arrangements made through comparable benefits or services.

Upon development of the IPE, federal law required the customer and qualified counselor to sign the IPE and the customer be provided a copy. Federal law also required the IPE be amended if there were substantive changes in the employment goal, services to be provided, or providers of the services. IPEs and amendments were not effective until they were agreed upon and signed by both the customer and qualified counselor.

The implementation of the order of selection (OOS) in May 2018 substantially affected the number of IPEs being developed. Between July 1, 2015 and May 6, 2018 (prior to the OOS), the New

Hampshire Bureau of Vocational Rehabilitation (NHVR) developed 4,567 IPEs, averaging 134 IPEs per month. Once it entered an OOS, NHVR was required to continue providing services to customers who had an effective IPE and had been receiving services prior to the OOS. Other customers who had been found eligible but did not have an effective IPE were placed on a waitlist until resources were available and NHVR released them from the waitlist, unless the customer's assigned priority category was open for services or the customer obtained a waiver to begin receiving services. NHVR began releasing customers from the waitlist in September 2018 and released 100 to 300 customers from the waitlist at a time. Between May 7, 2018, and June 30, 2019 (during the OOS), NHVR developed 574 IPEs, averaging 44 IPEs per month. By December 2019, NHVR had released all customers, opened all priority categories and no longer had a waitlist. However, as of November 2020, it was still in an OOS.

**IPE Signature Authority And Supervisory Review**

To ensure IPEs and amendments were consistent with federal requirements, NHVR management required counselors to have signature authority to finalize IPEs and amendments. NHVR required supervisory review for counselors without signature authority before IPEs could become effective. Historically, the requirement generally applied to vocational rehabilitation counselor (VRC) Is. NHVR managers reported all or most VRC IIs and VRC IIIs held authority prior to the implementation of an OOS in May 2018. Supervisory review included reviews from regional leaders (RL), VRC IIIs with signature authority, or the Field Services Administrator.

With the implementation of the OOS, all counselors' IPE signature authority was reportedly rescinded. Management reportedly established a process for VRC IIs and VRC IIIs to regain their signature authority, which began in October 2018 on a case-by-case basis. By June 2019, 20 of 32 counselors (63 percent) did not have signature authority, and required supervisory review before IPEs could be considered effective.

We found some cases with case costs exceeding the thresholds established by NHVR for supervisory review did not receive it. Additionally, supervisory reviews did not always detect issues such as missing IPE components including vendors and cost estimates. Finally, we found some IPEs could have benefitted from supervisory review.

**Observation No. 14**

**Improve Supervisory Review Over The IPE Development Process**

NHVR management attempted to ensure compliant and consistent IPE development for each applicant by granting IPE signature authority to some counselors, while requiring supervisory review and approval for counselors without IPE signature authority. Additionally, NHVR required supervisory review if the IPE was estimated to cost above a certain amount. However, NHVR did not have a process to revoke signature authority, the process to restore signature authority to certain counselors was informal and undocumented, controls over signature authority and supervisory review were not comprehensively monitored, review requirements and performance expectations were not clearly communicated, and supervisory review, when it did occur, was inconsistently documented. As a result, some IPEs were noncompliant with federal or NHVR requirements,

processes could have been more efficient, and at least some time spent on supervisory review appeared ineffective.

**Certain IPEs Did Not Receive Required Supervisory Review**

NHVR controlled IPE signature authority through its electronic case management system by allowing only counselors with authority to finalize the "plan" data page when developing IPEs or amendments. Prior to the OOS, most VRC IIs and VRC IIIs appeared to have authority, while VRC Is did not. During the OOS, all counselors' signature authority was rescinded, although authority had been restored to some VRC IIs and VRC IIIs. We were unable to assess decisions made by VRC IIs or VRC IIIs as it pertained to IPE signature authority prior to the OOS, as management did not document which counselors had authority during that time. Regardless of signature authority, any IPE estimated to cost over $10,000 required review from a supervisor and any IPE estimated to cost over $20,000 required review from the Director or designee. However, supervisory review was inconsistently documented.

Our file review of 97 case records contained 178 IPEs and amendments developed during the audit period and found instances in which signature authority and IPE thresholds did not always serve as an effective control over IPE and amendment development. Some counselors who, according to NHVR's records did not have signature authority at the time, finalized IPEs or amendments rather than receiving final approval from the RL or VRC III with signature authority, effectively bypassing NHVR controls. For example, 13 of the 178 IPEs and amendments (seven percent) were finalized by counselors who did not have signature authority at the time. We also found 17 of the IPEs (ten percent) exceeded thresholds for supervisory review, but either did not receive a supervisory review or did not receive the appropriate level of supervisory review. The number of IPEs which exceeded thresholds and did not receive supervisory review was likely higher due to counselors inconsistently including and updating estimates for services in the case management system and varied practices for developing multiple IPEs. Ineffectively implemented controls introduced the potential that inconsistent or noncompliant IPEs and amendments could be approved and finalized by counselors without authority.

**Supervisory Review Did Not Always Identify Noncompliance With IPEs**

When supervisory reviews occurred, supervisors did not always identify or address noncompliance with IPEs or amendments. Of the 178 IPEs and amendments we reviewed, 88 (49 percent) received supervisory review. However, 62 of those IPEs and amendments (70 percent) contained issues which were not addressed even though supervisory review occurred. In addition to supervisory reviews inconsistently occurring, we found noncompliance with federal IPE requirements.

- Descriptions of the entity chosen by the customer to provide services and the methods to procure services were missing, as we discuss in Observation No. 20. Instead, the providers were listed as "to be determined" and did not appear to be updated through amendments once the provider was determined.
- Criteria listed on IPEs were missing, did not provide measurable standards to assess progress toward the employment goal, or did not reflect the current status of the customer's progress, as we discuss in Observation No. 27. Missing or limited criteria would have

hindered a counselor's ability to effectively evaluate progress toward achievement of the employment outcome.

- Hardcopies were missing from some case records creating an incomplete record of services, as we discuss in Observation No. 46. Missing records hindered NHVR's ability to determine compliance with requirements such as stipulating the customer and counselor must sign the IPE or amendment before changes were effective.
- IPEs and amendments did not contain a customer signature or contained an inauthentic customer signature, as we discuss in Observation No. 19. Other IPEs and amendments had discrepancies in services listed in the hardcopy and electronic copy in the case management system and did not have a corresponding customer signature to indicate agreement to those changes, as we discuss in Observation No. 46.
- IPEs were required to contain the timeline necessary to achieve the employment outcome; however, one amendment specified service provision dates which extended beyond the timeline contained in the IPE.
- Services were already rendered to some customers prior to the creation of certain amendments, as we discuss in Observation No. 19. This was contrary to requirements stipulating the IPE contain all services needed to achieve the employment outcome with the agreement and signature of the customer and counselor prior to rendering those services.
- Other services that were rendered were either deleted through subsequent amendments, as we discuss in Observations No. 16 and No. 22, or not included on the IPE if provided through a comparable benefit as we discuss in Observation No. 23. Omitting services required to achieve the employment outcome created an inaccurate record of services.

Although not a federal requirement, other issues were identified but did not appear to be addressed, indicating supervisory reviews were not always thorough. For example, one customer who was a college student was missing the required *Financial Aid Transmittal Form*, but the IPE with college tuition was approved by the supervisor without any documentation of follow up. In another case, mileage was included on an IPE with an estimate of $60,000, which could reasonably be concluded the estimate was provided in error. However, even though the amount estimated on the first IPE in the audit period would have required supervisory review and approval, the IPE did not receive review. Additionally, although the IPE received subsequent supervisory review through six other changes to the IPE, the error remained unaddressed. We found similar deficiencies relating to federal requirements and general inconsistency within 59 of the 90 IPEs and amendments (66 percent) that did not receive a supervisory review. Considering the similar deficiencies we identified in IPEs which received supervisory review and those that did not, the overall effectiveness of reviews being conducted was questionable.

**Recommendations:**

**We recommend NHVR management improve the IPE supervisory review and approval processes by:**

- **tracking which counselors have signature authority and when signature authority is rescinded or restored;**
- **assigning appropriate signature authority and supervisory review responsibility to counselors, supervisors, and managers;**
- **developing a process to monitor whether those without signature authority are approving IPEs;**
- **developing, implementing, and refining written requirements for supervisory review of IPEs and amendments;**
- **developing procedures to ensure counselors timely and accurately address issues identified during supervisory reviews; and**
- **routinely assessing effectiveness of NHVR controls with signature authority and supervisory review requirements, analyzing information to identify trends and potential issues, and remediating deficiencies identified.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As the audit report indicates, "Prior to the OOS, most VRC IIs and VRC IIIs appeared to have authority, while VRC Is did not." Only counselors with a Master's level, or equivalent, are allowed signature authority. VRC Is come into the bureau with a Bachelor's degree and agree to attain the Master's degree. It is appropriate that they do not have signature authority, as they are not considered a "qualified professional" without the Master's degree.*
2. *As a management strategy, at the initiation of the Order of Selection, the agency did temporarily withdraw IPE signature rights for RCIIs. The agency did not withdraw signature rights from the RCIIIs. RCIIIs would have needed these rights to fulfill their duties as support and back up to supervisory staff.*
3. *The electronic case management system is designed such that only individuals with signatory rights to do so can approve the plan in the system. Individuals, other than those given signature authority, cannot finalize or approve eligibility determinations. Signature authority is identified in the case management system. As the system is designed, those without authority would be unable to make and approve these determinations. At any time in the system, the agency can determine who has appropriate authority to complete the eligibility process. While the agency did not keep historical record or changes, an individual without rights would not have been able to perform the action within the case management system.*
4. *Rather than repeat areas of disagreement identified in other observation areas listed within this observation, the specific continuing areas of disagreement are identified under the specific observation noted (e.g., observations 16, 19, 20, 22, 23, 27 and 43).*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *As identified in the agency response in observation no. 3, in January 2020, NHVR began to track signatory authority start and end dates, so that a list of staff who has that authority within a given time frame could be provided to the auditors in the future, if necessary. The agency will review this process and assess need for additional processes or changes to develop a more formalized process to track signature authority status of each counselor beyond what occurs now which is communication between Regional Leaders and the Field Service Administrator regarding recommendation for changes in signature authority after a promotion or performance concern. Target date for the assessment and identification of any additional actions: June 2021. This work will be done in conjunction with the additional supervisory review observations (observation no. 15 and observation no. 16).*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**NHVR notes in Remark 2, that it did not withdraw signature rights from VRC IIIs as they "would have needed these rights to fulfill their duties as support and back up to supervisory staff." We did not find documentation that VRC IIIs should have retained signature authority following implementation of the OOS and this understanding was not documented. Additionally, we were unable to confirm this process, as it contradicted information previously reported by NHVR managers, RLs, and counselors who reported that signature authority was rescinded for *all* counselors immediately following the implementation of the OOS. This was supported by documentation provided by NHVR in September 2019 showing when each counselor's authority, including VRC IIIs, was restored. Additionally, we question the effectiveness of an internal control that purportedly permitted counselors who were unable to approve *their own* IPEs to review and approve the IPEs of other counselors.**

**In reference to Remark 3, NHVR's internal controls did not always function as intended, which is why we recommend NHVR monitor compliance with signature authority requirements. NHVR acknowledges it did not keep track of signature authority for counselors. Additionally, there was no formal process for management to determine when and how signature authority should be restored for a counselor. Without these formal processes, NHVR management could not verify internal controls were working as designed nor could it ensure signature authority was provided appropriately to counselors. We also note while the electronic case management system was designed to only allow individuals with signature authority to finalize decisions, documentation provided by NHVR in September 2019 showed counselors, that NHVR identified as not having signature authority, were able to finalize decisions.**

### Estimating IPE Costs

As an internal control intended to help monitor costs, NHVR required supervisory review from an RL or a VRC III with signature authority for any IPE estimated to cost $10,000 or more, and review from the Director or Field Services Administrator for IPEs estimated to cost $20,000 or more. NHVR used its electronic case management system to implement this control by prohibiting VRC Is and VRC IIs from completing the "plan" data page for any IPE reaching the $10,000 threshold. Similarly, it prohibited RLs and all counselors from completing the data page if the IPE reached the $20,000 threshold. After NHVR implemented an OOS, it added an additional level of review by requiring the Commissioner approve IPEs estimated to cost $50,000 or more.

For the case management system to trigger these thresholds, the "plan" data page contained a field for counselors to record the estimated cost for each service on the IPE. The case management system used the estimated cost counselors entered for each service to calculate the total estimated IPE cost. If the total IPE cost was estimated to be above the threshold, the case management system triggered supervisory review by prohibiting the counselor from completing the "plan" data page.

Estimated case costs were also used to help NHVR and Department of Education management monitor regional office spending. NHVR required regional offices to compile projections based on each customers' anticipated needs for the upcoming quarter. Counselors calculated the cost for services that they expected would be provided to each customer on their caseload based on the costs estimated for individual services on their IPE. Each counselor's quarterly projection for their caseload was reviewed by the regional leader, combined with the other counselors' projections, and sent to the central office where a quarterly budget was created for each regional office. Central office staff tracked regional office spending and produced weekly reports for the NHVR Director, Field Services Administrator, and Commissioner. NHVR management identified overspending on client services as one of the reasons it needed to implement an OOS.

### Observation No. 15

## Expand The Use Of Supervisory Review For Certain Cases

Management is responsible for monitoring activities to ensure its objectives are achieved efficiently and effectively. Adequate monitoring ensures customers are progressing appropriately and achieve employment outcomes sooner, while at the same time, safeguarding limited financial resources. However, NHVR had no process to identify other cases for review which may not have met its monetary threshold but could have benefited from additional scrutiny. These included cases where the actual cost far exceeded the estimated costs in the most updated IPE, cases which had been open for long periods of time, or cases with significant gaps in communication.

### Actual Costs Exceeding Estimates By As Much As Double Were Not Flagged For Review

IPEs included services a customer would need to meet their established employment goal, as well as how much the service was estimated to cost. The total estimated cost for an IPE triggered the supervisory threshold in the case management system. The case management system prevented a VRC I or VRC II from approving an IPE estimated to cost $10,000 or more. Similarly, it prevented

anyone except the Director or the Field Services Administrator from approving an IPE estimated to cost $20,000 or more. According to NHVR personnel, costs included in the IPE were purely estimates and it was typical for actual costs to exceed the estimates. However, NHVR did not have a process to monitor how much actual costs exceeded IPE estimates or to flag those exceeding their estimates by a predetermined margin.

It was common for a new IPE to be developed if a customer changed their employment goal or the IPE was due to expire. These new IPEs replaced prior IPEs in their entirety in the case management system, as we discuss in Observation No. 20. The case management system did not automatically add the estimated cost of services from prior IPEs to the most recent IPE and instead, used the cost estimates from the most recent IPE to trigger the supervisory review threshold. In our review of 97 cases, we found 13 exceeded the most recent IPE estimate by at least two times. Of these thirteen, nine cases exceeded their estimate by five times, and three cases exceeded it by more than 20 times. For example:

- In one case, the most recent estimate on the IPE was $7,300 but the actual cost of the case exceeded $188,000, more than 25 times the original estimate. This case included $106,000 in vehicle modification and consultation costs which were not included in the IPE.
- In another case, the only IPE in the file estimated services to cost $3,050; however, the actual cost of the case exceeded $106,000, more than 30 times the original estimate. This included a vehicle modification and consultations which were each estimated in the IPE to cost $0; the modification and consultations cost almost $104,000.

**Lengthy Cases Were Not Consistently Reviewed**

Federal regulations required VR agencies to assess an individual's progress towards achieving their employment goal. NHVR did not have policies, procedures, or other guidance addressing supervision over lengthy cases. Existing controls in the case management system used the cost estimates from the most recent IPE to trigger the supervisory review threshold, which would not have flagged all lengthy cases for supervisory review. Between State fiscal years (SFY) 2017 and 2019, NHVR closed 7,581 cases. On average, a case remained open for 1.8 years before being closed. However, we found 518 cases (seven percent) were open for at least five years before closure, more than two times the overall average.

We note it may be reasonable for some cases to be open for longer periods of time; however, NHVR management did not have a process to identify these cases to determine whether they were progressing towards an employment goal. While RLs reported regularly meeting with counselors to review their caseload, there was no guidance regarding the types of issues to look for, and at what point a case could require more in-depth supervisory or Director review. Customers' rehabilitation outcomes were delayed if cases were not progressing towards an employment goal.

***Some Cases Were Open For More Than Ten Years***

Of the almost 7,600 cases closed at some point during the audit period, we found 69 cases (one percent) were open for more than ten years before closure. On average, these cases were open for 12.5 years from application to case closure, with nine cases open for at least 15 years, and one

open for more than 20 years. While it may be reasonable for some cases to be open for ten years or more, NHVR did not have a process to identify these cases for review. While this was a very small percentage of NHVR's caseload, these cases were costly, and many did not achieve an employment outcome.

- High Average Case Costs – On average, these 69 cases cost approximately $27,000, with three cases exceeding $100,000, and one case costing almost $220,000. In contrast, the average cost of active cases during the audit period was $2,848.
- Most Cases Taking Over Ten Years Were Closed As Non-rehabilitated – We found 47 of the 69 cases (68 percent) were ultimately closed as non-rehabilitated (i.e., for a reason other than rehabilitation). In 15 cases, NHVR noted the customer either refused services, did not require VR services, or was too disabled to benefit from services. Additional supervisory review may have helped identify these issues earlier so other options could have been explored.
- Some Cases Still Open After Ten Years – We found an additional 27 cases open before July 1, 2009, were still open as of July 1, 2019. On average, these cases had been open for 12.6 years, and had cost an average of $37,700 per case, with four cases already exceeding $100,000 by July 1, 2019. Four of the 27 cases had been open for at least 15 years and two had been open for at least 20 years

***Annual Reviews Not Always Conducted As Required***

Federal regulations and NHVR rules required the IPE be reviewed at least annually by a qualified counselor and the customer to assess progress towards achieving the employment outcome identified in the IPE. However, we found annual IPE reviews did not always occur as required. Our review showed 39 cases were open for at least one year after the initial IPE was developed, essentially requiring at least one annual review. Of these, 33 (85 percent) were missing at least one annual review signed by both the counselor and the customer, and 29 (74 percent) were missing multiple annual reviews. One case was open for 17 years after the initial IPE was developed, but there was only evidence of one annual review in the file.

Annual reviews were generally the responsibility of the counselor assigned to the case, not someone removed from daily case processing. While the counselors may have been the most knowledgeable about the case and the customer's circumstances, a reviewer, external to the case, may have been able to more objectively determine whether customers were progressing appropriately or whether other action should be taken.

**Some Cases Experienced Significant Gaps In Communication**

NHVR generated a weekly case monitoring report identifying cases where there had not been a case note in the case management system for 90 days or more. However, these reports were not always monitored or followed up on and some cases appeared on the report for several weeks without resolution.

Of the 97 cases we reviewed, 16 (16 percent) had gaps in communication between the counselor and customer of one year or more, with eight cases having gaps of two or more years, and two cases having gaps of four years or more. Four cases (four percent) experienced multiple communication gaps of one year or more.

**Recommendations:**

**We recommend NHVR management improve oversight by establishing:**

- **a process to compare actual costs against IPE estimates;**
- **margins for which actual costs may reasonably deviate from IPE estimates and a process to identify and review cases that fall outside of these limits;**
- **thresholds for when lengthy cases should be automatically flagged for review by a supervisor or other NHVR management and a process to identify and review cases reaching these thresholds;**
- **a process to identify cases which have had little activity or gaps in communication between the counselor and the customer; and**
- **a process to ensure issues identified are addressed and rectified timely.**

**NHVR should also consider the level of review that should be conducted for these cases, what reviewers should consider, when a review should be triggered, how it should be documented, and whether reviews should be conducted by supervisors or staff other than the person responsible for the daily case processing.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR has a central disagreement about how the auditors describe the use of the IPE and the actual use of the IPE. The audit team continually represents amendments to the plan inaccurately as used by the bureau. The narrative in the observation states that 'These new IPEs replaced prior IPEs in their entirety." This is expanded upon further in observation 20, however this is not how the IPE process works. The initial IPE is the IPE that is amended, as needed, throughout the life of the case. There are two ways to amend a plan a) through a plan amendment – this feature allows for changes made to services or b) through the data page titled 'New Plan' – this allows for changes to any and all parts of the plan including services. Plan costs would encompass from initial plan through any amendments made to the plan. The Amendment, or a 'New Plan' page would cover the time from that amendment forward. There is no requirement for including past services in current amendments to the plan.*
2. *The IPE is part of the electronic case management system used by NHVR, along with over 35 VR agencies across the nation. Costs are not cumulative and there is no benefit to the Bureau or services to participants to include this action, the bureau does not use this estimated cost for any internal bureau planning or actions. Specific case expenses such as van modifications would be and are reviewed through other processes.*

3. *Estimated case costs on the IPE are not used to help NHVR management monitor regional office spending. The quarterly projections identified in this report are not derived from the system IPE. These projections are developed based on the services anticipated to occur during the quarter and the costs anticipated to be needed for those services. Each counselor completes this activity using costs known or anticipated for the quarter and not the estimate at the time of plan development.*
4. *NHVR services are individualized and related to the participant's needs and their employment goal. While the percentage is low (7%), some cases require longer plans in order to accomplish their goals.*
    - *An individual who was in high school and planned on attending college as part of their plan may well have a plan that was 6 or more years in length.*
    - *A participant who was planning on attending a 4 year program would be expected to take 4 years in training and then may need additional time to find and settle into a job (with making sure they were stable on the job and then monitoring their stability for a minimum of 90 days – 5 years is an average for this type of case).*
    - *If the individual was not able to attend college full time that would extend the length of time that an individual needed to complete a plan for employment.*
    - *As acknowledged in the above, depending on the participant's individual needs it may be reasonable for a case to be open for 10+ years (as occurs in 1% of the caseload). These are typically individuals with more significant issues and needs and it may take time and some different strategies to see if there are services that can help them achieve an employment outcome. As they are individuals with more significant needs, there may be more barriers in their way to success and therefore the higher percentage of non-successful of this small group. One of the examples provided in the report was a customer who in the course of working with VR experienced several life changing experiences in addition to their disabilities that necessitated delays in progress including the birth of two children and the death of their spouse.*
5. *The bureau encourages customers to pursue credentials and career pathways which would potentially increase the number of individuals taking longer to complete a plan for employment. Assisting customers to achieve credentials is one of the focuses identified in the most recent amendment to the Rehabilitation Act.*
6. *The bureau does not agree that processes are required for comparing actual costs to IPE amendments as this is not information the bureau uses in budgeting or planning, and the bureau does not currently have capacity to add peripheral information reports as part of routine business.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR has begun to review policy and procedures and will, as part of that effort, review supervisory review processes in light of the audit observations (observations no.14, 15 and 16). Through this work the bureau will identify categories of cases that may need to be identified for additional review activity. The bureau will also explore including supervisory review as part of the developing quality assurance efforts.*

- *The bureau released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In Remark 1, NHVR contends "The initial IPE is the IPE that is amended, as needed, throughout the life of the case…. Plan costs would encompass from initial plan through any amendments made to the plan." However, NHVR's Remark 2 states that "costs are not cumulative…" Regardless, the electronic case management system did not contain a field to calculate the total estimated case costs, as NHVR contends. The only place where total estimated case costs can be found is on the IPE document itself. The electronic case management system treated the total estimated costs of the IPE differently depending on the method used to amend it. When adding a new service to an IPE, counselors had three options.**

- **Using the "plan amendment" feature – requires the counselor to open an existing plan. This feature adds the new service to the corresponding IPE. When the IPE is reviewed in the case management system or printed, the estimated costs associated with new or deleted services are added to the "estimated plan costs" section in the IPE document.**
- **Using the "new plan" feature to add only new services – does not require the counselor to open an existing IPE. This feature creates a stand-alone IPE. When the IPE is reviewed in the case management system or printed, the "estimated plan costs" section only reflects the cost of the services included in this stand-alone IPE. This feature does not automatically calculate the total estimated costs of the "initial IPE through any amendments made to the plan." To determine the total estimated case costs, counselors would need to *manually* calculate the costs using all IPEs included in the customer's case. For cases which contained multiple IPEs, auditors had to manually calculate the total estimated costs for the majority of plans we reviewed.**
- **Creating a new plan using the "clone plan" feature – requires the counselor to open an existing IPE. Creates a stand-alone IPE; however, by cloning the plan, all services that were part of the pervious IPE are copied onto the new version. When the IPE is reviewed in the case management system or printed, the estimated costs associated with new or deleted services are added to the "estimated plan costs" section.**

**In Remark 2, NHVR states it "does not use this estimated cost for any internal bureau planning or actions." However, during a conversation on July 12, 2019 the person responsible for programming the case management system stated it was programmed to trigger supervisory review if the *estimated* cost of the IPE exceeded the established thresholds. The NHVR Director was present for this conversation and the auditor confirmed this statement twice during the conversation. NHVR's *Operational Manual* incorporated these thresholds by allowing counselors to approve their own IPEs if the "total cost of the plan" are below specific thresholds. The NHVR Director, the previous Field Services Administrator, the Policy Administrator, three RLs, and three counselors we interviewed**

**also corroborated the thresholds are triggered based on the estimated case costs. If NHVR contends that estimated case costs are not used for any internal actions, then programming the case management system to require supervisory review of cases estimated to cost above a certain threshold, which NHVR reported is its primary control to monitor case costs, is essentially ineffective.**

**In Remark 3, NHVR contends "estimate case costs on the IPE are not used to help NHVR management monitor regional office spending." This statement is contradicted by personnel we interviewed. The previous Field Services Administrator and the Policy Administrator stated RLs were required to projected how much their regional office would spend each month on customers. Based on each regional office's estimate, the central office allocated budgets to each regional office. Central office staff tracked regional office spending against these budgets and produced weekly reports for the NHVR Director, Field Services Administrator, and Commissioner. RLs we interviewed reported counselors estimated these costs by reviewing each customer on their caseload and, based on the services listed on their IPEs, estimating the cost of services their customers would need in the upcoming quarter. When NHVR first implemented the OOS, these budget projections were developed monthly, but eventually transitioned to a quarterly basis.**

**In reference to Remark 4, the report states, "We note it may be reasonable for some cases to be open for longer periods of time…." While it may be appropriate for customers attending college to remain open for a long time, NHVR did not have a process to determine whether this was the circumstance for all customers, or whether other services could have been provided to help the customer obtain an employment outcome sooner.**

**Observation No. 16**

**Ensure Internal Controls Over Supervisory Review Thresholds Are Operating As Designed**

Some IPEs did not include reasonable cost estimates, potentially allowing them to be excluded from review requirements which were designed to ensure accountability over case costs. According to NHVR management, the review thresholds of $10,000 and $20,000 applied to the cumulative estimated costs over the life of the case. As part of this process, NHVR required IPEs to include a cost estimate for all services. The electronic case management system was designed to flag for review IPEs meeting or exceeding these thresholds. However, we found:

- some IPEs did not contain cost estimates for all services, including those provided by vendors;
- costs in previous IPEs may not have been included in subsequent IPEs, potentially allowing them to be excluded from the total estimated cost when cases were flagged for review; and
- some services that had already been provided and paid for were not included in subsequent IPEs, excluding their costs from the total estimated cost of the case.

**Some IPEs Did Not Contain A Cost Estimate For Vendor-provided Services**

We found IPEs sometimes contained services intended to be provided by vendors that were estimated to cost $0. It was reasonable for NHVR-provided services, such as guidance and counseling and sometimes job development or job placement services, to contain a cost estimate of $0. However, it did not appear reasonable that a service intended to be provided by a vendor would contain an estimated cost of $0.

Of 88 customers we reviewed who had an IPE developed, 42 customers (48 percent) had at least one vendor-provided service estimated to cost $0 in their IPE. NHVR paid vendors almost $130,000 for 22 customers who had at least one service estimated to cost $0 on their IPE. Some customers had multiple services paid for that were estimated to cost $0, including:

- over $102,500 in vehicle modification related expenses for three customers;
- over $6,200 in tuition and training related expenses for four customers;
- almost $4,000 in disability-related skills training for three customers;
- over $3,300 in assistive technology equipment and related expenses for three customers;
- over $3,000 in community rehabilitation program (CRP) job search and job development services for five customers; and
- over $10,500 in other services including driver education, clothing, eye wear, assessments and analyses, transportation, and software for 15 customers.

On average, individual customers had almost $5,900 in services paid for that were estimated to cost $0 in their IPEs. Individual customers received services ranging between $125 and $103,000, with ten customers receiving over $1,000 in services that were estimated in their IPEs to cost $0. One case we reviewed had an estimated IPE cost of $3,050. However, the IPE contained the following services, all with estimated costs of $0: vehicle modification, vehicle modification consultation, job development package, barrier intervention, assistive technology equipment, assistive technology assessment, and benefits analysis. As of January 2020, NHVR paid over $106,000 for this customer.

Cost estimates were used to trigger thresholds for supervisory review. The case management system calculated the total estimated cost of the IPE using the amounts entered for each service. When an estimate was entered as $0, these costs were not included in the total estimated case cost, potentially allowing some cases to be excluded from supervisory review. Of the 22 cases where the IPE contained $0 cost estimates, 12 cases (55 percent) had actual payments totaling over $10,000, including 11 cases which had actual payments totaling over $20,000.

**Some Cases With Multiple IPEs Could Be Excluded From Review**

According to NHVR staff, new IPEs were developed if the customer changed their employment goal, or if the end date of the plan needed to be extended because the customer needed additional time to complete services. New IPEs could be created in two ways: by copying the existing IPE to retain the previous IPE's services then modifying the needed fields, or by creating an entirely new IPE with new services. NHVR management did not have guidance for which was the preferred method.

When an entirely new IPE was created, the case management system did not automatically add the estimated cost of services of the new IPE to estimated costs of previous IPEs. Therefore, the case management system triggered supervisory review based on the cost of each *individual* IPE and its associated amendments, not the cumulative estimated costs across all IPEs. Consequently, if multiple IPEs were developed for one customer, each with estimated costs of less than $10,000, review by an RL would not occur even if cumulatively, unduplicated estimated costs across all IPEs exceeded the threshold. Similarly, if each individual IPE had estimated costs of less than $20,000, review by the Director or designee would not occur. The estimated cost of each individual IPE was calculated and displayed on the last page of the IPE; however, the case management system did not have any data fields or page layouts to track the cumulative estimated costs for the entire case.

Table 8 shows six cases from our file review which illustrate how cases may not be flagged for review when multiple IPEs, each under the review thresholds, were developed. The first case in the table shows a customer with two IPEs which NHVR estimated would $6,900 and $7,300, respectively. Individually, these IPEs did not meet the threshold for required review. However, when unduplicated costs from each IPE were added together and services estimated to cost $0 were considered, the estimated cost for this case was approximately $16,000 and should have been triggered for review. NHVR spent over $188,000 on the case, and we did not find evidence in the case record of any supervisory review. Only one of the six cases (17 percent) contained evidence of review, but the case was assigned to a VRC I who would have required supervisory review anyway. The remaining five cases, all assigned to VRC IIs or VRC IIIs, did not contain evidence of supervisory review.

**Table 8**

**Cases With Multiple IPEs Each Under Supervisory Review Thresholds**

| Case | Number Of IPEs Developed | Estimated Cost Of Each IPE (Range) | Unduplicated Estimated Costs | Payments[1] | RL Review[2] | Director Review[3] |
|---|---|---|---|---|---|---|
| 1 | 2 | $6,900 - $7,300 | $16,000 | $188,050 | No | N/A |
| 2 | 3 | $1,000 - $7,650 | $12,250 | $10,300 | No | N/A |
| 3 | 4 | $2,150 - $4,200 | $12,400 | $7,000 | No | N/A |
| 4 | 4 | $2,700 - $4,250 | $11,200 | $9,593 | Yes | N/A |
| 5 | 3 | $9,000 - $19,900 | $24,500 | $96,500 | No | No |
| 6 | 5 | $450 - $10,400 | $21,600 | $17,300 | No | No |

Notes:
[1] As of January 2020.
[2] RL or authorized VRC III review is required for cases estimated to cost $10,000 or more.
[3] Director or designee review is required for cases estimated to cost $20,000 or more.

Source: LBA analysis of information from NHVR's case management system.

**New IPEs Did Not Include Services Already Paid Through Previous IPEs**

Some services were deleted from IPEs even though they had already been paid for, while in other cases, subsequent IPEs did not include costs for services that had been paid for under previous IPEs. Excluding services and their associated costs that NHVR had already been paid out on behalf of a customer skewed the total estimated case costs and may have allowed some IPEs to be excluded from review. Specifically, we found:

- Some Services NHVR Paid For Were Deleted From IPEs – One customer received over $24,000 in tuition and computer hardware, while another customer was provided $1,300 in CRP and driver evaluation services. However, these services were eventually deleted from their IPEs, potentially allowing the IPEs to be excluded from the review thresholds.
- Some Services NHVR Paid For Were Not Included In Subsequent IPEs – We found two cases in which subsequent IPEs excluded services that had already been paid for under a previous IPE. In one case, the customer's first IPE included estimated costs for an evaluation and benefits counseling. NHVR paid $2,500 for these services; however, the second IPE developed excluded these costs. In another instance, NHVR paid over $800 for various services that were not included in a subsequent IPE.

**Recommendations:**

**We recommend NHVR management assess its current practices to ensure reasonable cost estimates are captured for each case and ensure all cases meeting cost estimate thresholds are flagged for required review. As part of this assessment, NHVR management should:**

- **determine whether the case management system can accurately calculate and track cumulative cost estimates for each case when multiple IPEs are developed;**
- **ensure the case management system appropriately flags for review all cases with cumulative estimated costs meeting the thresholds;**
- **ensure all services intended to be provided by a vendor have reasonable cost estimates, develop a method to identify vendor-provided services that have been put into an IPE with an estimated cost of $0, and ensure these cost estimates are corrected prior to an IPE being approved;**
- **develop guidance on how new IPEs should be handled, including when it is appropriate for cost estimates from previous IPEs to be included in current IPEs; and**
- **ensure services already paid for under previous IPEs are retained as part of the cumulative cost estimate for the case.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As noted in the previous observation, NHVR disagrees with the auditor's characterization of the use of the IPE. The IPE is an ongoing document, the most recent amendment of the*

*plan is what the participant and counselor are currently working on. Previous services that have been completed do not need to be carried forward on the document being used for current active services. While costs are included routinely in plan development, costs on the plans are estimates as actual cost may not be known when the plan is written. The bureau does not use this estimate in financial planning or other fiscal procedures.*

2. *Services are not deleted from the IPE record and the case costs are retained in the system. The latest amendment to the IPE shows the services that are current.*
3. *The IPE is part of the electronic case management system used by NHVR, along with over 35 VR agencies across the nation. Costs are not cumulative and there is not benefit to that Bureau or services to participants to include this action, the bureau does not use this estimated cost for any internal bureau planning or actions.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau acknowledges that $0 cost estimates may have been overused in IPE development and that additional procedural guidance is needed to assure consistency across the bureau in entering cost estimates on plans.*
- *NHVR has begun to review policy and procedures and will, as part of that effort, review supervisory review processes in light of the audit observations (observations no.14, 15 and 16). Through this work the bureau will examine the use of the IPE, including entering costs estimates on the initial IPE and subsequent amendments. The bureau will also explore including supervisory review on the IPE as part of the developing quality assurance efforts.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**As noted in the rejoinder to Observation No. 15, NHVR staff reported estimated case costs are used to trigger supervisory review thresholds. These thresholds are programmed into the case management system. If NHVR contends that estimated case costs are not used for any internal actions, then programming the case management system to require supervisory review of cases estimated to cost above a certain threshold, which NHVR reported is its primary control to monitor case costs, is essentially ineffective.**

**Timeliness Of IPE Development**

Dating back to July 2001, federal law and regulations required VR agencies to develop standards to ensure "timely" and "prompt" development and implementation of IPEs. NHVR management implemented a standard to develop IPEs within 120 days of eligibility determination, which was reported in the *VR Portion Of WIOA State Plan For The State Of New Hampshire* (*State Plan*) at least as early as October 2011. In January 2014, WIOA introduced a revised requirement that IPEs

be developed "as soon as possible, but not later than… 90 days after" an eligibility determination. The 90-day time limit was incorporated in federal law in December 2015 and federal regulations in July 2017. A central office manager noted NHVR "officially implemented the 90 day requirement when required," but reported NHVR began proactively updating practices and training ahead of formal federal adoption, around July 2015. By October 2015, management reported staff were working towards the revised standard and had begun monitoring cases to meet the 90-day time limit.

An IPE was in compliance with federal laws and regulations if it was developed within the applicable time limit; agreed to, signed, and dated by the customer; and approved, signed, and dated by a qualified counselor. Federal reporting requirements further clarified that the "IPE is effective on the date on which both the [qualified counselor] and [customer] reach agreement, as indicated by the signatures and dates on the IPE. If the two signatures bear different dates, the later date should be considered the effective date of the IPE."

Beginning in December 2015, federal law permitted one exemption from the 90-day time limit, if NHVR and the customer agreed to a specific extension of time. Prior to the OOS, 1,277 of 4,567 cases with initial IPEs developed had extensions (28 percent). During the OOS, 127 of 574 cases with initial IPEs developed had extensions (22 percent).

We found IPEs were not always completed within the time limits specified for their development. However, we found unaudited data on effective IPE dates from NHVR's case management system was not reliable. We were unable to verify overall compliance with the 90-day time limit, or timeliness of IPE development generally since NHVR IPE data inflated compliance rates, although we were unable to determine by how much. Data accuracy was affected by issues including invalid IPEs that were not signed by the customer and a qualified counselor as required by federal regulations, backdating of effective IPE dates, some IPEs were not developed by the time an extension expired, and some IPE extensions were invalid or questionable. Supervisory review did not always detect these deficiencies.

Inaccurate data showing a higher compliance rate could have affected decision-making by NHVR management such as by making the improvement of controls over compliance rates a lower priority. Additionally, inaccurate data would have affected the accuracy of compliance rates reported to the Rehabilitation Services Administration, NHVR's federal oversight agency by making NHVR appear more compliant than it was with the 90-day time limit.

**Observation No. 17**

**Improve Timeliness Of IPE Development And Address Compromised Data**

Timeliness requirements for IPE development focused on timely customer movement from eligibility to service provision. However, historical concerns with timeliness remained through our current audit, even though management reported implementing more stringent controls during the OOS. Additionally, staff routinely backdated IPEs, which compromised data used for decision-making and made some IPEs appear compliant with the federal time limit.

**Timeliness Concerns Remained Unresolved**

Noncompliance with IPE timeliness requirements dated back at least a decade. The 2010 federal Rehabilitation Services Administration monitoring report found NHVR noncompliant because management had not developed a policy on NHVR's standard for IPE development. The lack of a policy reportedly contributed to confusion among staff, who had "varying perceptions of the agency's standard for developing an IPE." The Rehabilitation Services Administration required NHVR to take necessary steps to establish standards for prompt IPE development. However, NHVR management never documented the 120-day standard through rules or policy.

The 2016 *Single Audit Of Federal Financial Assistance Programs* identified three of 40 cases (eight percent) which were not developed within the federal 90-day time limit. Additionally, the 2017 single audit identified five of 40 cases (13 percent) were not developed within the time limit. The single audits recommended NHVR management establish controls and procedures to better monitor IPE completion, including identifying cases close to the time limit and identifying and correcting noncompliance. NHVR management concurred, reported it had expanded training, and indicated policies and procedures needed to be updated. However, we found noncompliance with the time limit and noncomprehensive policies and procedures remained through at least June 2019.

**Some IPEs Were Not Developed Within Time Limits**

To assess compliance and timeliness, we reviewed unaudited data from NHVR's electronic case management system on IPEs developed between December 2015 and June 2019, to account for differences in requirements and practice. We found some IPE development dates appeared inaccurate due to NHVR's use of backdating, and some IPEs were ineffective as they were not signed by both the customer and a qualified counselor. Accordingly, we qualify our use of, and our conclusions resting upon, NHVR effective IPE dates.

IPE development was inefficient at times, resulting in longer wait times for some customers before obtaining VR services. We also found NHVR had no guidance on supervisory review of IPEs, including when a counselor should request supervisory review, or how many days a supervisor should take to review and approve an IPE, to ensure adequate review and time limit compliance.

***Noncompliance With Federal 90-Day Time Limit***

In July 2014, federal law adopted a time limit that required *all* IPEs be developed "as soon as possible," but no later than 90 days after eligibility. At this time, NHVR was required to implement the 90-day time limit for IPE development. However, NHVR policies, procedures, and training did not define "as soon as possible." Among the 3,916 IPEs developed between December 2015 and May 6, 2018, we found:

- Two-thirds of IPEs (2,622 or 67 percent) were developed within 90 days.
- One hundred IPEs (three percent) were not developed within the 90-day time limit and did not have an extension. These IPEs took, on average, 283 days. One took 3,656 days, or approximately ten years.

- An additional 1,194 IPEs (30 percent) were not developed within 90 days. However, the case management system recorded an extension for these cases.

***IPE Development During OOS***

There was ambiguity between NHVR's IPE development process and federal laws and regulations during the OOS. NHVR implemented the OOS on May 7, 2018, and updated the *NH Vocational Rehabilitation Policy Manual (Policy Manual)* to specify IPEs would be developed within 90 days of the customer's release from the waitlist, if the customer still required NHVR services. This practice did not appear unreasonable; however, neither federal law nor regulations permitted specific exemptions for an OOS. Additionally, neither NHVR administrative rules nor the amended *State Plan* specifically allowed this practice. The only exemption federal laws and regulations permitted was if NHVR and the customer agreed to a specific extension of time.

We conducted two separate analyses on the 574 IPEs developed between May 7, 2018, and June 2019 to account for these differences.

- Federal 90-day Time Limit Relative To Eligibility – Federal law and regulations did not appear to allow a specific exemption for customers on a waitlist during an OOS. Using this criteria, we found 110 IPEs (19 percent) were developed within 90 days, while 337 (59 percent) were not developed within 90 days and did not have an extension, taking 232 days on average. One took as long as 465 days to complete. An additional 127 IPEs (22 percent) were not developed within 90 days; however, the case management system recorded an extension for these cases.
- NHVR's 90-day Standard Relative To Waitlist Release – NHVR's practice allowed counselors to develop an IPE within 90 days after a customer's release from the waitlist. Using this criteria, we found 530 IPEs (92 percent) were developed within 90 days, while three (one percent) were not developed within 90 days and did not have an extension, taking 355 days on average. One took as long as 378 days to develop. An additional 41 IPEs (seven percent) were not developed within 90 days; however, the case management system recorded an extension for these cases.

When NHVR implemented an OOS, all customers who did not have an effective IPE were placed on the waitlist. This included customers who had already started IPE development, but did not yet have an effective IPE. Once these customers were released from the waitlist, NHVR practice reset the time limit, even though some time had already been spent developing an IPE before being placed on the waitlist. By calculating the start of the 90-day time standard from the date the customer was released from the waitlist, NHVR omitted all time between the eligibility determination date and the date a customer was placed onto the waitlist. In some cases, doing so made IPEs appear compliant with the federal 90-day time limit and resulted in a much longer wait time for services.

We reviewed all 529 cases placed on the waitlist and found 84 cases were placed on the waitlist *after* the eligibility date without an extension. This included four cases where more than 90 days had passed between eligibility and the time the customer was placed on the waitlist. In one case, eligibility was determined 91 days before NHVR implemented the OOS and placed the customer

on the waitlist. The customer's IPE was not developed prior to their placement on the waitlist, and as a result, the customer remained on the waitlist for 329 days before being released. An IPE was developed 39 days later, 459 days after the customer's eligibility determination. As a result, NHVR spent a total of 130 days developing the IPE without an extension: 91 days prior to placing the customer on the waitlist and 39 days after releasing the customer from the waitlist.

**Compliance Could Not Be Assessed Due To Unreliable Data**

We were unable to verify overall compliance with the 90-day time limit, as unaudited data on effective IPE dates from NHVR's electronic case management system was not reliable. We were able to identify specific instances of compliance and noncompliance through our case file review and other analyses. We primarily analyzed 58 initial IPEs developed between July 2015 and June 2019 from our file review of 97 case files, although we also analyzed select cases with inconsistent or outlying data from our review of unaudited IPE data. Although these reviews were subjective and limited in scope, we found NHVR data underestimated noncompliance, although we were unable to determine by how much. Inaccurate data would have also affected NHVR decision-making and the accuracy of compliance rates reported to the Rehabilitation Services Administration.

***Unsigned IPEs Were Incorrectly Assigned Effective Dates***

Federal law, regulations, and guidance required qualified counselors and customers to both sign an IPE for it to be effective. An IPE was ineffective if it had not been signed by the customer and by a qualified counselor. NHVR required counselors without IPE signature authority have a supervisor review and approve IPEs before they became effective. Ineffective IPEs could not be compliant with timeliness requirements, and customers with ineffective IPEs should not have been receiving services. However, we found issues with IPE signatures that appeared to render some IPEs ineffective. Additionally, we found NHVR staff misrepresented effective dates for IPEs that did not have both customer and counselor signatures. Misrepresenting effective IPE dates was inappropriate, but management had few processes in place to identify whether IPE effective dates were misrepresented.

We found ten of 58 initial IPEs (17 percent) did not have at least one required signature:

- Two of the ten (20 percent) had no customer signature, including one also missing the counselor's signature. As with supervisory review of eligibility determinations, supervisory review of IPEs appeared to occur primarily through the electronic case management system as reported by one RL. Although the *NHVR Counselor Desk Reference (Desk Reference)* required counselors to attach a scanned copy of IPEs and any amendments to the electronic case file, we found few scanned IPEs. Supervisors reviewing only the electronic case file would not have known if the hardcopy IPE had actually been signed in many cases. One of the two IPEs was reportedly effective prior to the OOS, in September 2017, while the other was reportedly effective during the OOS, in May 2019. In both cases, counselors reported customers verbally agreed to IPEs, and that IPEs were mailed to customers for signature. However, this practice was noncompliant with federal requirements and guidance.

- Nine of the ten (90 percent) were not approved and signed by qualified counselors. NHVR did not have a formal process for obtaining electronic signatures. One supervisor reported that "supervisors typically do not physically sign the [IPEs]." Supervisors would conduct their review and "then enters the date that the counselor provided. The assumption is that the physical [IPE] has already been signed by the [customer] and the [counselor]." However, the supervisor's approval in the electronic case management system would not appear on the printed version of the IPE, which was needed to document a qualified counselor signed the IPE. Additionally, supervisor approvals in the case management system would be overwritten any time the "plan" data page was updated. We found:

    - at least six IPEs were signed by VRC Is, and RLs reviewed and approved the IPEs electronically but did not sign them;
    - one IPE was signed by an VRC II without signature authority during the OOS but not reviewed by a supervisor; and
    - one IPE was not signed by anyone from NHVR, although it was reviewed and approved by a supervisor in the case management system.

Counselors and managers were aware IPEs needed to be signed by both the customer and the counselor before they became effective, as specified in federal law and regulations, federal guidance, administrative rules, the *Policy Manual*, the *Desk Reference*, and in training materials. Additionally, a standard letter sent by counselors to customers specified, "the IPE does not become effective until it is agreed upon and signed by both you and your Counselor." However, we found all ten IPEs missing at least one required signature, making them ineffective, but had a misrepresented effective date.

In one case, the VRC III recorded an effective IPE date, even though the counselor knew the IPE was not effective. The counselor sent NHVR's standard letter when the customer was assigned to an open waitlist category, specifying the IPE was not effective until signed by both the customer and counselor.

- On May 17, 2019, the counselor recorded the IPE as effective. However, there was no documented communication between the counselor and customer on this date.
- On May 20, the counselor sent a letter requesting the customer complete the IPE by signing it. There was no documented contact of any kind until August 15.
- On August 29, the counselor printed the IPE from the electronic case file. The customer reportedly had a meeting with the counselor on that date, but the meeting was not documented.

Case notes did not document when the customer signed the IPE. The IPE was not attached to the electronic case file, although it was included in the hardcopy case file. The first five pages of the IPE were printed from the electronic case file, while the sixth page - the signature page - was from the hardcopy IPE form and dated May 17, but signed only by the customer.

### *IPEs Were Often Backdated*

The *Desk Reference* permitted counselors and RLs to "backdate" effective IPE dates in the case management system. Staff could backdate by up to 14 days on their own, or for longer periods of time with central office approval. NHVR staff routinely backdated effective IPE dates. Among the 48 IPEs signed by both a customer and qualified counselor, we found 24 (50 percent) were backdated. Supervisors typically backdated effective IPE dates to the date counselors developed or signed the IPE, instead of using the date of their approval. We found 21 of 24 backdated IPEs (88 percent) were reviewed by a supervisor, and 17 of the 21 IPEs reviewed by a supervisor (81 percent) included a request from the counselor for the supervisor to backdate the IPE. In one case, a supervisor backdated the effective IPE date by 13 days, making it appear compliant with NHVR's 90-day standard. In this case:

- The VRC I and the customer developed an IPE on May 17, 2019. This date was recorded as the IPE effective date.
- On May 20, the counselor, who was not "qualified," submitted a request to their supervisor to review the IPE, 90 days after the customer's release from the waitlist. The counselor specifically noted "IPE is signed 05/17/19."
- At some point between May 20 and May 29, the supervisor responded, indicating, "plan is signed, but case note is missing," and requested the case note be completed.
- On May 29, the counselor completed the case note.
- On May 30, the supervisor approved the IPE, ten days after NHVR's 90-day standard from waitlist release. Since the supervisor was the "qualified" counselor, the electronic case management system should have recorded an effective date of May 30.

While most of the backdated IPEs (22 of 24, 92 percent) were backdated by 14 days or less, we could not determine how long one had been backdated, and one did not have a customer signature for 569 days after its effective date before being signed. We also observed significant backdating among amendments and subsequent IPEs.

Backdating IPEs appeared inappropriate as federal laws and regulations stated an IPE was not effective until it was signed by both the customer and a qualified counselor. Additionally, if the customer and counselor did not sign it on the same day, the later date should have been used as the effective date. Further, State law required the Commissioner to "make and maintain records containing adequate and proper documentation of the… decisions… of the agency…." The *Desk Reference* did not acknowledge State records requirements, although it cautioned that staff "should not rely on backdating as a normal way of doing business." NHVR policy, procedure, and training materials did not identify situations where backdating would be appropriate or inappropriate. Management had no processes in place to identify and assess the appropriateness of backdating.

### *Some Effective Dates Were Difficult To Identify*

One of 58 initial IPEs (two percent) contained a date entered by NHVR, not the customer. Federal guidance specified that IPEs were effective when both the customer and counselor had signed *and*

dated them. If the counselor and counselor signed on different dates, "the later date should be considered the effective date of the IPE." If the counselor dated the IPE for themselves and for the customer or printed a signature date from the case management system, it was difficult to ascertain whether the customer had actually signed the IPE on that date, or at a later date. We also observed this practice with subsequent IPEs and amendments.

**Compliance Monitoring Was Limited In Effectiveness**

NHVR processes to monitor compliance with the federal 90-day time limit for IPE development were either ineffective or reactive, identifying noncompliance only after it had occurred. Additionally, management did not timely or consistently address noncompliance and did not ensure staff were compliant with federal requirements.

- Existing Controls Focused On Maximum Time Limits – "Activity due" reminders, weekly case monitoring reports, and NHVR's monthly internal audit focused solely on compliance with the 90-day time limit, not on ensuring IPEs were developed "as soon as possible" in accordance with federal law and regulations.
- Weekly Case Monitoring Reports Did Not Ensure Noncompliance Was Addressed Timely – NHVR used weekly case monitoring reports to identify and address noncompliant IPEs. Cases were included on the report once an IPE already exceeded the 90-day limit without obtaining an extension.
- Effectiveness Of "Activity Due" Reminders And Reports Was Questionable – NHVR staff reportedly monitored upcoming time limits through the case management system's "activity due" feature. An "activity due" reminder was automatically generated 30 days before the 90-day time limit as a reminder to the counselor. "Activity due" reports could be generated for a counselor's entire caseload or by regional office, but there was no guidance on how frequently staff should generate and review these reports and monitoring appeared ineffective. Some RLs also reported delegating monitoring to support staff.
- Internal Audit Process Did Not Afford Opportunities To Correct Noncompliance – NHVR had a monthly audit process where the RL reviewed two active cases from each regional office. RLs were required to identify whether an IPE had been developed within the 90-day time limit or an extension had been obtained, and whether the date of the hardcopy IPE matched the date in the case management system. However, reviews happened after IPEs had already been developed, leaving no opportunity to correct noncompliance with timeliness requirements; a very small number of cases were reviewed, which limited NHVR's ability to address discrepancies between hardcopy and electronic case file dates; and management reported the information was not yet used for programmatic improvement.

**Recommendations:**

**We recommend NHVR management ensure compliance with the federal time limit for developing IPEs and ensure IPEs are developed as soon as possible by:**

- **seeking and obtaining guidance from the Rehabilitation Services Administration on how to comply with the federal 90-day time limit to develop an IPE when customers are placed on a waitlist;**
- **developing, implementing, and refining written requirements for timelines on supervisory review and approval and guidance on timeliness performance targets;**
- **routinely measuring staff compliance with federal and program requirements on meeting time limits and analyzing information to identify trends and potential issues with compliance;**
- **remediating deficiencies among individual counselors, regional offices, or agency-wide, as needed;**
- **identifying data and information necessary for monitoring compliance with timeliness targets; and**
- **developing, implementing, and refining processes to routinely collect, monitor, and analyze compliance data and information.**

**We recommend NHVR seek and obtain guidance from the Rehabilitation Services Administration to determine whether backdating effective IPE dates is permissible, and if so, under what circumstances. If there are circumstances under which backdating is permissible, then the Commissioner and NHVR management must properly control the use of backdating and ensure compliance with federal requirements and applicable State laws on records management by:**

- **developing, implementing, and refining written requirements on recording effective IPE dates to reflect federal requirements and guidance that an IPE not be "effective" until both a qualified counselor and the customer have signed and dated the IPE;**
- **revising, implementing, and refining written criteria for situations when backdating IPE dates may be appropriate;**
- **developing, implementing, and refining written processes for staff to utilize and request backdating of IPE dates, including establishing clear timeframes for when backdating may be requested, by whom, what information is needed to request backdating, and a process for requesting backdating outside of established timeframes; and**
- **developing, implementing, and refining processes to assess the validity and accuracy of effective IPE dates and to address inaccurate date in a timely and formal manner.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR strives to meet the time standard for the development of Individualized Plans for Employment. As identified above, the bureau completed IPEs within the 90-day time frame or with an extension 97% of the time under the order of selection.*
2. *The auditors identify in the 2016 Single Audit Of Federal Financial Assistance Programs identified three of 40 cases (eight percent) which were not developed within the federal 90-day time limit. The observation did not include that these three cases had extension forms*

*in the file. And that the 2017 Single Audit identified five of 40 cases (13 percent) were not developed within the time limit. Four of these selections had extensions in the case.*

3. *NHVR backdating procedure was developed to account for actions being completed in the field or when staff where not able to access and enter data into the system until a later date. Recent technology now allows for more timely entry of data and as such the NHVR had provided updated guidance to staff regarding the use of backdating. There is no federal prohibition of backdating and has been used as a strategy to handle issues with not being able to enter data in real time in sister VR agencies across the country.*
4. *Under an order of selection, regulations and policy require the bureau to determine priority of services to assure that individuals with most significant disabilities receive services first with available bureau resources. This permits the bureau to place individuals on a wait list upon eligibility and start the 90 day IPE development period once they have been released from the wait list. These provisions are in the NHVR policy and have been reviewed and approved by the Rehabilitation Services Administration. The audit report states, "Federal law and regulations did not appear to allow a specific exemption for customers on a waitlist during an OOS." As stated here, Rehabilitation Services Administration approved the NHVR practice and the auditor statement is simply misleading.*
5. *As the audit report points out, some cases extend beyond the federally mandated target of 90-days. The NHVR strives to meet the goal of qualifying individuals as soon as possible and certainly within the 90-day time period. What the audit report does not capture are the often challenging circumstances some disabled clients are managing as they work toward gainful employment. It is not uncommon that medical, family or other life challenges associated with in individual's disability impedes NHVR and their own ability to meet strict timelines. NHVR will continue to strive to meet all timelines while balancing the important human context in which this work takes place.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *In April 2020, the bureau disseminated procedural guidance for dating IPEs.*
- *NHVR is has begun work to review and update policy and training materials to assure staff have the information and resources to address timeliness of IPE development. This work is targeted for completion by June 2021.*
- *NHVR implemented an electronic signature platform that is intended to make it easier for clients to provide signatures and authorizations, and significantly improve signatory compliance. The simple process of providing signatures, while a seemingly simple process for someone without a disability, can prove difficult and at times daunting, for a disabled individual. This alone can result in processes drawn out over extended periods of time.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**NHVR's Remark 1 is misleading. As noted throughout this chapter, NHVR IPE data inflated compliance rates due to unreliable data affected by backdating, misrepresentation, and other issues although, as stated, we were unable to determine by how much. Unreliable data similarly affected our ability to determine how long it took to develop IPEs for the entire population. In a report encompassing FFYs 2016 through 2018, and released in late 2020, the Rehabilitation Services Administration also found issues with IPE dates in its review of NHVR. Federal reviewers noted that 10 percent of case records they reviewed did not contain a signed IPE. They also reported 10 percent of case records contained inconsistent IPE dates between hard copy records, the electronic case management, and federal reports.**

**In reference to Remark 2, the 2016 single audit cited the three cases not in compliance with federal time limits contained extension forms which were "not signed by both parties, as is required…" It concluded the "State is not in compliance…" The 2017 single audit cited that of the five cases it found that were not in compliance, one case had *no* extension, while the other four cases contained extension forms which were "not signed by both parties, as is required…" It concluded again that the "State is not in compliance…"**

**In reference to Remark 4, as noted in the Observation, while requiring an IPE to be developed within 90 days of a customer's release from the waitlist does not appear unreasonable, neither federal law nor regulations permitted exemptions from the 90-day time limit for an OOS. NHVR did not provide documentation indicating the federal Rehabilitation Services Administration had approved this practice. Additionally, NHVR administrative rules did not include an exemption from the 90-day time limit for an OOS.**

**Observation No. 18**

**Ensure Compliant Use Of IPE Extensions**

Extension requirements were intended to ensure customers were aware of both the exemption from the 90-day time limit to develop an IPE, and the additional time the process might take. However, we found some extensions were invalid, expired before an IPE was developed, or were inefficient. Inaccurate and unreliable data affected management decision-making and the accuracy of compliance rates reported to the Rehabilitation Services Administration by making NHVR appear more compliant than it was with extension requirements.

**Some Extensions Were Invalid Or Expired**

To ensure compliance with federal requirements, NHVR procedures required the customer and counselor sign a *Plan Development Extension* form to indicate agreement. Per the *Desk Reference*, if the counselor was unable to obtain a signature, procedures required the counselor document in the case record that the customer agreed to an extension during discussions and the counselor was further required to send a letter with the extension form to the customer via mail to obtain the signature indicating agreement. In our review of 14 cases containing an IPE extension, we found only one of the initial extensions met all these requirements. However, full compliance in this one

instance remained questionable due to the counselor dating the form for the customer, and there was no evidence in the case record that a meeting or discussion about an extension took place with the customer on that date. As shown in Table 9, the initial IPE extensions in the 14 cases were filed after the 90-day time limit to develop an IPE had passed; not fully compliant with agreement and signature requirements; or expired by the time an IPE was developed, a subsequent extension was filed, or other action was taken.

**Table 9**

**Requirements And Compliance Rate Of Initial IPE Extensions**

| Federal Or NHVR Requirement | Compliant Extensions | Noncompliant Extensions | Percent Noncompliant |
|---|---|---|---|
| Filed Timely[1] | 5 | 9 | 64 |
| Extension Contained Date Specifying Extension Period | 13 | 1 | 7 |
| Action Taken Before Extension Expired[2] | 8 | 6 | 43 |
| Customer Signed Extension | 9 | 5 | 36 |
| **Five Instances In Which Customer Did Not Sign Extensions** | | | |
| Case Note Documented Customer Agreement | 0 | 5 | 100 |
| Evidence A Letter Was Sent To Customer To Obtain Signature | 1 | 4 | 80 |

Notes:
[1]The case management system captured the start date as the date the counselor entered the extension into the system, regardless of whether there was a completed extension form. We determined compliance with timeliness based on the date of customer agreement, as evidenced by the date of the customer's signature when available, in accordance with federal law.
[2]Actions included developing an IPE, filing a subsequent extension, or closing the case.

Source: LBA analysis of completed IPE extensions.

**Some Cases Had Multiple Extensions Contributing To Inefficient Processes**

Prior to an exemption from the 90-day time limit, federal law required NHVR and the customer to "agree to an extension of that deadline to a specific date by which the [IPE] shall be completed." Federal guidance further clarified regulations permitted an agreed-upon extension to a specific date without imposing a time limit on the extension, but noted the extension should not be "so long as to cause unnecessary delays in providing services." If the customer disagreed with an extension, the counselor should determine whether the IPE could be written with its mandatory components based on available information and the understanding that the IPE could be amended. If the counselor determined they could not write the IPE and customer still disagreed with an extension,

federal guidance stated the counselor should refer the customer to the Client Assistance Program (CAP) for help resolving the disagreement and inform them of their due process rights.

However, in practice, NHVR limited the initial extension to up to 90 days and permitted multiple extensions when an IPE could not be developed within the specified time frame. Federal law required an IPE be completed "not later than a deadline of 90 days" after the eligibility determination unless the customer and the counselor "agree to an extension of that deadline to a specific date by which the [IPE] ***shall*** be completed." [emphasis added] Federal laws and regulations only referenced a single extension to exempt IPE development from the 90-day deadline. Federal guidance outlined additional procedures should the extension not be agreed to or timely; therefore, it was unclear whether subsequent extensions were valid. Our file review of 14 cases with an extension showed six cases (43 percent) had two or more extensions. Of these six:

- three cases (50 percent) had two extensions, with one having the IPE developed 62 days after the initial IPE was due, one having the IPE developed 110 days after the initial IPE was due, and one resulting in case closure 99 days after the initial IPE was due;
- two cases (33 percent) had three extensions, with one case having the IPE developed 204 days after the initial IPE was due and one case having the IPE developed 356 days after the initial IPE was due; and
- one case (17 percent) had five extensions with the IPE developed 439 days after the initial IPE was due.

Further, allowing multiple extensions did not appear to always meet NHVR's practice of limiting extensions to 90 days, nor did they appear to comply with federal guidance stipulating the extension date should "not be so long as to cause unnecessary delays to providing services." NHVR management stated supervisors should ensure reasons for the extensions were appropriate and that the new timeline seemed reasonable for the situation. However, counselors did not always document progress with gathering necessary information to develop an IPE and reasons for multiple extensions. Additionally, some reasons cited by management for extensions, while accepted in practice, did not appear to be appropriate. For example, IPEs were to be developed for eligible individuals who required services, but management indicated some multiple extensions were created when counselors were reluctant to close cases for customers who may not yet be ready for services or to pursue employment. In our review of cases with an extension, we did not find evidence in the case record customers were referred to the CAP in instances in which the IPE was not developed by the initially specified date or when an agreement was not documented. Referring customers to the CAP when appropriate could have facilitated more efficient processes.

**Additional Data Accuracy Issues**

We found data accuracy issues which compromised information available for decision-making and made some IPEs appear compliant with extension requirements. The 14 cases we reviewed contained 25 completed extensions. Of the 25 completed extensions, 11 (44 percent) were backdated including one that was originally dated and then overwritten on the form by the counselor to reflect an earlier date rather than the actual date the plan extension form was signed and agreed to by the customer. Further, we could not verify whether backdating occurred in one case with five extensions due to the counselor dating all five extensions for the customer. However,

case documentation only provided evidence that a meeting occurred during the time the second extension was completed. There was no evidence in the case record meetings or discussions occurred corresponding with the other four other extensions to indicate the customer signed or agreed to extend IPE development on those dates.

**Guidance On Extensions Was Limited**

NHVR did not have clear guidance on the use of extensions. Outside of limited federal guidance, there were no administrative rules, policies, or comprehensive procedures for IPE extensions. For example, during the audit period, there was no written guidance on whether extensions should be reviewed by a supervisor, nor was there information available to the customer to inform them of the extension process and their rights. Three counselors responding to our survey also cited IPE extensions as an area that was not consistently applied in practice and would benefit from additional training. Consequently, unclear and limited guidance likely contributed to noncompliance and untimely extensions.

**Recommendations:**

**We recommend NHVR management improve compliance with federal and program extension requirements by:**

- **developing, implementing, and refining written guidance on obtaining necessary documentation, including applicant signatures, in a timely manner;**
- **ensuring administrative rules, policies, and procedures clearly and comprehensively describe the extension process including referring customers to the CAP at the appropriate time; and**
- **refining training materials to fully align with federal and program requirements and incorporating them into training sessions.**

**We recommend NHVR management seek and obtain guidance from the federal Rehabilitation Services Administration to determine whether multiple extensions may be completed for each IPE exemption. If multiple extensions are permissible, NHVR management should properly control the use of multiple extensions and ensure compliance with federal requirements by developing, implementing, and refining written guidance on the use of multiple extensions.**

**We also recommend NHVR management improve its monitoring efforts by:**

- **identifying data and information necessary for monitoring extension requirements and timeliness of extensions and IPEs made under extensions, and developing, implementing, and refining processes to routinely collect, verify, monitor, and analyze compliance data and information;**
- **routinely measuring staff compliance and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and equitable manner and refining performance expectations and processes as needed.**

**We further recommend NHVR management ensure backdating of IPE extensions aligns with its determination of whether backdating is generally appropriate, as recommended in Observations No. 4 and No. 17.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR consulted with Rehabilitation Services Administration regarding multiple extensions and confirmed that they are allowable and a practice that is used throughout the country as a means to document reasons why a plan for employment cannot be made.*
2. *Regulations state agreement with extension and not specifically a customer signature for the extension. NHVR strives to gather the signature as documentation of the agreement, however, at times this is had been challenging to obtain if not completed in person. From Regulation: Standards for developing the individualized plan for employment. The individualized plan for employment must be developed as soon as possible, but not later than 90 days after the date of determination of eligibility, unless the State unit and the eligible individual agree to the extension of that deadline to a specific date by which the individualized plan for employment must be completed.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating bureau rules, policy and training materials to assure staff have the information and resources to accurately identify and record the use of extensions in the individualized plan for employment and in the case record. This work is targeted for completion by June 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the bureau. This program once built, will monitor compliance independently from local offices. Compliance with IPE timeframes and use of extensions is anticipated to be included in this monitoring. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, NHVR did not provide documentation verifying the federal Rehabilitation Services Administration had confirmed this practice as allowable.**

**In reference to Remark 2, NHVR implemented a signature requirement to document agreement. As we note in the Observation, we found noncompliance with this requirement. NHVR procedures also allowed alternate methods of documenting customer agreement if a signature could not be obtained. We also did not find consistent documentation of customer agreement in the case record when a signature could not be obtained.**

**Observation No. 19**

## Ensure IPEs And Amendments Are Signed By The Customer And Signed Timely

NHVR frequently did not obtain customer signatures on IPEs, but still assigned effective dates and provided services to customers. Federal law and regulations required an eligible customer and qualified counselor sign an IPE before it became effective. However, NHVR did not have clear policies and procedures to ensure customer signatures on IPEs and amendments were consistently obtained or obtained timely. Therefore, counselors implemented a variety of approaches to attempt documenting compliance with federal law and regulations which inconsistently resulted in obtaining a customer signature. Without obtaining a customer signature on IPEs and amendments, payments were made under an ineffective IPE. Additionally, customers were unable to properly consent to NHVR's planned employment goal and service provisions and hold NHVR staff accountable for implementing the agreed upon IPE.

### Subsequent IPEs And Amendments Were Often Not Signed By Customers

NHVR was generally effective at obtaining signatures from a customer when developing an initial IPE. Our file review of 88 customers with at least one initial IPE developed found 80 initial IPEs (91 percent) included a customer signature. However, subsequent amendments and new IPEs were frequently not signed by customers. Of the 88 customers with IPEs in our file review, a total of 116 second, third, and fourth iteration changes were made to their initial IPE. Of those 116 IPE changes, 62 IPE changes (53 percent) did not contain a customer signature agreeing to the change.

To create a new IPE or an amendment, counselors had to create a draft in the case management system, print it, and obtain a physical signature from the customer. NHVR did not have a process to obtain electronic signatures. Electronic signatures may have allowed NHVR to streamline the IPE amendment process and improve compliance signature requirements.

### Inconsistent Methods For Obtaining Signatures Or Agreement Timely

Federal law required an effective IPE to include a customer and counselor signature. Without a uniform process to obtain a timely signature before implementing an IPE or amendment, counselors used multiple methods resulting in inconsistent levels of compliance with federal law and regulations.

#### *Mailing Out IPEs For Signatures*

Besides scheduling an in-person meeting with a customer to discuss an IPE or amendment to obtain a customer signature, one of the more common alternative methods was mailing an IPE or amendment to the customer to sign, date, and return. This required NHVR staff to draft an IPE or amendment in the case management system, print the draft version, and mail a paper copy to the customer for their signature. This was only compliant if NHVR staff did not assign an effective date on the "plan" data page in the case management system before a customer returned a signed copy. Specifically, the effective IPE date in the case management system was used by NHVR as the official effective date. NHVR did not have a policy, procedure, or training document clarifying

that IPEs and amendments should only be finalized in the case management system after a customer provided a signature. Consequently, in some cases, NHVR staff finalized IPEs and amendments and paid for goods and services while still soliciting a customer signature.

***IPE Backdating***

Another method to achieve apparently timely IPE signatures included backdating the customer signature on an IPE or amendment to align the hardcopy IPE effective date with the effective date in the electronic case management system. Of the 88 cases in our file review with an initial IPE developed, we found 16 cases (18 percent) where initial IPEs were backdated. This practice made NHVR appear more compliant with federal law and regulations.

Backdating an IPE compromised the otherwise compliant practice of mailing out an IPE for a customer signature. NHVR staff who backdated IPEs sometimes mailed hardcopy IPEs having already dated the customer signature section. Therefore, any delays in a customer returning a signed IPE could appear compliant through backdating. NHVR staff assigning an effective IPE date in the electronic record and mailing out a hardcopy for a signature may have assumed backdating the signature would reconcile the two records. However, NHVR may have not considered the possibility the customer would not sign and return the IPE, resulting in the effective IPE date being misrepresented.

While reviewing hardcopy files, we noticed IPEs printed from the case management system included the print date as part of the document. We compared the print date with the signature date to help us determine whether IPEs were backdated, or "signed" before they were printed. After informing NHVR management about a potential finding on IPE backdating, the time stamp at the bottom of the IPE was removed. Therefore, NHVR management's ability to identify the occurrence of IPE backdating moving forward was hindered.

***Other Less Common Methods Were Used To Document Agreement***

In addition to mailing out IPEs for signature and backdating IPEs, NHVR staff implemented a variety of other methods which were not permitted under federal law and regulations to document consent or obtain a signature.

- Obtaining A Signature Retroactively To Cover Multiple Amendments – We found at least two cases where counselors drafted multiple amendments without obtaining signatures for the new services when they were provided. Instead, the counselors incorporated all services that had already been provided into one amendment form, and had the customers sign one amendment. In one case, three amendments were drafted and in the second case, nine amendments were drafted. The case with nine drafted amendments included $45,000 worth of services provided over a two-year period prior to obtaining a customer signature.
- Documenting Verbal Agreement – We found at least two cases where counselors documented in a case note that the customer verbally agreed to the changes to the IPE. In one of those two cases, the customer never signed the IPE and later disputed the verbal agreement after receiving services. Federal law and regulations required IPE services to be

communicated to customers in writing and customer agreement be provided via a signature and date.

- Customer's Signature Date Was Not Used – We found four cases where customers signature dates were not used as the date the IPE or amendment was effective when required. Instead, the counselor's signature date and the IPE draft date, which were generally earlier than the customer's signature date, were used. We also found computer-generated dates were inserted into the customer's signature line before the document was printed and presented to the customer for signature. If the signatures bear different dates, federal guidance required the later date be used as the effective date.

**Signatures Or Dates Connected To Signatures May Have Been Inauthentic**

NHVR did not have a policy outlining the importance of obtaining an authentic signature demonstrating customer agreement and what constituted an invalid signature. We found inauthentic or questionable signatures, including:

- Customer Signatures Appeared To Be Photocopied – We found at least one case where the customer's signature on two IPEs appeared to be photocopied onto the documents. In one IPE supposedly signed by the customer in February 2019, the IPE was not printed until late August 2019. However, according to the case management system, the case had been closed in early August 2019. According to a case note in mid-August 2019, the counselor attempted to contact the customer for a signature but noted the customer was unresponsive. The second IPE supposedly signed by the customer in December 2017, was not printed until September 2019, 21 days after we informed NHVR management we had randomly selected the file for review and almost two years *after* it was supposedly signed. The photocopied signature on this IPE was an exact match to the photocopied signature on the IPE dated February 2019 with ink blotches in the exact same spots.
- Computer-generated Customer Signature Used – Our file review found two cases where the IPE appeared to be signed with computer-generated font in the customer signature line. NHVR did not document in the case file the customers were unable to provide a handwritten signature or outlined any specific accommodations required for the customer to document their signature. In fact, both customers had provided handwritten signatures at some point with no explanation for the switch to a computer-generated signature in the file. In one of the two cases, NHVR management provided emails between the customer and the counselor, which were not contained in the case record, indicating the counselor had attempted to obtain the customer's signature on two separate occasions but the customer had provided a computer-generated signature instead. Without documentation or a clear policy on the use of computer-generated signatures, it was unclear if these customers agreed to the enactment of the IPE or amendment.

**Unsigned IPEs Did Not Ensure Customers Exercised Informed Choice And Limited NHVR Accountability**

The purpose of obtaining the customer's signature was to ensure the customer agreed with the employment goal and planned services outlined in the IPE, after being informed of their choices

as required by federal regulations. Signing the IPE demonstrated the customer agreed with the employment goal and services, exercising their informed choice in the process. While we found the IPE development and amendment process rarely resulted in the customer refusing to sign the IPE, disagreements in employment goals or service provisions did occur. In practice, NHVR allowed informal agreement in instances where a customer signature could not be obtained, which conflicted with federal requirements.

In one case we reviewed, the counselor started the IPE development process by scheduling interviews with multiple job developers for the customer to ask questions about services, thereby allowing the customer to make an informed choice. The counselor reported the customer was skeptical of the effectiveness of the job developer's abilities to serve their needs, but the counselor reported the customer verbally agreed to services without providing a signature on the IPE. During the next seven months following the verbal agreement, the customer received services but refused to sign the IPE. Although the counselor started developing the IPE by informing the customer of their choices without the customer's signature, NHVR could not document it ensured the customer made the choice.

Customer agreement and transparency in service planning could also improve accountability. After an IPE or amendment was developed, federal regulations and NHVR policy required a customer to receive a signed copy. A signed copy of the most current IPE provided the customer with an expectation of the services they might receive through NHVR. Therefore, a customer could inquire about any service or good on the plan not implemented and request an explanation. The enactment of IPEs and amendments without a customer signature hindered the customer's ability to hold NHVR accountable and safeguard against the possible misappropriation of resources by NHVR staff. For example, if a counselor added a service or good to an IPE without the customer's knowledge, the service or good could be misappropriated without detection by the customer or NHVR management.

**Increased Risk To Grant Funding For Implementing Unsigned IPEs**

In NHVR's *State Plan*, which was required to receive federal grant funds, NHVR agreed to comply with federal laws governing IPEs, including the requirement that IPEs be signed by a customer to be effective. However, NHVR was noncompliant with the *State Plan* because it paid for goods and services without an effective IPE. Federal law and regulations allowed federal grant payments to be withheld or limited for noncompliance with a submitted *State Plan*. Therefore, the practice of implementing IPEs without a customer signature could put NHVR at risk for the loss or delay of grant funding.

**NHVR Could Benefit From A Process For Obtaining Electronic Signatures**

NHVR management was cognizant of the importance of obtaining customer agreement and written signature before implementing an IPE. NHVR management acknowledged implementing IPEs without a signature was occurring in the field offices and was noncompliant with federal law and regulations. As a possible solution, NHVR management reported the need for an electronic signature process to improve compliance. However, NHVR did not possess the technology to

enable this solution during the audit period, nor did they develop a temporary solution until a technological solution could be implemented.

We found other state VR agencies allowed for electronic signatures. Therefore, this technology was likely allowed under federal regulation and could improve NHVR's compliance. However, some of the proposed uses of an electronic signature from NHVR still required an in-person meeting and existing gaps in policies, procedures, and training during the audit period would hinder the effectiveness of this solution unless fully addressed.

**Recommendations:**

**We recommend NHVR management continue its efforts to explore an electronic signature process. These efforts should include:**

- **consulting the Rehabilitation Services Administration to verify any new technology is compliant with federal laws and regulations; and**
- **analyzing the workflow of an electronic signature process to identify gaps in policies, procedures, and training which could result in an IPE being enacted without a customer signature.**

**We also recommend NHVR management ensure current IPE development processes are compliant with federal laws and regulations by developing policies, procedures, and training materials that include:**

- **a process to ensure that only IPEs that are signed and dated by the customer are finalized and become effective in the case management system;**
- **ensuring services are only authorized for cases with an effective IPE or amendment;**
- **methods authorized by management to obtain a customer's signature, and procedures associated with each method;**
- **a description of when it is appropriate for NHVR staff to write on the customer's signature and date section of the IPE form or a prohibition of such activity; and**
- **a description of what is considered a valid signature and a process for providing accommodations when appropriate.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR backdating procedure was developed to account for actions being completed in the field or when staff where not able to access and enter data into the system until a later date. Recent technology now allows for more timely entry of data and as such the NHVR had provided updated guidance to staff regarding the use of backdating. There is no federal prohibition of backdating and has been used as a strategy to handle issues with not being able to enter data in real time in sister VR agencies across the country.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *In April 2020, NHVR disseminated procedural guidance on dating IPEs.*
- *In May 2020, NHVR adopted DocuSign as an option for gathering an electronic customer signature.*
- *NHVR is updating policy and training materials to assure staff have the information and resources to accurately identify and record the use of comparable benefits in the individualized plan for employment and in the case record. This work is targeted for completion by June 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**Observation No. 20**

**Clarify When An IPE, Amendment, Or Internal Correction Is Appropriate**

NHVR procedures for when to create a new IPE, an amendment to an IPE, or an internal correction were unclear leading to inconsistencies and noncompliance with federal requirements.

**NHVR Policies And Practices**

NHVR's *Policy Manual* was consistent with federal requirements by referencing a single IPE and specifying any amendments to the IPE were to be incorporated or affixed to the initial IPE. Software limitations in the case management system and NHVR practice required a new IPE be created under specific conditions, resulting in multiple IPEs in the case management system. Management reported any subsequent IPEs developed were considered amendments to the initial IPE. However, procedures and training materials did not specify that new IPEs were considered amendments to the initial IPE or provide guidance on how to review subsequent IPEs and amendments as part of the entire case. Without this additional guidance, NHVR procedures, training materials, and practices conflicted with federal requirements and the *Policy Manual*. Specifically, the *Desk Reference* stated a new IPE should be created for changes other than to services, while an amendment should be created for adding, deleting, or editing services. A training document further conflicted with requirements by noting an amendment *or* new IPE could be written to reflect a change in services. Consequently, NHVR personnel's understanding of when to create an IPE or amendment varied.

Our interviews with 12 NHVR staff indicated almost all staff stated a new IPE should be developed when the employment goal changed or if the IPE was expiring. More than half also stated an amendment should be developed when adding new services, and at least four staff reported amendments were used to *delete* services customers no longer needed. However, one staff each reported various other reasons for developing a new IPE or amendment, including:

- a new IPE should be developed to change the criteria for evaluating progress toward the employment goal;
- an amendment should be developed to change the dates of the IPE;
- an amendment should be developed to change the dates of service;
- a new IPE *or* amendment could be developed to add new services; and
- a new IPE *or* amendment was dependent on counselor discretion and either could be developed for any reason.

***Change In Service Providers***

Although federal requirements and the *Desk Reference* specified changes to providers required an amendment to the IPE, it was not NHVR practice to amend the IPE for this purpose. If the provider was unknown at the time of IPE or amendment development, counselors placed "TBD" (i.e., to be determined) under the service provider section. Regardless of federal requirements, services were still provided to the customer without an amendment. We reviewed 69 cases with 304 services documented in an IPE or an amendment during the audit period that also resulted in a corresponding authorization. We found 96 authorizations (32 percent) did not have the same provider listed in the IPE or amendment. In 65 of the 96 instances (68 percent) the provider was listed as "TBD," to be determined, on the IPE or amendment.

**Retaining Services Across IPEs**

Software limitations prevented counselors from amending the IPE. Personnel reported that if the IPE was due to expire (i.e., the plan was taking longer to complete than originally estimated), the date the IPE was estimated to be completed could not be amended. Therefore, a new IPE had to be created. Management reported regardless of the reason for a new IPE, subsequent IPEs were treated as an amendment to the initial IPE. While an amendment would add estimated costs of services to the existing IPE, the case management system did not automatically add the estimated cost of services from previous IPEs to the new IPE. Additionally, federal regulations did not appear to allow for multiple IPEs to be effective at the same time. New IPEs replaced prior IPEs in their entirety in the case management system. Consequently, lack of procedures defining how counselors should develop subsequent IPEs led to inconsistent IPE development and ineffective supervisory review.

Without guidance, counselors could create subsequent IPEs in either of the following ways:

- Option One – Create an entirely new IPE with only the new services needed to obtain the employment goal. A new plan would not receive the same scrutiny if the total costs were under the threshold for supervisory review. Specifically, if a counselor created an entirely new IPE, it did not incorporate any previous services or cost estimates, effectively resetting the thresholds for supervisory review and was more likely to be reviewed as an independent IPE rather than an amendment to the initial IPE. This option did not accurately portray the time, financial resources, and customer's efforts dedicated toward obtaining an employment outcome.
- Option Two - Copy the previous IPE, thereby retaining the previous IPE's services, and adding any other services needed to obtain the employment goal. This approach allowed

counselors to retain the services the customer already used or would still need and allow for appropriate adjustments to cost estimates. This would provide for a more accurate review by allowing for a holistic assessment of progress toward employment, including if the goal changed over time.

NHVR management reportedly relied on cost estimates of anticipated services to formulate regional office budgets. Counselors calculated the cost for services that they expected would be provided to each customer on their caseload based on the costs estimated for individual services on their IPEs. Counselor's quarterly projections were reviewed by the RL, combined with the other counselors' projections, and sent to the central office where a quarterly budget was created for each regional office. If counselors consistently utilized option two to create subsequent IPEs, estimates over the total case would have been substantially more accurate despite software limitations. We reviewed the most recent IPE for 31 cases closed between July 2016 and August 2019 and found cost estimates for services entered into the case management system totaled approximately $155,000. However, when we collected cost estimates for these same cases by adding costs for services from all IPEs created for each case, the estimates totaled approximately $1.17 million. Actual expenditures for these 31 cases was over $1.24 million, approximately $1.09 million more than the estimates included on the most updated IPEs in the case management system.

**Internal Corrections**

NHVR did not have a formal process for completing an internal correction of an IPE. NHVR management described internal corrections as minor adjustments counselors could make to the IPE without an amendment or supervisory review. Generally, internal corrections were used for making technical adjustments which would not affect providing services to the customer such as updating the terminology on a service. We identified three cases where a service had not been added to the IPE but was noted as an internal correction to address the omission.

- In one case, the counselor included travel costs in the estimated costs for a consultant and created an internal correction to separate the travel costs from the consultant's fees. This appeared to be consistent with how management and counselors reported internal corrections were to be used.
- In another case, the counselor completed an amendment form to change the name of a service. Although federal law and regulations required amendments contain the customer and counselor's signature, the counselor noted on the amendment form it did not require a customer signature. While this change appeared to be consistent with how an internal correction was reportedly used, the use of the amendment form made it appear a new service was being added to the IPE without the required signature.
- In another case, the counselor proposed a change to the customer's services and attempted to obtain the customer's agreement. However, the customer was nonresponsive, and NHVR did not obtain agreement or a signature. The counselor then proceeded with the change as an internal correction without the customer's agreement. Under federal regulations, this was considered a substantive change requiring an amendment.

**Recommendations:**

**We recommend NHVR management develop and clarify policy, consistent with federal requirements, for when a new IPE, amendment, or internal correction is appropriate. In determining the appropriate method to use, management should ensure estimated costs for services added to the IPE are included in the total estimated cost of that case.**

**When developing policy for counselors, NHVR management should include:**

- **clear guidance on when counselors should use each type of correction to address substantive changes to employment goal, services to be provided, or the providers of the services;**
- **procedures to ensure vendors are updated through amendments prior to customer's receiving services and internal corrections are limited to technical changes which do not conflict with federal requirements; and**
- **monitoring procedures to verify internal controls prompting supervisory review are operating effectively.**

**After developing and clarifying policy, NHVR management should update training materials by incorporating related changes and conduct trainings for timely implementation.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau does not agree that there are software limitations in the case management system that as the auditors describe it, "required a new IPE be created under specific conditions, resulting in multiple IPEs in the case management system." This opinion directly relates to how the case management system is formatted, and not an improper practice by staff or the bureau. NHVR has only an original IPE, as identified in federal regulations and rules. Any modifications, regardless of whether there are changes to services within a plan, a new employment goal, or change in criteria, are considered amendments to the original IPE.*

   *The issue identified by the auditors is directly related to the case management system used by NHVR, along with over 35 VR agencies across the nation. Within this case management system, there are two options to select from when entering plan data for an amendment. The two options are 1) New Plan or 2) Amendment. Within NHVR's case management system, the selection of a New Plan, allows for any changes that need to be made to a plan. The Amendment option only allows the counselor a streamlined option to amend the plan if the changes needed are only in adding or editing the service portion of a plan. This concern presented by the Auditors is directly related to how the system was developed and the names of data pages. This internal practice is related to the naming of data pages within a case management system rather than function.*

- *There is only one initial plan. Every change beyond that is an amendment to the plan. It appears that the name of the plan amendment pages are confusing (to auditors and staff could not explain them). The name New Plan is the name of the data page in AWARE. It does not mean we have discontinued the old plan and started from scratch. It is used when anything is being amended in the plan (can be used to amend any and all parts of the plan). The amendment option provides an opportunity for amending just services, so that the participant does not need to go back through the entirely of the plan to make service changes to the plan.*
- *Costs are estimates and go across an entire plan. Again these are not separate plans but one plan that has been amended. These are estimates, they are not final costs. Estimated costs and final costs listed are pretty close (Estimates: $1,167,000. Actual: $1,243,000). Estimates are not a regulatory requirement of plan.*

2. *The cases identified as potential internal control issues all used this appropriately. There were not changes in the services agreed upon by the customer in any of these instances and the change was related to vendor billing and payment.*
    - *One case identified as an internal correction: The counselor did not include a supportive travel time fee (which is broken out into two services in plan). The primary service was on the plan and provided. This was caught when the invoice was received and did not change services provided to the participant. This is an internal process.*
    - *A second case the internal correction had to do with billing and payment and not to add any services not already planned with participant. The services planned were part of a larger package that was authorized, a Pre-employment services package. However when provided the participant only participated in one informational interview and not other services in the package, the vendor only billed for the one service. The internal correction was to allow the bureau to pay for the service provided and not overpay for services that were not provided.*
    - *A third case the internal correction was to enter the correct service name. The plan already contained job person assessment (daily). The change was to add the service without the qualifier of daily – Job Person Assessment. This change was necessary due to bureau naming of services for payment to CRP, did not change the services agreed on and provided to participant.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to accurately identify complete and record the individualized plan for employment and its subsequent amendments in the case record. This work is targeted for completion by June 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace*

*the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, while NHVR states it considers the initial plan the only plan, and any subsequent changes are considered an amendment to the plan, the case management system did not automatically treat subsequent IPEs as amendments. Instead, when a subsequent IPE was developed, it replaced the previous IPE in its entirety in the case management system, unless counselors consistently included case estimates, previous services rendered, and new services on subsequent IPEs. Developing IPEs in this manner would account for prior IPEs and services rendered. As stated in the Observation, there were certain limitations in the case management system that required counselors to create a new plan, and an amendment was not an option. Cost estimates were not cumulative across multiple plans as NHVR indicated. The case management system did not have a field to calculate the total estimated case costs across all IPEs. When a subsequent IPE was developed, the case management system did not automatically add the estimated cost of services from previous IPEs to the new IPE. The total estimates provided in the audit report were calculated by the auditors after manual analysis of those cases to eliminate the cost of duplicate services contained within IPEs.**

**NHVR's internal controls programmed into the electronic case management system were designed to be effective based on the most recent IPE; not the cumulative total of all IPEs developed in a case. The only way a counselor could ensure internal controls were working as designed was to include case estimates, previous services rendered, and new services necessary to achieve the employment outcome on subsequent IPEs when they were developed. Further, NHVR appears to recognize limitations in the software system as evidenced through interviews with management and staff, references in the *Desk Reference*, and references in training materials, which all stipulated instances in which a new IPE was required to be developed instead of an amendment. NHVR changing the name of subsequent IPEs to "amendments to the IPE" does not remedy these limitations.**

**In reference to Remark 2, NHVR lacked formal procedures, creating inconsistencies and noncompliance or the appearance of noncompliance. While NHVR contends all cases used internal corrections appropriately, we found this was not true. Under federal regulations, one of the internal corrections should have been an amendment. The counselor proposed a change to limit the services necessary to achieve the employment outcome on the IPE. The counselor attempted to obtain the customer's agreement for the change but did not obtain customer agreement or signature. The counselor then proceeded with the change as an internal correction instead of an amendment.**

**Monitoring Progress Towards Employment Goals**

Employment goals, while ultimately chosen by the customer, were federally required to be consistent with the customer's unique strengths, resources, priorities, concerns, abilities,

capabilities, interests, and informed choice. NHVR was required to provide information to the customer enabling them to exercise informed choice in determining their employment goal and the services necessary to attain their chosen goal. To facilitate choosing the employment goal and appropriate services, customers could take an assessment designed to identify their goals and needs consistent with federal criteria. If the IPE could not be developed with the mandatory components using available information to the maximum extent possible, the counselor could order further assessments to help identify an employment goal, barriers to employment, or to determine the nature and scope of services necessary to achieve the goal.

Management was responsible for ensuring resources were used efficiently, effectively, and in compliance with federal and State regulations. The nature and scope of services available to customers ranged in purpose and included physical, recreational, or psychological therapy; job readiness services such as college training, job development, or supported employment; and mobility services such as rehabilitation technology or personal assistance services. Costs for these services could be minimal or in excess of $100,000, depending on the customer's needs. Certain services available were subject to a comparable benefits review to determine the source of payment or provider of services. Regardless, any service which contributed to the attainment of the employment goal was required to be documented on the IPE. Federal regulations required an accurate record of services. Additionally, a complete and accurate record was necessary to effectively evaluate customer progress toward achievement of the employment goal on an annual basis as well as to ensure services provided, including those through other entities, were appropriately documented for case closure in the event the customer was deemed rehabilitated.

We found employment goals were not always aligned with assessments or other documentation of the customer's strengths, resources, priorities, concerns, abilities, capabilities, and interests. Additionally, some services provided to customers did not appear to contribute to their employment goal or were only tangentially related.

**Observation No. 21**

**Ensure Employment Goals Are Appropriately Supported**

Employment goals on some IPEs were inconsistent with federal criteria potentially contributing to non-rehabilitated closures. To increase the probability a customer would achieve an employment outcome, federal law required IPEs include an employment goal that was consistent with the customer's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. Counselors were required to complete and document an assessment for each customer to ensure the employment goal aligned with these criteria. However, we found instances in which documentation supporting the employment goal was not always available, assessments did not always supported the identified employment goal, additional resources to establish an agreed-upon employment goal were not always utilized, and the employment goal noted on certain IPEs was incorrect.

**Rationale For Employment Goal And Additional Assessments Inconsistently Documented**

Federal regulations required documentation in the case record describing the extent to which the customer exercised informed choice while selecting an employment goal. NHVR policies further specified the case record include documentation supporting the need for, and plan relating to, the exploration of the abilities, capabilities, and capacity to perform in realistic work situations. NHVR required a comprehensive assessment to be conducted and documented to include the specific rationale for the chosen employment goal and services necessary. If additional information was required prior to selecting an employment goal, the counselor could choose an assessment instrument or other job exploration activities that were reliable, fair, valid, cost effective, easy to administer, and appropriate to the customer's needs. The customer could complete the assessment with the counselor, with a vendor, or through a self-assessment depending on the method chosen. However, documentation of the rationale and assessment supporting the employment goal were inconsistently documented in the case record.

We reviewed 88 cases with a completed IPE and found the rationale for the initially chosen employment goal was not clearly documented in the comprehensive assessment for 18 of those cases (20 percent) before the employment goal was established. Additionally, assessments conducted to support the goal were inconsistently documented in the case record. We found 15 cases in which an additional assessment was requested to obtain further information, but the assessment was either not included in the record, or there was no documentation the assessment results were reviewed with the customer to make an informed decision about the employment goal.

**Assessments Did Not Appear To Support Goal On IPE**

NHVR required counselors complete a comprehensive assessment for the customer to select an employment goal consistent with federal regulations. To the degree necessary, federal law specified assessments be used to evaluate the customer's:

> *...personality, interests, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational aptitudes, personal and social adjustments, and employment opportunities of the individual, and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors that affect the employment and rehabilitation needs of the individual.*

However, we found information in available assessments did not always support the employment goal in the IPE or realistically align with the customer's strengths, abilities, capabilities, or interests. Consequently, NHVR resources were ineffectively utilized and these cases were more likely to result in non-rehabilitated closures. For example:

- A customer with an employment goal of "couriers and messengers" had prior experience in a similar field of work. However, the customer reported they did not do well in the role. Additionally, the disability and functional limitations provided in the file detailed the customer had medical diagnoses and concerns that were not conducive to employment involving substantial driving. The case was closed ten months after development of the IPE

when the customer reported they did not require services, nor did they believe they could physically continue to work.

- A customer with an initial employment goal of "nonfarm animal caretaker" expressed interest working with animals and had prior related experience. However, a preliminary assessment indicated the customer's interest was more of a hobby rather than wanting to *work* with animals. Additionally, a report provided by another support agency indicated the customer did not like the related position. Eventually the goal was changed to "stock clerks" to obtain an assembly-type position, but this employment goal was also not fully supported as the RL noted there were concerns about the customer's willingness to work in a field related to the employment goal. A subsequent community CRP report confirmed the customer was not motivated to work and the case was closed a year after the initial IPE was developed.
- A customer with an employment goal of a teacher applied to NHVR while employed in an educational support role and sought to further their career. However, although the customer reported they wanted to advance their career, they also cited that working in the educational support role was "too stressful." While the customer had experience in the field, there were no other assessments or evaluations to support the capabilities of the customer continuing work in the field. Further, even though the IPE had already been developed, the customer was receiving career exploration activities from a CRP vendor one month later to determine an appropriate employment goal, indicating the goal was not fully supported at the time of IPE development.
- A customer with an initial employment goal of "administrative services manager" reportedly completed a career assessment, but discussion of the assessment results and the assessment itself were not documented in the file. There were also minimal case notes regarding the development of the IPE. Three subsequent IPEs were developed over the next two years with three different employment goals. Although the most recent employment goal of "counselors" was developed based on the customer completing additional in-house career assessments, the customer indicated they were drawn toward careers that did not align with their capabilities and strengths which usually resulted in them leaving their employment. Additionally, according to case notes, the counselor expressed concern about the customer pursuing employment in positions that would require supervisory responsibilities or working in the human services field. The counselor suggested the customer seek employment in a field other than human services, and positions that would not require responsibility for others. The counselor's suggestions to avoid these positions may have been more suitable to the customer's capabilities and strengths. However, the counselor did not recommend seeking other job exploration activities from a vendor to determine the customer's ability to obtain stable employment until nearly three years after the initial IPE was developed.

**Other Resources Not Utilized When Disagreement On Goal**

Although the customer was ultimately responsible for choosing the employment goal, if the counselor had concerns or did not believe the chosen goal aligned appropriately with federal criteria, additional processes could take place to ensure the goal was mutually agreed upon. Minimally, if there were concerns about the achievability of the employment goal, training

materials indicated the counselor was expected to outline additional criteria in the IPE to timely assess the customer's progress so that the employment goal could be readdressed and modified if necessary. If an agreement on an appropriate goal was still not met, federal regulations required NHVR develop and implement relevant procedures to ensure the customer was provided information necessary to the development of the IPE. Necessary information included a description of rights and remedies available to the customer such as recourse for customers dissatisfied with any determinations made by NHVR personnel that affected the provision of services. These processes included obtaining review of the determination through an impartial hearing or mediation process and providing availability of the CAP for the hearings or mediation processes.

Documenting additional criteria in IPEs and documenting in the case record when customers received information on remedies available during disagreements would:

- provide counselors with additional information when assessing customer progress and annual reviews,
- inform supervisors that counselors have used all resources available to assist customers in achieving their employment goal, and
- provide verification NHVR was compliant with federal law, regulations, and internal policies.

We found additional criteria were not consistently included in IPEs to timely address concerns with employment goal. Additionally, NHVR reportedly provided information on remedies to all customers as well as referenced in the *Policy Manual* that it was appropriate to provide the information to the customer if there was disagreement between the customer and the counselor. However, we did not find evidence in some case records that customers were informed of these resources at appropriate times. The *2016 NHVR Comprehensive Statewide Needs Assessment* also reported that 72 percent of customers surveyed were not aware of the CAP. By not including additional criteria in the case record and not consistently providing information on available resources, NHVR risked utilizing staff time and resources inefficiently. Additionally, these cases were more likely to result in non-rehabilitated closures.

- A customer chose an employment goal of "childcare worker;" however, assessment results indicated the customer did not have any of the abilities needed for the career. Although the counselor expressed concerns about the employment goal after the initial IPE was developed, two additional IPEs were developed with the chosen employment goal over a period of five years and no additional criteria were included to assess progress. Case notes indicated the customer struggled with achieving requirements needed to become a childcare worker and the counselor continued to express concerns about the employment goal, but the employment goal was not reassessed.
- A customer had an initial employment goal of "janitors and cleaners," but the customer was not interested in the employment goal. Although the customer expressed interest an employment goal which required extensive training and specialty certification, the counselor did not believe it aligned with the customer's strengths and abilities. No additional criteria were added to assess progress and there was no indication information was provided to the customer about available resources to determine a mutually agreed upon goal. The customer received CRP and other services for the janitors and cleaners

employment goal over the next two years, but reportedly turned down related jobs to volunteer in an uncertified capacity in their preferred employment field. The counselor questioned the ability of the customer to obtain paid employment in that field, noting NHVR had spent over $9,000 toward the employment goal of janitors and cleaners. The counselor also indicated the formal employment goal did not fit with the customer's aspirations resulting in potentially providing more services without the customer obtaining a janitorial or cleaning position. The case became contentious and advocates for the customer became involved. Although case notes indicated RLs were made aware of issues regarding disagreement about the employment goal, there was no indication fair hearing or mediation information was provided to the customer as a resource. Eventually, the case was transferred to another counselor, the employment goal was changed to the customer's preferred goal, and the case closed five years later at a cost of $96,542 without the customer obtaining employment.

- A customer had an initial employment goal of "audio and video equipment technicians" but eventually changed their goal multiple times to better align with their interest in writing. The counselor expressed concerns about the employment goal and added more criteria to the IPE to better assess progress toward the goal. However, the employment goal evolved into working towards self-employment, which the counselor did not fully support. In addition to the employment goal, the customer's guardian expressed disagreement regarding other decisions made by the counselor and NHVR throughout the seven years the case was open such as tuition payments, desired services, and case closure. While the file indicated NHVR management and former DOE management were involved to address disagreements, there was no indication fair hearing or mediation information was provided to the customer as a resource. The case was initially closed as rehabilitated with a total case cost of $122,089, but was reopened within two weeks due to the customer stating their self-employment was not stable.
- A customer had an initial goal of "market research analysts" which was changed within six months to "computer user support specialists." However, the customer stated they were not interested in either employment goal, nor were the goals mutually supported by the customer, their representatives, CRP vendor, and counselor. A year later, the employment goal was changed to better align with the customer's interest in writing, but the counselor had concerns about the customer's prospect of obtaining stable employment in the field. Although the counselor included additional criteria in the IPE to assess progress toward the goal such as using school resources to obtain internships and actively begin job searching by a specific date, the customer was not held to the criteria in a timely manner when expectations were not being met. Toward the end of the customer's college education, when the customer was to begin an active job search, the customer indicated they did not desire to seek employment after completing their degree as agreed to with the counselor. Two years later, the counselor met with the customer and their representatives about concerns regarding the employment goal. There was no indication information was provided regarding a fair hearing or mediation process at any point over the duration of the case. The case remained open until the customer agreed to closure, almost five years after the initial IPE was developed, after being informed they would no longer be able to receive services for a writing employment goal because the customer was not progressing towards the goal.

**Incorrect Employment Goals**

Services provided were required to directly contribute to the employment goal noted on the IPE. Should the customer obtain stable employment in accordance with the IPE and meet other criteria, the case could be closed as rehabilitated. Federal regulations and NHVR policy required NHVR maintain accurate records for each customer. Management was ultimately responsible for establishing processes to ensure NHVR data was reasonably free from error. However, we identified four cases in which the employment goal was not changed timely on the IPE or was recorded erroneously leading to inaccurate data and the appearance services being provided did not directly relate to the employment goal.

- Two cases in which the employment goal noted on the IPE was inaccurate. In the first case the customer received $25,584 in services for seven years for the employment goal of a hotel business manager, but the employment goal noted on the IPE was "business continuity planners." The second case was opened prior to implementation of the current case management system. The employment goal was correctly noted on the hardcopy of the initial IPE as "teachers and instructors" but when conversion to the case management system occurred, the employment goal was incorrectly entered as "informatics nurse specialists."
- One case in which the employment goal was not changed until three years after the customer decided to change their goal. The customer received $10,737 in services towards the new employment goal for nearly three years under the IPE with the previous employment goal before the employment goal was updated on the IPE.
- One case in which the employment goal was changed on the IPE to reflect the customer's current employment in customer service. However, the customer continued to work towards and receive services for an employment goal of "social human services assistants" in which they wished to advance. The goal should have remained social human services assistants based on federal requirements that services must directly contribute to the employment goal. Changing the goal to the customer's current employment meant the customer had actually obtained stable employment in accordance with the IPE twice over the duration of the case and therefore steps should have been taken to close the case.

**Recommendations:**

**We recommend NHVR management ensure customers' IPE goals are consistent with the customer's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice by:**

- **ensuring counselors clearly document the rationale for employment goals and retain copies of additional assessments in the case record;**
- **ensuring counselors are aware of, and properly utilize, available procedures such as including additional criteria on IPEs and periodically providing information on fair hearing and mediation to more effectively and timely address dissatisfaction or disagreements related to employment goals; and**
- **establish a process to periodically review counselors' compliance with requirements.**

**In establishing a review process, NHVR management should require RLs to periodically verify employment goals appropriately align with federal criteria by reviewing required assessments when approving or reviewing IPEs.**

**We also recommend NHVR management improve accuracy of customer records by developing a review process to ensure IPE goals accurately reflect the intended employment goal or are changed when necessary.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *A concern was shared with the auditors relative to their observations included here. The seemingly "Monday morning quarterbacking" each of these cases fails to capture the organic and human processes involved with determining vocational choices. Any experienced individual knows that making definitive selections about employment is highly dynamic. Individuals without disabilities find themselves in multiple careers over a lifetime. Those with disabilities, who may have experienced fewer options growing up, may have even more difficulty making definitive decisions. In addition, NHVR works hard to employ an asset based approach that deliberately strives to help clients aspire to high attainment and not simply settle. Finally, there are some clients not truly intentional about finding gainful employment, although they are engaged in the NHVR system.*
2. *By regulation, the bureau is directed "to the extent possible, the employment outcome and the nature and scope of rehabilitation services to be included in the individual's individualized plan for employment must be determined based on the data used for the assessment of eligibility and priority for services." Most often, there is some need for additional assessment, however the bureau balances that need for additional assessment with the customer's informed choice relative to both the need and extent of assessment services. The decision- making process is a collaborative one, and the decision reflects the vocational rehabilitation counselor's application of professional judgement; applicable laws, regulations, and policies; and sound planning considerations of the individual's employment factors, including the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. As a result IPE goals are developed with the best information available at the time of the plan development, with the customer's agreement, based on their informed choice. The plan is not a set, once and done document. It, rather, is a living document that can be changed to fit the changing information and the career development of the customer.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to effectively complete individualized plan for employment plans with customers. This work is targeted for completion by June 2021.*

- *The bureau has issued a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, performance auditors are obligated to report information on the situation that exists at an agency, the factors responsible for internal control weaknesses, and the effect or potential effect of those weaknesses, which is used to develop meaningful recommendations for corrective action. Auditors made objective assessments of cases provided in the Observation based on federal laws, regulations, NHVR requirements, and documentation available in each customer's case record. We agree the unique situation of each customer is integral to their work with NHVR. However, counselors inconsistently documented the rationale, additional assessments, or extenuating circumstances that further impacted the customer's ability to achieve their employment outcome.**

**Additionally, VR is an employment program whose purpose is to "assess, plan, develop, and provide [VR] services for individuals with disabilities…*so that individuals may prepare for and engage in gainful employment*." [emphasis added] Under federal law and regulations, to be eligible for these services, the applicant must require VR services to "prepare for, secure, retain, advance in, or regain employment." If NHVR finds customers are "not truly intentional about finding gainful employment," they may no longer be eligible for services and NHVR should assess whether steps should be taken toward case closure.**

**Observation No. 22**

## Ensure Services Provided Contribute To Achievement Of The Employment Goal

NHVR provided certain services and goods to customers which did not appear to directly contribute to achieving an employment goal or address a known barrier to employment. NHVR also inappropriately provided some services before an IPE was developed and removed some services from IPEs which had already been provided. As a result, some services did not appear to be necessary for the customer to achieve their employment goal or may not have been provided at the appropriate time.

As stewards of public resources, NHVR management was responsible for safeguarding assets and assuring resources were used for authorized purposes. Establishing and maintaining effective internal controls over financial resources would have provided reasonable assurance that resources were managed in compliance with federal regulations and NHVR policy.

### Unrelated Or Unnecessary Services Provided

Federal law and NHVR policy stipulated counselors must conduct an assessment to determine a customer's rehabilitation needs and to determine the nature and scope of services to be included in the IPE. Federal regulations required services in the IPE must be needed to achieve the

employment outcome, and must assist customers in securing retaining, advancing, or regaining an employment outcome. According to NHVR's *Policy Manual*, these services should directly contribute to achieving the employment goal. NHVR policy further stated:

> *Services **must lead directly** to employment goals that are feasible, timely and attainable within the fiscal constraints of the program…. NHVR will only support the most cost-effective option that **leads to the individual's employment goal and that is required to meet the individual's needs**. [emphasis added.]*

***Payments For Services That Did Not Appear To Be Related To The Employment Goal***

We found instances in which services and goods provided to customers did not relate directly to their employment goal. Additionally, these services also did not appear to address any barrier to employment based on assessments in the customer's file, which would help the customer achieve the employment goal, thereby facilitating noncompliance and cost-ineffectiveness. For example:

- A customer with the employment goal of being a self-employed "massage therapist" was provided goods to address the customer's low vision barriers. An assistive technology consultant specifically recommended that low vision items provided by NHVR should directly relate to the business. While certain low vision aids provided were reasonably associated with the employment goal such as a talking clock, talking watch, and notebook, other goods appeared to have no relation to the employment goal. These included $92 paid for cut-resistant gloves, heat-resistant gloves, a cutting board, measuring cups, measuring spoons, and a digital thermometer. There was no explanation, such as a case note or CRP report, in the file for how these items led directly to the achievement of the employment goal. A follow-up CRP report noted the customer was using the kitchen items for personal enjoyment.

  When the instance was brought up to NHVR management for clarification, management stated program purchases for visually-impaired customers were meant to also address independence at home and not just employment goal-related barriers. However, federal regulations and NHVR policy were specific in that services must be directly related to the employment goal. Additionally, our correspondence with the U.S. Department of Education Office of Inspector General confirmed that similar purchases under a VR program would be questionable. The Office of Inspector General reiterated that costs in the IPE must include explanations for why the expenses were necessary to facilitate the desired employment outcome and also noted federal *Uniform Guidance* stipulated costs must be reasonable and necessary to be allowable.

- A customer with the employment goal of "computer user support specialist" self-reported having vision issues to the extent that it was difficult to read small print and provided no medical documentation related to their vision. Additionally, when a consultant evaluated the customer's assistive technology needs two years earlier, the consultant only recommended that the customer zoom in on small print for work and no assistive technology was needed. Regardless, the customer was determined eligible for services and was provided $540 for glasses without an updated assessment or evaluation of the customer's vision.

- A customer had a documented employment goal of "counselor." However, the customer had been in stable employment for the past three years and was not at risk of losing their position. Additionally, a case note from the initial meeting with the counselor read, "[Customer] said [they] did not have any expectations of services or wants with [NH]VR but finds it helpful to talk aloud about [their] plans and ideas." To be eligible for VR services, federal law stipulated the applicant require services to obtain, advance in, or retain employment. Based on the initial meeting, it appeared the customer did not require services and should have been found ineligible. Instead, the customer was provided guidance and counseling services for five years until the customer eventually retired. For the first two years of the case, the counselor met with or communicated with the customer monthly. Although there was no progress toward an employment goal during those first two years, the counselor continued to conduct annual reviews, created two new IPEs upon expiration of the previous IPE, and met with or attempted to contact the customer every three months until case closure. While no vendor services were provided, counselor resources were ineffectively utilized instead of appropriately directed toward other customers who required services.

***Payments For Maintenance Services Did Not Appear To Meet The Federal Definition***

We found NHVR paid for maintenance services contrary to federal regulations and NHVR policy. Under federal law, maintenance was monetary support provided for expenses that were both: 1) in excess of the customer's normal expenses, and 2) necessary for the customer to be able to receive other services documented in the IPE. The following examples were improperly paid for by NHVR even though they did not meet both requirements for maintenance services:

- A customer was taking an online course paid for by NHVR which was directly related to their employment goal. However, the customer requested NHVR also pay for their internet service to complete online training, even though according to case notes, the customer was already paying for internet as part of their normal expenses. NHVR agreed to pay for four months, but eventually paid $150, which included a fifth month without any explanation, toward maintenance services that were not in excess of the customer's normal expenses.
- A customer was attending multiple two-day trainings paid for by NHVR which was directly related to their employment goal. The training agenda stipulated breakfast would be provided at the trainings, but participants would be required to provide their own lunch. NHVR paid a flat rate of $52 toward maintenance for each two-day training session for the participant to purchase lunch, but initially did not request receipts from the customer to verify the food purchased was limited to what was needed to attend the trainings. Eventually, NHVR did require receipts for reimbursement. However, the receipts provided showed the customer purchased groceries such as frozen vegetables, spices, cooking oil, and rice, instead of lunch for training sessions. Regardless, the customer was still provided payment for nine two-day training sessions for a total of $375 toward maintenance that did not appear to be in excess of the customer's normal expenses.

**Unclear Whether Services Should Have Been Provided Before IPE Development**

NHVR provided certain services to customers before the development of the IPE, in some instances contrary to federal law and NHVR policy. Federal law stipulated a comprehensive assessment could be done to the extent that additional data was necessary to make a determination of the employment goal and scope of services to be included in the IPE. However, the comprehensive assessment was limited to information that was necessary to identify the needs of the individual and for development of the IPE by using existing information "to the maximum extent possible." Therefore, pre-IPE services were limited to assessments for making determinations of eligibility, vocational assessments, and assessments for identifying barriers to employment. All other services provided that contributed toward obtaining the employment outcome were required to be included on the IPE.

We found instances in which NHVR provided assessment and evaluation services when existing information appeared to be available to develop the IPE with the mandatory components. Additionally, some pre-IPE services did not appear to relate to determining eligibility, deciding on an employment goal, or identifying barriers to employment. For example:

- One customer, who did not have an IPE developed until one and a half years after eligibility was determined, had driving and transportation identified as barriers to employment prior to IPE development. Despite existing information being available to develop the IPE, the customer was provided in-house benefits counseling over the course of five meetings and a $375 driver evaluation before the IPE was developed.
- Low vision and transportation were already identified as barriers to employment for another customer prior to IPE development. Despite existing information being available to develop the IPE, the customer was provided $732 in low vision evaluations and training, rehabilitation technology consultations, and driver evaluation services before the IPE was developed.
- One customer, who did not have an IPE developed until three years after eligibility was determined, had already received $12,464 in services including rehabilitation technology consultations, driver evaluations, vision evaluations, and CRP services. Even though the IPE had yet to be developed and an employment goal had not been documented, NHVR made eight payments over a two-year period each ranging from $150 to $2,000 described as "Eval tuition" and additional payment for $1,023 described as "Tuition/Fees College" before the IPE was developed. In total, NHVR paid almost $9,500 to two community colleges before the IPE was developed.

**Services Provided Were Removed From The IPE**

Federal regulations specified the IPE was a written document and in the event a customer's case was closed due to achieving the employment goal, the record of services had to contain documentation that services provided under the IPE contributed to the achievement of the employment goal. NHVR policy also stated NHVR would establish and maintain a case record for each person who applied for services which included the IPE, any amendments to the IPE, and documentation on the nature and scope of services provided by the program. Per federal

regulations, the customer could request NHVR amend information if they believed the information contained in the record of services was inaccurate or misleading. Since subsequent IPEs and amendments were reportedly meant to be reviewed as an amendment to the initial IPE, deleting services through an amendment would indicate the service was not provided or needed. However, we found two instances in which an inaccurate record of services was created due to the counselor deleting services that had already been provided to customers. One customer was provided $25,962 in tuition and computer hardware services, while another customer was provided $1,300 in CRP and driver evaluation services prior to amending the IPEs to delete those services. Additionally, the amendment to delete the CRP and driver evaluation services was never provided to the customer for their review and approval.

**Recommendations:**

**We recommend NHVR management:**

- **clarify whether goods and services not directly related to the employment goal are allowable under federal guidance, and if allowable, provide guidance to ensure counselors document explanations for why these purchases are necessary to achieve the employment goal;**
- **clarify when maintenance payments are appropriate and develop procedures to determine whether costs are in excess of the customer's normal expenses;**
- **incorporate supervisory review over required assessments to ensure services appropriately reflect the customer's strengths, capabilities, and cost-effectiveness of the service;**
- **review usage of pre-IPE services and develop guidance to ensure counselors utilize existing information to the maximum extent possible and include all other necessary services on the IPE; and**
- **improve accuracy of customer records by clarifying when to delete services which were determined to be unnecessary and were not provided to obtain the employment goal.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *It is unclear to NHVR why the auditors continue to reiterate observations of the same nature. The content of this observation is substantively similar to that of observation 20 and does not appear to add necessary content or context that could not have more efficiently been included in that observation.*
2. *A concern was shared with the auditors relative to their observations included here. The seemingly "Monday morning quarterbacking" each of these cases fails to capture the organic and human processes involved with determining vocational choices. Any experienced individual knows that making definitive selections about employment is highly dynamic. Non-disabled individuals find themselves in multiple careers over a lifetime. Those with disabilities, who may have experienced fewer options growing up, may have*

*even more difficulty making definitive decisions. In addition, NHVR works hard to employ an asset based approach that deliberately strives to help clients aspire to high attainment and not simply settle. Finally, there are some clients not truly intentional about finding gainful employment, although they are engaged in the NHVR system.*

3. *Part of an individual being successful as an employee is the ability to prepare for work. This includes being able to get up on time and prepare oneself for the day. For some individuals this may include assuring that the individual knows how to and can safely take care of themselves. Self-care is one of the limitations that the bureau identifies as essential for successful workers. This means being able to maintain activities of daily living, including being able to cook for oneself safely and effectively in order to maintain their health to continue to work. These services are tied to the individual being successful as a viable employee. These are the same functional capacity areas that are used in eligibility and in comprehensive assessment when identifying the nature and scope of services an individual will need to be successful in their chosen employment goal. That a necessary skill can also be used to the enjoyment of the individual does not take away from its necessity as a crucial piece to overall success as an employee, or business person.*
4. *The audit report questions whether services provided are "allowable." All services provided by the bureau are allowable under the scope of VR services. When a VR counselor agrees to provide a service they are indicating that the particular service chosen is "reasonable and appropriate" as a service meeting federal requirements.*
5. *As the audit report indicated, the individual identified in the above observation was found eligible for services with a visual impairment. Glasses prescription would have not been part of an assistive technology evaluation. There would have been no reason to do or update an assistive technology evaluation for this service. Prescriptions are provided by optometrists and ophthalmologists. Glasses are provided under a current prescription which would have included an assessment of the customer's current vision.*
6. *While an individual may be employed, and not at danger of losing their job, they may apply for and be found eligible for VR services. An individual can be found eligible if they need services to obtain or advance in employment. In the example provided, given the participant's disabilities in this case, there were some serious concerns that he would have been able to make a change without assistance. Due to his disability he had experienced difficulty completing paperwork in a timely manner, difficulty spending extended time on work task, difficulty focusing on some tasks when working in a noisy environment, difficulty with prioritizing and organizing work tasks which impacts productivity, and difficulty meeting deadlines. It was also noted that at times he required extra supervision to meet most employer expectations. At the initial meeting, it was noted that while he had been working at his current employer, the conditions there were disincentives for him and he wanted to explore alternative options. He was seeking assistance to do just that. "…ready to explore other options. He notes that there is much staff turnover and most move on after 3 years. He does not feel he can advance there any further. Additionally, the job requires an excessive amount of his time, he said he must be available from 7 am to 8 pm and works about 65 hours a week…."*
7. *Maintenance is an allowable service provided through the bureau. In the case cited above, the customer required internet access specifically to participate in the services, i.e., online training. While he had been paying this expense, he identified an issue with resources to*

*continue to pay for this service which put his completing his training at risk. The bureau assisted for short term to allow him to complete the training program.*

8. *The audit team noted the following example: "A customer was attending multiple two-day trainings paid for by NHVR which was directly related to their employment goal. The training agenda stipulated breakfast would be provided at the trainings, but participants would be required to provide their own lunch. NHVR paid a flat rate of $52 toward maintenance for each two-day training session for the participant to purchase lunch, but initially did not request receipts from the customer to verify the food purchased was limited to what was needed to attend the trainings. Eventually, NHVR did require receipts for reimbursement. However, the receipts provided showed the customer purchased groceries such as frozen vegetables, spices, cooking oil, and rice, instead of lunch for training sessions." The training took place 120+ miles from the customer's home. It was determined that it was more efficient and effective for the customer, to stay overnight in the area of the training. The original agreement with the participant was set up as a stipend for meal purchase. He had been able to set up a room with a friend in the area, this reduced the bureau's support in the area of maintenance as NHVR would not have to support a hotel cost for the 9 sessions as well. As this was a per diem rate, receipts were not required. When later renegotiated as a reimbursement, the customer provided receipts. The participant is Pakistani and had access to a kitchen through his friend – that he chose to purchase food to cook versus prepared food was his choice and may have been made in relation to his culture or his disability. It was a purchase outside of his normal at-home expenses, was within the agreed upon amounts for food purchase to participate in the training, and was agreed upon in the rehabilitation planning.*
9. *Services provided prior to a plan are to assist the customer and the bureau determine the nature and scope of services to be included in the IPE. Driver evaluation, low vision evaluation, rehabilitation technology consultations and benefits planning are all potential services that are used to assist in those activities.*
10. *As identified in observation 20, an individual's IPE includes the initial IPE and all subsequent amendments.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to accurately identify and record the use of services in the individualized plan for employment and in the case record. This work is targeted for completion by June 2021.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, Observation No. 20 discusses limitations in NHVR's case management system and provides recommendations to develop IPEs, amendments, and**

**internal corrections consistently. There is no overlap between these two Observations, as this Observation is specific to services provided to achieve the employment outcome.**

**In reference to Remark 2, auditors made objective assessments of cases provided in the Observation based on federal laws, regulations, NHVR requirements, and documentation available in each customer's case record. We agree the unique situation of each customer is integral to their work with NHVR. However, counselors inconsistently documented the customers' circumstances, such as barriers to employment, and inconsistently obtained or retained follow-up documentation for certain services.**

**Additionally, VR is an employment program. If NHVR finds customers are "not truly intentional about finding gainful employment," they may no longer be eligible for services and NHVR should assess whether steps should be taken toward case closure.**

**In reference to Remark 4, as stated in the Observation, the Office of Inspector General, a federal oversight agency, reiterated that cost for services in the IPE must include explanations for why the services were necessary to facilitate the desired employment outcome. As stewards of public resources, if NHVR views all purchases under its program as "allowable," even if counselors did not document the need for the service, it is not acting in the best interests of the public or its customers and risks waste of funds or fraud.**

**Comparable Services Provided Under Another Agency**

According to federal regulations, the *State Plan* must assure that prior to providing an accommodation or VR services, NHVR was required to determine whether comparable services and benefits (comparable benefits) existed under any other program and whether those services and benefits were available to the customer without delay. Federal regulations exempted certain services from this requirement including assessments for determining eligibility and VR needs, guidance and counseling, referrals to secure needed services from other agencies, job-related services such as job search and placement assistance, rehabilitation technology, and post-employment services. Federal regulations further required if comparable benefits were readily available under another program, NHVR had to use those benefits to meet, in whole or part, the costs of the VR services. The IPE was required to include any services provided by NHVR, or from any other source, that were determined necessary to achieve the employment goal.

**Observation No. 23**

**Document Comparable Benefits**

Counselors inconsistently documented whether comparable benefits were available and did not always include them in IPEs when they were available. Additionally, costs attributable to comparable benefits were not always included in IPEs and appeared to be inaccurately and inconsistently reported to the Rehabilitation Services Administration.

**Inconsistent Documentation Of Whether Comparable Benefits Were Available**

Federal law required state VR agencies to determine whether comparable benefits were available under any other program prior to providing certain VR services. It required these comparable benefits be used unless it would interrupt or delay: 1) the progress toward achieving the employment outcome, 2) an immediate job placement, or 3) services to an individual at extreme medical risk. Federal regulations exempted some services from this requirement.

While NHVR did not issue guidance regarding how to document whether comparable benefits were available for non-exempt services, training documents stressed the importance of case notes to provide accountability and to demonstrate that required activities were taking place. Additionally, RLs and counselors reported no formal assessment existed, but stated case notes should document the counselor's assessment of whether comparable benefits were available. The IPE contained an area to indicate the cost of comparable benefits provided. The majority of IPEs we reviewed contained $0 in comparable benefits, indicating comparable benefits were not available. However, counselors inconsistently provided case notes rationalizing their decisions, including whether they determined if comparable benefits were available. Without documentation, NHVR was unable to ensure compliance with federal law requiring a determination of comparable benefits prior to providing certain VR services.

**Comparable Benefits Were Inconsistently Included In IPEs**

Federal regulations required the IPE describe the specific rehabilitation services to be provided to achieve the intermediate rehabilitation objectives and ultimately, employment outcome. It also required the IPE describe the terms and conditions for providing those services including whether comparable benefits were available to the individual under any other program. If no other comparable benefits existed, or if NHVR determined other comparable benefits would delay progress toward the customer's employment goal, NHVR was required to provide the service.

NHVR procedures and guidance did not address the requirement to document comparable benefits in the IPE. Policy only reiterated requirements in federal law to document the terms and conditions of the individual's responsibility to pursue, and other agencies to provide, comparable benefits or services through other resources. We found four instances in which NHVR customers received comparable benefits or services from other entities totaling approximately $35,750 that were not documented in IPEs leading, to inaccurate reporting of estimated case costs and services that would be needed to achieve the employment outcome. The four instances included:

- A customer was attending college to obtain a bachelor's degree necessary to achieve their employment outcome. The training service and tuition costs associated with the customer's third year of college were added to the IPE with a comparable benefit estimated to cost $24,562. However, the comparable benefits service for the first two years of college was not included on the initial IPE, even though case notes indicated the customer was receiving tuition assistance through other available resources for these two years. It was unknown how much the tuition costs were for the first two years of college.
- The case management system recorded a customer as having limited mobility for a functional limitation and an impediment to employment. The customer needed a new

wheelchair to work toward an employment goal. The counselor informed the customer NHVR would not pay for the wheelchair because it was not necessary to achieve the employment outcome. However, the customer noted needing the wheelchair in order to leave the house. NHVR's decision to not provide this service appeared inconsistent with federal law and NHVR policies. The wheelchair was not included on the IPE as a needed service or recorded as a comparable benefit although without the wheelchair, the development of the IPE and other needed services were postponed. Eventually, the customer's insurance paid 80 percent of the estimated $11,000 cost and the customer paid the remaining 20 percent through their own fundraising efforts.

- A customer receiving hearing aids also required hearing exams, which were paid for through their insurance. The counselor added the services but did not include estimates or comparable benefit costs. It was unknown how much these exams cost.
- A counselor documented in a case note that the customer was receiving services for benefits counseling and technology assessment from other vendors at no cost to NHVR. According to a case note, the technology assessment and associated services were needed for the customer to communicate. The provider offered to assess the customer's work site and modify the communication device to accommodate employment needs at no cost to NHVR. The services and comparable benefit costs were not included in the IPE, but similar NHVR services costs ranged $45 to $58 per hour for benefits counseling and $95 to $135 per hour for technology assessments plus travel or mileage fees for each.

**Comparable Benefits Inconsistently Received Review Even When Included In The IPE**

Even if the counselor included costs from other sources, such as the customer or comparable benefits on the IPE, the file case management system only prompted supervisory review if estimated IPE costs to NHVR exceeded thresholds. For example, a counselor could have services estimated at $9,000 for NHVR costs and $12,000 in comparable benefits totaling over $21,000 in IPE costs. However, these costs would not prompt supervisory review since the NHVR costs did not exceed thresholds. Additionally, if there was a delay in receiving the service, a counselor could authorize NHVR payment for comparable benefit services without creating an amendment or a new IPE, which would also bypass review requirements. Therefore, even though NHVR may eventually be responsible for paying for the services, IPEs with potential total case costs above thresholds were inconsistently receiving supervisory review.

**Inconsistent Reporting**

The Rehabilitation Services Administration required annual reports contain data on instances in which comparable benefits were available for services NHVR provided. NHVR also reported the "annual contribution to IPE costs through comparable benefits" in the *State Plan* and *2016 NHVR Comprehensive Statewide Needs Assessment*. However, reports produced in the same calendar year contained conflicting data. Specifically, NHVR's FFY 2016 federally required annual report did not include any instances in which comparable benefits were provided. However, the *State Plan* reported costs of $65,295, and the *2016 NHVR Comprehensive Statewide Needs Assessment* reported costs of $404,927 in comparable benefits for the same time period, which indicated

customers received comparable benefits. It also appeared the annual federal reports continued to exclude comparable benefits in subsequent years.

Although NHVR asserted it developed a strategy to obtain the annual contribution to IPE costs through comparable benefits, those numbers were misrepresented in the *State Plan* and *2016 NHVR Comprehensive Statewide Needs Assessment*. Instead of using the amount paid for services provided, the *State Plan* and *2016 NHVR Comprehensive Statewide Needs Assessment* actually used counselor estimates. Additionally, as noted previously, comparable services were not always included in IPEs even when they were used, further contributing to inaccurate comparable benefit costs in the *State Plan* and *2016 NHVR Comprehensive Statewide Needs Assessment*.

**Recommendations:**

**We recommend NHVR management:**

- **develop guidance for documenting whether comparable services and benefits were available;**
- **include all VR services necessary to achieve the employment outcome on the IPE and corresponding costs, regardless of the program providing the service or payment;**
- **ensure all IPEs exceeding threshold amounts receive supervisory review, regardless of payment source; and**
- **ensure comparable benefit cost data reported to all external entities is valid and accurate.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The audit report indicates that costs attributable to comparable benefits are not always included in IPEs and appeared to be inaccurately and inconsistently reported to the Rehabilitation Services Administration, however, comparable benefit identification and estimated costs on the plan are not used in federal reporting. There is no federal reporting that comes from these fields in the IPE.*
2. *While there is regulation that identifies a requirement to include the responsibilities of other entities as the result of arrangements made pursuant to the comparable benefits requirements, there is not a specified requirement that the IPE include the extent of the comparable benefit source's participation in paying for the cost of services, as is required for eligible individuals.*
3. *NHVR staff seek out comparable services and benefits prior to providing any vocational rehabilitation services, except those services listed as exempt, as provided for in law, regulation and policy.*
4. *A $0 amount listed in comparable benefits on the IPE does not necessarily indicate that comparable benefits were not being used as required. Comparable benefit provision may not be needed or required for certain services. There are services that are exempt from the comparable benefit search requirement and as such would show a $0 in comparable*

*benefits on the plan, and not require documentation. There are also instances where the comparable benefit, or the amount of the benefit are not known at plan development. In these instances, the case record would document the comparable benefit search. If these were available, the case record would document the use of these benefits, including the comparable benefit source. The four instances identified in the observation provide demonstration that the bureau identified and documented the use of comparable benefits in service provision in the case record.*

5. *Services that are in place and being provided by another source prior to plan development would not be required to be included in the plan.*
6. *There is no comparable benefit cost data that the agency is required or currently reports to external entities. There is no federal reporting requirements to account for cost figures on comparable benefit provisions. The agency reported cost figures in the 2016 State Plan as information and planning data under the Evaluation and Reports of Progress section as a measurement strategy under bureau generated goals and priorities. Comparable benefits costs were similarly reported in the 2016 Comprehensive Statewide Needs Assessment for information and planning purposes. In neither instance was this a required reported element. NHVR subsequently identified that capturing these costs figures was not providing data that was relevant to these two reports, or bureau planning. The auditor statement that, 'It appeared the annual federal reports continued to exclude comparable benefits in subsequent years' is not an indication that the bureau is failing to report required information in federal reporting. The discrepancy identified between the two reports has been explained as human error in preparation of the report; a copying and pasting error rather than a discrepancy of data generated from the case management system.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to accurately identify and record the use of comparable benefits in the individualized plan for employment and in the case record. This work is targeted for completion by June 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 6, as we discuss in the Observation, NHVR included estimates of comparable benefits in the *State Plan* and *2016 NHVR Comprehensive Statewide Needs Assessment*, both of which were federally required documents. We did not state that *cost estimates* were used in the FFY 2016 federally required annual report (known as the "RSA-911" report) and after. We stated that NHVR did not submit any instances of comparable benefits in the "RSA 911" reports, which was not consistent with what it documented for the**

**same year in the *State Plan* and the 2016 NHVR *Statewide Comprehensive Needs Assessment*. All data NHVR reports, whether to the public or its oversight agency, should be accurate and reliable, not just in situations that NHVR may view as "required."**

### Potentially High-Cost Services

Vehicle modifications and college tuition were some of the high-cost items and services NHVR provided for its customers. Vehicle modifications had potential costs exceeding $100,000, depending on the customer's needs. RLs stated that while it was important for counselors to determine whether other means of transportation were available prior to seeking a vehicle modification, several regions in the State did not provide sufficient public transportation making vehicle modification services vital to a customer's ability to independently obtain competitive employment. Despite the potential for high costs, we found the vehicle modification process did not have comprehensive formal procedures, procedures that had been established were inconsistently followed, and case records did not contain all required documentation, including documentation of review.

NHVR encouraged customers to obtain educational achievements; however, leveraging college education to directly obtaining employment outcomes was likely challenging. Therefore, college cases may have required counselors to monitor the educational progress of students and support these customers in ultimately obtaining an employment goal.

### Observation No. 24

### Formalize And Document Vehicle Modification Process

In both our 2001 *Bureau of Vocational Rehabilitation and Service Delivery* performance audit (*2001 LBA Audit)* and current audit, NHVR management identified vehicle modifications as an area of concern, partly because of its increasing costs. Regardless, our *2001 LBA Audit* found vehicle modification files did not contain required documentation, and our current review of ten vehicle modifications completed on files active during our audit period found issues persisted. We found:

- files still did not include all required documentation,
- the overall process was not fully established in policy,
- available policies and guidance were applied inconsistently, and
- documents requiring managerial review were inconsistently complete or were inaccurate.

### Files Did Not Contain Required Documentation

Documentation required by NHVR policy or guidance was not always retained in case files. Instead, some documentation and forms for an individual case were located only in the physical file, while others were located only in the electronic case management system. Other components documenting the process were retained only in management emails, were only referenced in counselor case notes, were incomplete, or were absent from any record. Documenting processes

and retaining relevant forms for vehicle modifications was necessary to ensure proper procedures were followed and allowed consistent and informed management review.

Several forms not referenced in policy were required by NHVR's guidance or reportedly used in the vehicle modification process, but it was not NHVR practice to retain them. NHVR's 2007 *Update To Vehicle Modification Process And Best Practice* required the counselor and customer complete the *Driver Evaluation Intake* form. The form was provided to the vendor by NHVR to conduct driver evaluations. None of the ten files we reviewed contained the *Driver Evaluation Intake* form. In 2018, NHVR implemented a *Participant Checklist*, which contained information for the Vehicle Modification Coordinator to determine whether the customer met criteria for a vehicle modification. The checklist was also reviewed by multiple parties throughout the approval process. The 2018 update required the counselor complete the *Participant Checklist* and send it to the RL for approval. The 2018 guidance further specified the *Participant Checklist* "should be sent to the Vehicle Modification Coordinator in order to initiate the vehicle modification process…"

Both the 2007 *Update to Vehicle Modification and Best Practice* and the 2018 *Vehicle Modification Guide* required specific forms and reports be completed and reviewed by management. We identified the following instances where forms and reports were inconsistently retained in the customer's case record:

- one file was missing the *Justification of Obligation of Funds*;
- one file was missing an updated *Financial Needs Assessment*;
- one file was missing an updated *Driver Evaluation Report*;
- three files were missing preliminary or final inspection reports;
- four files were missing approved purchase orders, three of which were for modifications in excess of $100,000; and
- five files were missing initial or final quotes for vehicle modification work.

Additionally, at least four cases were missing documentation in the case record because management retained some approvals and consultant evaluations or inspections only in email. We were provided some of the missing documentation only after we inquired about these items.

**Lack Of Formal And Comprehensive Policies**

When developed comprehensively, policies document the activities and assign responsibility for an organization to achieve objectives efficiently and effectively. In October 2002, NHVR updated the *Policy Manual* to revise limited policies regarding the vehicle modification process. Although the process has evolved since 2002, NHVR did not update or adopt comprehensive policies. Instead, changes to the process were communicated via a March 2007 guidance letter entitled *Update to Vehicle Modification and Best Practice*, the *Vehicle Modification Guide* released in 2018, and informally through management directives. Federal regulations, State law, and administrative rules did not address vehicle modification requirements or processes. Consequently, portions of existing policy conflicted with itself, guidance and directives did not have corresponding policy, and other guidance was unavailable or conflicted with components of the existing policy.

***Conflicting Policy***

At least two components of policy related to vehicle modifications conflicted with itself and NHVR practices: comparable benefits and vehicle purchases. Federal regulations, administrative rules, and part of the *Policy Manual* exempted rehabilitation technology, including vehicle modifications, from comparable benefit requirements. However, another part of NHVR's *Policy Manual* stated, "Purchase of and installation of lifts, hand controls, and other assistive technology for a vehicle… may be provided by the agency after applying financial needs and *comparable benefits*." [emphasis added] While the *Policy Manual* conflicted in this area, other guidance and the Vehicle Modification Coordinator reported vehicle modifications did not require comparable benefits.

Before 2002, the *Policy Manual* appeared to allow NHVR to purchase vehicles. A 2002 update to the Policy Manual stated, "NHVR may not purchase vehicles, including vans." However, NHVR updated the *Policy Manual* in 2007, but the language regarding vehicle purchases before 2002 still remained. Additionally, guidance developed since 2007 did not clarify the policy. The 2007 *Update to Vehicle Modification and Best Practice* indicated NHVR could purchase a vehicle during the vehicle modification process with an approved waiver, while the 2018 *Vehicle Modification Guide* did not address vehicle purchases. Management and personnel reported NHVR could not purchase vehicles.

***Certain Processes And Requirements Were Not In Formal Policy***

Federal regulations required VR agencies maintain *written policies* covering the nature and scope of each service it provided and the criteria under which it was provided, including vehicle modifications. Federal law required state VR programs to conduct public meetings to provide the opportunity for public comment, as well as consider the views of certain stakeholders prior to the adoption of any policies or procedures governing the provision of VR services. Since at least 2007, NHVR created guidance, informally setting directives and criteria for providing services rather than updating its vehicle modification policies from 2002. Therefore, most of the processes and requirements for vehicle modifications were not set in policy as federally required, nor did they receive public comment. Areas in guidance or described by management that did not have corresponding policy included:

- requirements imposed on customers such as being currently employed or within one year of becoming employed, limiting the age of a customer's wheelchair, and limiting the age and mileage of the customer's vehicle, which was also not documented in any guidance;
- requiring forms and reports be reviewed and approved such as a *Justification of Obligation of Funds,* which included justification for how the vehicle modification would assist the customer in overcoming their barrier to employment*,* and the *Driver Evaluation Report,* which NHVR requires vendors to provide; and
- other requirements such as requiring a consultant to perform a vehicle inspection prior to finalizing the vehicle modification and obtaining approvals from the Director or Commissioner depending on the estimated cost of the modification.

***Inconsistent Application Of Policy, Guidance, And Practices***

We reviewed ten vehicle modifications which started the process between 2010 and 2017. The *Policy Manual* and 2007 *Update to Vehicle Modification and Best Practice* applied to all ten vehicle modifications. Although these vehicle modifications were subject to the same requirements, we found inconsistent application.

- The *Policy Manual* stated vehicles could be modified if it was demonstrated that it was necessary to obtain the IPE goal and driver training could be provided only when public transportation or other means of transportation were unavailable or unsuitable. In one case, the consultant expressed concerns, consistent with restrictions in the *Policy Manual,* noting the customer would be living in an area with accessible disability services and transportation options. Regardless, NHVR completed the vehicle modifications and training, costing in excess of $100,000, without demonstrating alternate transportation options were unavailable or unsuitable as required by the *Policy Manual*.
- The *Policy Manual* stated the customer was responsible for driver's licensing and insurance costs. The *Update to Vehicle Modification and Best Practice* required documentation of how the insurance would be paid, as well as a certificate of insurance, prior to release of the modified vehicle. In two cases, each with vehicle modifications costing $100,000 and completed within one year of each other, the consultant recommended NHVR follow up on insurance or a driver's license. However, these cases were handled differently.

    - In one case, the consultant recommended NHVR obtain verification the modifications were covered under the customer's insurance. NHVR followed up with the customer and obtained the verification.
    - In another case the consultant conditionally approved the vehicle modification subject to the customer obtaining a driver's license and NHVR verifying insurance. Even though a driver's license is required by State law to drive a vehicle, and one vendor provided adaptive driver training only with proof of insurance, the Vehicle Modification Coordinator informed the counselor that NHVR could not require customers to have a driver's license or insurance. One RL stated during an interview that a driver's license was required if the vehicle modification was intended for the customer to be able to drive.
- The *Policy Manual* stated NHVR would not provide financial assistance for another vehicle modification within three years of the first modification, unless the Director or designee waived costs based on a change in disability, change in availability of alternative programs, or when it could be demonstrated that the customer would not otherwise be able to obtain those services resulting in an inability to achieve the IPE goal.

    - In one case, the customer obtained a second vehicle modification within three years of the first modification after purchasing a new wheelchair, without first going through the NHVR vehicle modification process. The customer completed and paid for a vehicle modification without first including NHVR in the process. The customer then requested reimbursement from NHVR for the cost of the modification. NHVR reimbursed the customer nearly $10,000 for a portion of the

completed vehicle modifications, even though the vehicle modification did not go through NHVR processes such as verifying accredited vendors bid on the modifications. Additionally, it did not appear the customer met any of the factors which would have qualified them to receive assistance within three years of the first vehicle modification.

- In a similar case, NHVR denied a customer's request for a $695 reimbursement after the customer modified their vehicle to accommodate a new wheelchair within three years of the first vehicle modification.

**Managerial Review Deficiencies**

Components of the vehicle modification process required different levels of review and approval by NHVR management. The NHVR Director was responsible for issuing the final approval. We found evidence of the Director's final approval in eight of the ten files we reviewed. However, only one of those eight approvals was provided through an actual signature. Instead, the Director reviewed information provided by the Vehicle Modification Coordinator and approved the modification through email, leaving the *Justification of Obligation of Funds* incomplete and undocumented in the customer's case record. Consequently, reliance on information provided via email, at times, omitted accurate or important information to make a well-informed decision. Despite several levels of review before the vehicle modification request was sent to the Director, some deficiencies were not detected or corrected.

- Both the 2007 and 2018 vehicle modification guidance required the counselor to develop the IPE, or an amendment to the IPE, to include the vehicle modification. We found one case in which the vehicle modification, driving evaluation, and consultation services were not included in the IPE at all. In another case, the IPE estimated the costs of vehicle modification and related services at $0 and the total case cost was only estimated to be $3,050. NHVR management reported services estimated to cost $10,000 or more and $20,000 or more required different levels of supervisory review. Based on the total estimated costs on the IPE, neither case met the supervisory review threshold; however, these vehicle modifications cost approximately $100,000 each but did not trigger the thresholds for supervisory review.
- In three cases, we found the vehicle modification consultant emailed concerns or recommendations to a former NHVR manager. We were provided these emails when we inquired about other missing documentation. None of these emails were included in the physical file, referenced in the case management system, or forwarded to the Director to be addressed prior to final approval. Some of these included a recommendation to negotiate a lower bid for some aspects of the vehicle modification, concerns about providing a vehicle modification to a student in an area where public transportation was accessible, and a recommendation to obtain more recent customer medical documentation.

**Recommendations:**

**We recommend NHVR management improve its vehicle modification process by:**

- **reviewing its current policies, guidance documents, and practices to clarify areas that appear to conflict and incorporate activities which may be missing from the process;**
- **adopting comprehensive policies including outlining forms it requires counselors to complete, other documentation requirements, and other criteria necessary when approving a vehicle modification; and**
- **documenting and retaining all forms, reports, records, and approvals used in the vehicle modification process in the customer's file to ensure procedures have been followed as well as to ensure thorough, accurate, consistent, and well-informed decision-making.**

**We also recommend NHVR management determine if any administrative rules are needed for vehicle modifications, especially for requirements it imposes that are binding on those outside of NHVR employees.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *A "Justification of Obligation of Funds" form is developed to summarize the need, cost and vendor for vehicle modifications. The counselor forwards this form to the supervisor, field service administrator, director, and if over $50,000, the Commissioner, to approve by signing the form. This form is then attached to the electronic case record.*
2. *Vehicle modification is a complicated service that includes many steps including evaluations and reviews. The bureau has been working over the last couple of years to ensure the process is as clear and complete as possible. This has included refining processes and forms from the 2007 Policy Manual as well as ongoing staff training.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating rules, policy and training materials to assure staff have the information and resources to assist customers with vehicle modification as a vocational rehabilitation service. This work is targeted for completion by June 2021.*

**Observation No. 25**

## Improve Monitoring Efforts And Strengthen Policies For College Training Cases

NHVR did not have controls to monitor and ensure policies applicable to customers attending college were consistently implemented and NHVR resources were safeguarded. Support for college typically included a considerable allocation of financial and staffing resources over an

extended period. While NHVR implemented additional policies and specialized reviews for other high-cost services, such as vehicle modifications, customers attending college did not consistently receive additional scrutiny by NHVR management. No robust and consistent monitoring methods existed during the audit period to ensure college customers were treated uniformly, and the counselor handling college cases left NHVR before the audit period. However, some college files we reviewed from one regional office indicated those cases were assigned to one counselor who handled most college cases in that regional office. NHVR management reported regional offices were instructed to monitor compliance with collecting required college documents but were not given a standardized process to implement. Consequently, some customer files did not contain required documentation on financial aid filings and student progress, and inconsistent college planning efforts risked the inefficient use of NHVR financial resources.

**Demonstrating Financial Need**

NHVR policy and federal regulations required college students to demonstrate a maximum effort to secure grant assistance from outside sources before NHVR provided financial support. NHVR required students submit a *Financial Aid Transmittal Form* (FATF) to the institution's financial aid office annually. The FATF determined the student's remaining financial need after other sources of financial aid were applied.

During the audit period, NHVR allowed a maximum of $5,500 annually for tuition, school fees, room, books, and supplies associated with attending college after determining the customer's financial need. In our file review, we found NHVR paid for 16 customers to attend college. We found the following inconsistencies with NHVR's financial aid policies.

- Seven customers (44 percent) attending college did not consistently submit an FATF prior to NHVR providing funding. NHVR paid the maximum amount for one of the seven before the FATF later indicated the customer did not demonstrate financial need.
- Two customers (13 percent) received a total of $1,900 for books above the maximum funding level, while one customer was denied additional funding to cover coursework-required expenses.
- One customer (six percent) received maximum funding instead of a substantially lower amount as indicated by the FATF. There was no documented approval by the Director, or designee, as required by NHVR policy.

NHVR policy stated if a customer "needs to access a program based on their disabilities," NHVR could exceed the $5,500 maximum and provide funding up to the in-state cost to attend the University of New Hampshire. In our review of NHVR cases and interviews with NHVR management, the policy was understood to apply to college programs specifically serving students with disabilities. However, we found NHVR exceeded the maximum amount for two students attending graduate programs that deviated from this interpretation of the policy.

- One customer received $10,000 a year in funding to continue attending a school near their ongoing medical providers. This interpretation of the policy may have been inconsistent with the understanding reported by other NHVR managers, and could potentially allow the

higher tuition support rate for any student applying to any institution near their medical provider. For example, it was common that students with disabilities may need to coordinate ongoing care while attending college, regardless of which institution they attended.

- Another customer received $10,000 a year reportedly because federal Pell Grants were not available for graduate students.

**Transcripts Not Always Provided Timely**

After completing a semester and prior to the start of each upcoming semester, customers were required to submit their transcripts to NHVR. NHVR policy stated it would not provide funding: 1) if it did not receive a copy of the customer's transcript before the beginning of the next semester, 2) if the customer's grade point average fell below a 2.0, or 3) for failed classes. Transcripts also allowed NHVR counselors to verify services were provided and students maintained full-time enrollment status.

Our file review contained 12 cases where a customer completed at least one college semester. Of these, ten cases (83 percent) did not contain consistent documentation that NHVR received transcripts before the start of the next semester, hindering its ability to consistently implement its own policies.

**Full-Time Enrollment Status Not Enforced**

In May 2015, NHVR updated its *Policy Manual* to require students maintain full-time status unless a "medically documented disability-related issue [made] this impossible." In our sample, we found two customers were enrolled part-time after May 2015 without a medically documented exemption. While some of these customers may have been experiencing serious difficulties justifying a change in enrollment status, at least one part-time student had medical documentation which may have warranted a review of their part-time enrollment status. Consequently, some of these cases may have extended longer than necessary for a customer to achieve an employment goal timely.

**Grade Point Average Requirement Not Always Enforced**

NHVR policy required customers receiving college funding to maintain a grade point average above 2.0 or seek a waiver from the RL. However, NHVR policy also allowed customers on academic probation one semester to attain good standing before revoking financial support which, at times may have nullified the requirement to maintain a 2.0 grade point average. In nine cases where grades were submitted and documented in the NHVR case files, two customers (22 percent) had grade point averages below 2.0. In both cases, financial support was not revoked.

**Funding Provided To Retake Failed Classes**

NHVR policy prohibited funding for classes that were retaken by students without a waiver from the RL. Of the 12 customers attending college, we found at least two instances (17 percent) where NHVR paid for a customer to retake classes. In one of those cases, a customer had to retake three

different classes and NHVR paid for the customer to retake two of the three. In the other case, the counselor appeared to be unaware of how many times the customer had retaken a course which had been paid for by NHVR. No reason for this deviation from policy was provided.

**More Robust Policies Needed**

College training required a considerable investment in money, time, and effort for both NHVR and customers. The high cost and length of time to earn a college degree required additional controls in addition to those outlined in NHVR policy. We found gaps in policy on the consistent use of college planning, labor market research, graduate school, and changes in disability status.

***College Planning And Vocational Goal***

As a vocational program, NHVR funded college training with the objective of achieving an employment goal. NHVR policy stated funding for college would only be supported to achieve the employment goal, and only in the most cost-effective manner. However, we found an instance where funding was provided for a customer to obtain two undergraduate degrees at two separate colleges. These degrees did not appear to be needed to achieve the goal established in the IPE, as an entry-level position in the field identified as the employment goal could have been attained with an associate degree. While students could elect to pursue educational interests outside of a vocational goal, NHVR did not have policies to better define the most cost-effective path in the context of college training.

***Labor Market Research***

Federal regulations required counselors to be knowledgeable in utilizing labor market information for the purpose of the vocational planning process. However, NHVR had no policy to guide staff as to when or how labor market information should be used. Inconsistent use of labor market research for NHVR customers attending college may have resulted in inefficient IPE development. For example, our file review found two customers that communicated an interest in a similar employment goal before receiving funding. One customer, who was instructed to conduct multiple interviews researching the profession, eventually determined the employment goal was not viable, and successfully pursed another career path. This customer was receiving guidance from a counselor who was assigned most customers in that regional office who were attending college. The other customer was told the employment goal had a “bright outlook” without any documented research to support the analysis. This customer eventually lost contact with NHVR and the case was closed as non-rehabilitated.

In another case, no labor market research was conducted prior to the NHVR customer selecting a college major and career. The customer eventually did not obtain employment in their selected field. The incorporation of more robust and consistent labor market research prior to college training support could better ensure college training aligned with a viable employment goal.

### *Graduate School*

The only written policy for graduate studies was the requirement for approval from the NHVR Director. NHVR's policy also established guidance for counselors to consider, before granting a request to fund graduate school, but no formally defined vetting process existed. In our review of 97 cases, we identified one case where NHVR provided funding for a customer to start graduate school during the audit period. In this case, there was no documentation the counselor assessed the customer's request against NHVR guidance. Instead, the customer provided an email explaining their interest in pursuing a graduate program. We did not find evidence in the case record to satisfy multiple areas in NHVR's policy.

- An assessment that no job opportunities existed and that the customer explored other vocational options considering transferable skills and their undergraduate degree. There was no evidence this assessment was conducted.
- Documentation the customer had been successfully employed in the chosen field and that their disability impeded career advancement without a more advanced degree. The customer had not been employed for at least seven years prior to requesting funding for graduate school.
- An assessment of the future job market indicating the field was stable or growing, and there was good likelihood of locating a job in the field with an advanced degree. There was no evidence the customer or NHVR contacted prospective employers or conducted labor market research.
- Documentation indicating the customer was ineligible for job advancement due to their disability and needed retraining with an advanced degree. The customer had not been employed for at least seven years.

Graduate school provided NHVR customers with education that could increase employment opportunities, but it also posed additional risks to both customers and NHVR. For example, financial aid for graduate school was more limited than that for an undergraduate program, and graduate school could further delaying a customer's entrance into the workforce. Consequently, one of the students receiving funding for both an undergraduate and graduate degree from NHVR expressed frustration with the high amount of student debt they incurred prior to ceasing their job search and the case being closed after over ten years of NHVR services.

### *Changing Disability*

For customers with degenerative disabilities, the additional length of time required to complete college increased the likelihood the disability might change over time and potentially hinder the achievement of the originally planned employment goal. If a customer's disability changed, the underlying assumptions used to support the employment goal and services established in the IPE may no longer be applicable. In one case we reviewed, a customer with a possible degenerative disability was attending college part-time and took several years to complete an 18-month certification program. Upon completion of college, the customer decided not to enter the workforce and lost contact with NHVR. It is unknown exactly why the customer discontinued NHVR services after ten years working with NHVR and to what degree the customer's disability related barriers

played a role or changed overtime. However, NHVR's monitoring of the case did not contain annual reviews, progress notes, evaluations, and documentation of the customer's disability which could have helped the case progress more effectively. Consequently, students with medical waivers to attend college on a part-time basis and students with degenerative disabilities likely required increased monitoring, customer service, and evaluation from NHVR to support a successful outcome after receiving long-term college training.

**Recommendations:**

**We recommend NHVR management improve its monitoring of college cases and ensure requirements are applied consistently by:**

- **developing a standard process for regional offices to track and monitor that all required documentation, including the FATF and transcripts, are received before providing funding for subsequent semesters;**
- **developing a process to periodically review customers enrolled in college part-time, ensure medical documentation justifying part-time enrollment status is included in the file, ensure continued part-time enrollment is justified, and update enrollment status as needed;**
- **clarifying policies to ensure those addressing minimum grade point average and academic probation are aligned and do not provide conflicting guidance;**
- **tracking courses funded by NHVR for each customer to ensure funding is not provided for customers to retake a failed class;**
- **establishing a formal process for obtaining waivers for deviations from policies, including providing proper justification, ensure all required documentation is present, and approvals to deviate from policies are documented; and**
- **ensuring staff counseling and monitoring college cases are trained on policies affecting customers attending college.**

**We also recommend NHVR management address potential gaps in overseeing college cases by developing policies:**

- **on justification, criteria, and documentation needed to approve funding for graduate studies;**
- **to document and ensure that degrees funded by NHVR are clearly required for the employment goal identified in the customer's IPE;**
- **to document labor market research was conducted for college cases prior to committing college funding; and**
- **on considering the impact of degenerative disabilities and addressing changes in disability while enrolled in college.**

**NHVR management should also consider designating a coordinator to address college activities to help increase monitoring and ensure consistency.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As the audit report indicates, "Two customers (13 percent) received a total of $1,900 for books above the maximum funding level, while one customer was denied additional funding to cover coursework-required expenses." The VR staff are consistently concerned that the individuality of the program is not recognized. Although the bureau's policy and procedure states limits on services, there are always opportunities to waive areas when individual circumstances arise.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to assist customers with college training services. This work is targeted for completion by June 2021.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**While the specific needs of individual customers should be considered, NHVR should strive to ensure consistency. As we discuss in Observation No. 41, NHVR should establish specific criteria and document requirements when issuing a waiver to policy to ensure the consistent treatment of individuals with disabilities. The three cases identified in NHVR's response did not contain a waiver or any documentation for us to determine why they were treated differently.**

**Observation No. 26**

**Ensure Consistent Documentation For Computer Technology Purchases**

NHVR required specific criteria to be met and documented before hardware or software was purchased for a customer, including: a professional assessment to determine the customer's technology needs, a reason for the purchase related to the customer's disability, documentation of the need for the technology to achieve an employment goal, and RL approval. While NHVR established multiple steps and criteria for purchasing technology, NHVR did not establish a specific form or checklist to ensure all requirements were consistently fulfilled prior to purchase. Four cases in our file review contained computer technology purchases made in calendar year 2019. In three of these cases (75 percent), NHVR purchased computer hardware or software for customers that were inconsistently documented, risking noncompliance with NHVR procedures as shown in Table 10.

**Table 10**

**Documentation Of Compliance With NHVR Computer Technology Purchasing Procedures**

| Criteria For Technology Purchases | Documented | Not Documented | Partial Or Unclear Documentation |
|---|---|---|---|
| Assessment competed by qualified professional | 3 | 0 | 1 |
| Documentation of the disability-related rehabilitation need | 2 | 2 | 0 |
| Documentation the computer technology purchase was necessary | 4 | 0 | 0 |
| RL approval | 1 | 3 | 0 |

Note: In some cases involving multiple computer technology purchases, documentation was fully provided for some but not all purchases.

Source: LBA review of NHVR customer case files.

Federal regulations required all VR purchases be necessary for the customer to achieve an employment goal and NHVR policies required varying degrees of documentation prior to authorization. However, computer technology purchases required specific documentation and additional approval prior to acquisition. This increased oversight was necessary to prevent NHVR computer technology purchases from being used for non-rehabilitative purposes.

**Recommendations:**

**We recommend NHVR management develop a standardized checklist or adopt a detailed form to be completed prior to the approval of a computer technology purchase. Additionally, we recommend NHVR periodically review computer technology purchases for compliance and incorporate any areas of noncompliance into future training.**

*NHVR Response:*

*We concur with the recommendations.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to accurately assist customers with computer technology purchases. This work is targeted for completion by June 2021.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

## Case Monitoring And Oversight

Effective case monitoring required counselors to regularly communicate with customers, establish measurable criteria to assess customer progress through annual reviews, and comprehensively document information to ensure appropriate services were provided and accurate case records were maintained. Well-designed and implemented controls minimized the risk of resources being used improperly and would assist management in identifying areas of deficiency in a timely manner to achieve objectives efficiently and effectively. We found NHVR's case monitoring efforts were not effective in identifying cases that were not adequately progressing towards an employment goal.

**Observation No. 27**

**Improve Case Monitoring Efforts**

NHVR's efforts to monitor customer progress toward achieving their employment goal, as well as documentation of case monitoring efforts, were limited and ineffective. Limited case monitoring oversight and practices contributed to noncompliance with federal regulations and NHVR policy, authorization of improper payments for services, untimely case closures, and a greater likelihood customers would not obtain a successful employment outcome.

### Annual Reviews Were Not Conducted As Required

Federal regulations and NHVR rules required IPEs be reviewed at least annually by a qualified counselor and the customer to assess progress towards achieving the employment outcome identified in the IPE. Each IPE was required to include a description of the criteria that would be used to evaluate progress toward achievement of the employment outcome. However, we found counselors were not always compliant with annual review regulations, and criteria documented in IPEs were often limited, hindering counselors' ability to evaluate progress toward employment.

#### *Missing Annual Reviews*

Annual reviews were not conducted as required. Our review of 39 cases that were open for at least one year after the IPE was developed showed only six cases had all annual reviews as required, while 33 cases (85 percent) were missing at least one annual review. NHVR should have conducted a total of 209 annual reviews in these 39 cases; however, we found 151 of the required annual reviews (72 percent) were missing. Each of these cases was missing at least one annual review with one missing as many as 16 of the 17 required reviews that should have occurred over the course of the case.

The *Desk Reference* required both the counselor and the customer to sign and date the completed annual review to verify the assessment occurred with both parties. Of the 33 cases missing annual reviews, 11 cases did not contain *any* completed annual reviews; therefore, we could not determine whether these reviews occurred and were signed by both parties as required. The remaining 22 had at least one completed annual review. We found six additional cases contained all required annual reviews documented in the case record. However, among these 28 cases with at least one

completed annual review, only 15 (54 percent) had all reviews signed by both the counselor and customer.

Informal NHVR practices implemented by management contributed to noncompliance with completing annual reviews. NHVR management informally allowed a change to the IPE through an amendment to substitute as an annual review. Management reported counselors inconsistently documented when changes to the IPE were meant to substitute for the annual review; therefore, we were unable to determine how often counselors utilized this informal practice. Federal law stipulated the IPE should be amended as necessary if there were substantive changes to the employment outcome, services, or provider of services, but it did not appear to allow a provision for substituting an amendment as a replacement for the annual review. Nor did NHVR policy or procedures allow for substitution of the annual review. NHVR procedures only cited that amendments or a new IPE should be done as needed *during the annual review*. Permitting amendments to substitute for the annual review appeared noncompliant with federal law and did not allow for a holistic approach to assess customer progress.

***Untimely Annual Reviews***

Although federal regulations referenced development of a single IPE for the customer, NHVR determined review should occur to assess progress annually from the active IPE rather than the initial IPE which appeared inconsistent with federal requirements. Consequently, whenever a new IPE was created, it not only reset the implementation date of the IPE but reset the annual review date as well. Essentially, if a customer's initial IPE was developed, but the customer changed their goal six months later, a new IPE would be created. Under NHVR practices, the annual review would not be required until 18 months after the initial IPE was developed. In our review of 39 cases that required an annual review, 31 (79 percent) had the annual review date changed due to the development of subsequent IPEs. This delay could occur several times for certain customers hindering NHVR's ability to review IPEs timely and fully assess progress, or the lack of progress, toward an employment outcome. This process contributed to counselors completing untimely annual reviews in 23 out of 28 cases (82 percent) that contained at least one annual review.

**Limited Criteria To Assess Progress**

Effective criteria should be relevant to the employment goal and measurable to provide a framework for customer accountability and a foundation for conducting productive annual reviews. Each IPE was federally required to include criteria that would be used to assess the customer's progress toward achieving an employment outcome. The IPE contained a section called "Criteria for Evaluating Progress Towards My (Participant) Employment Goal." NHVR training materials stated criteria should be a "critical measure or threshold of performance by which Counselor and [customer] will know if the intermediate objective has been accomplished (or not)." Setting criteria with specific, measurable, attainable, and time-based objectives would assist counselors with assessing customer progress towards their employment goal. While NHVR training materials contained some direction, federal regulations did not provide guidance, nor did NHVR establish policy or procedures for determining appropriate criteria to evaluate progress. Limited guidance resulted in some IPEs containing no criteria, criteria that was not measurable, or criteria that was not relevant to the customer's progress towards the employment goal. The ability

of counselors to effectively monitor case progress was hindered without periodic progress reviews for all customers. We identified the following examples of limited criteria during our file review.

- No Criteria Included In IPEs – Some case record information did not convert to the new case management system when it was updated in July 2015, including certain IPE criteria. However, we found one case in which the IPE was missing criteria for nearly two years after the new case management system had been implemented. Although an amendment and two subsequent IPEs were created for the customer during that time period, the counselor did not add criteria during changes. In another case, after implementation of the new case management system, the hardcopy IPE that was reviewed and signed by the customer did not contain criteria, but the counselor subsequently entered criteria into the case management system. There was no evidence in the case record the customer agreed to the added criteria.
- IPEs Did Not Include Measurable And Specific Criteria – Criteria used in some IPEs did not provide measurable standards to assess progress toward the employment goal nor establish customer accountability. Some criteria identified on IPEs included statements such as "monthly contacts" with the counselor, "review monthly reports from employment specialist," "having new technology and using it in the job," "report changes and provide reports from [medical] care," and "progress will be evaluated on a monthly basis." These statements did not establish measurable and specific performance thresholds to determine whether intermediate objectives were met or whether the customer was progressing towards their employment goal.
- Criteria Did Not Reflect Current Status Of Customer's Progress – Criteria on certain IPEs did not, nor was it updated to, reflect the current status of the customer's progress toward the employment goal. In one case, criteria included items such as working with a job development coach and sending monthly reports to the counselor about the job search process. However, the customer had already obtained employment prior to the development of the IPE, making the criteria irrelevant. In three other cases, criteria were added to the IPE but also copied to subsequent IPEs making it irrelevant and outdated. The first case included rationale for why certain services were being provided rather than criteria to gauge progress towards the employment goal. The information under the criteria section was copied over to two subsequent IPEs spanning three years. The second case included as criteria the customer would have new technology and use it on the job. This criterion was copied over to four subsequent IPEs spanning more than seven years even though the customer was in college for some of this time. The third case copied the initial criteria, which was relevant to applying to colleges, over to the second IPE which was developed six years after the customer was already attending college. The same criteria remained on the IPE for another eight years until the case was closed as non-rehabilitated.
- Criteria Was Not Enforced – Customers were not always held to the criteria documented in the IPE. In one case, criteria documented on three IPEs required the customer submit grades to the counselor and maintain a C average. There was no indication in the file grades were consistently submitted nor were the missing grade reports requested by the counselor.

### *No Guidance On Using Criteria To Assess Progress Or Hold Customers Accountable*

For IPEs that included adequate criteria, there were no procedures to guide counselors in utilizing the assessment criteria to provide accountability. Additionally, counselors were responsible for conducting annual reviews to assess customer progress without any oversight from RLs. Although not required in policy or procedure, the NHVR Director reported there was a feature in the case management system for counselors to note whether the customer was fulfilling the criteria. For example, if the counselor required quarterly check-ins to monitor progress, the feature should be used to document what was discussed, next steps to continue progress, and refer to the note during the annual review to conduct an overall assessment. However, one member of NHVR management reported there was no expectation for counselors to document regular progress notes for customers and progress notes should be used only if necessary such as if a customer was not engaged in working towards their goal.

## Case Monitoring And Documentation

NHVR policies and procedures stipulated the minimum case monitoring and documentation expectations for counselors to ensure customers were progressing towards their employment goal and identify other areas that may require additional attention. Counselors were required to document case notes that were clear, concise, and provided an ongoing story including decisions, rationale for decisions, and customer progress. NHVR further emphasized case documentation, "should be done so that a third party, totally unfamiliar with the case, can promptly and easily see what is happening with the case and can understand why the [counselor] made a particular decision." Case notes were to encompass a variety of information such as NHVR guidance and counseling sessions, problem areas, information related to services rendered, collaborations made with vendors and other agencies, results of reports, and any outreach or communication with the customer. However, ineffectively implemented internal controls led to limited monitoring of case notes and documentation which hindered the ability of counselors to maintain complete case records and comprehensively assess customer progress.

### *Ineffective Internal Control Over Case Notes*

One of NHVR management's controls to ensure counselors were meeting certain deadlines was to send out weekly case monitoring reports to regional field offices which included counselor cases with 90-day gaps in case notes. However, the control was ineffective for the following reasons:

- Procedures Required More Frequent Communication – Although NHVR required counselors enter at least one case note every 90 days to document the status of the case, the *Desk Reference* required counselors to contact the customer every six to eight weeks. If the customer obtained employment, required contact became more frequent with at least one contact in the first week of employment and every three to four weeks thereafter until case closure. Per NHVR procedures, contact and attempts to contact must be documented in case notes. By these standards, the weekly case monitoring report did not timely capture deficiencies in contact requirements with cases on the report potentially ranging from four to eight weeks overdue depending on the circumstances. Our review also showed gaps in communication with customers ranged from four weeks to four years.

- Informal Exemption To Frequency of Contact – NHVR management reported counselors were not required to contact customers enrolled in college as frequently stating contact was expected once or twice a semester or about every three to six months. However, this exemption was neither formalized in procedures nor accounted for on the weekly case monitoring report. A separate internal control for customers enrolled in college did not exist to ensure communication with the customer was sufficient. As such, we found gaps in communication with customers enrolled in college ranged from three to 16 months.
- Reports Did Not Prompt Further Supervisory Review – Weekly case monitoring reports were generated by the central office and forwarded to RLs who then reviewed these reports to address timeliness issues with counselors. However, the reports did not initiate a more in-depth supervisory review to ensure case note content was comprehensive; only that the 90-day timeline was addressed. As a result, we found some case notes had been entered in a way that bypassed the weekly case monitoring report but did not include updated case information. For example, a case note would either be duplicated, only reference a previous case note, or simply blank with a single character so the case management system accepted the case note. Management acknowledged this was a concern with the control requiring counselors to enter a case note every 90 days.
- No Mechanism To Enforce Internal Control – Although management reported RLs followed up with counselors with cases identified on the report, we found some cases remained on the weekly case monitoring report for lengthy periods of time. For example, three cases remained on 66 case reports indicating each had gone at least a year and a half without a case note. We also found certain counselors repeatedly had many cases on the report. Prior to implementing the OOS, 18 counselors were listed on more than half of the weekly case monitoring reports issued from the end of September 2017 through April 2018, with five counselors averaging 30 or more cases on each report. During the OOS, 19 counselors were listed on more than half of the reports issued from June 2018 through October 2019, with four counselors averaging 30 or more cases on each report.

***Limited Supervisory Review***

NHVR had few additional internal controls to ensure case notes were sufficient and comprehensive to allow counselors to assess customer progress. NHVR management reported prior to 2014, monthly random reviews of 25 cases per regional office would be conducted by RLs and staff from the central office to audit compliance and accuracy of case records. However, case reviews had not been completed since 2014 reportedly due to implementation of the new case management system in calendar year 2015 with further interruptions occurring in 2018 when NHVR implemented the OOS. Without sufficient management oversight to ensure case notes were comprehensive, we identified two closed cases with case notes that did not meet timeliness or sufficiency standards, but did not appear to ever be addressed by management. The first case averaged less than two case notes per year encompassing a total of 19 case notes over the 11-year period the case was open. The other case encompassed nine case notes over the ten-year period the case was open which included approximately one-year, three-year, and four-year gaps in case notes. RLs reported NHVR began to reinstate the process in March 2019 by reviewing approximately four cases per month.

**Recommendations:**

**We recommend NHVR management ensure counselors holistically assess customer progress toward achieving an employment outcome by:**

- **assessing whether allowing substitutions to the annual review is compliant with federal law, considering requiring all annual reviews occur from the date of the initial IPE;**
- **ensuring all annual reviews are conducted timely;**
- **developing procedures and training counselors on how to develop adequate criteria that can be used to measure a customer's progress and ensure criteria remains relevant through the entire case;**
- **developing and formalizing procedures for counselors to effectively assess customer progress against criteria;**
- **assessing current minimum requirements for case monitoring and documentation to remedy conflicts within NHVR procedures and other internal controls;**
- **incorporating supervisory review processes into annual reviews to ensure procedures are implemented effectively; and**
- **reviewing current internal controls for monitoring case progress and developing more effective controls to ensure case note documentation meet minimum expectations.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As part of assisting a customer to implement their individualized plan for employment (IPE), the counselor and customer continually assess the progress toward achievement of the employment goal. The regulations identify that the plan needs to be formally reviewed at least annually. When the counselor and customer identify that there is a major change needed in the IPE, the plan is reviewed and amended. This review, which includes an amendment to the plan as a result of the review, satisfies the review requirement and is documented by the IPE document. As a result, the bureau does not agree, the results reported reflect the degree to which reviews were not completed as required.*
2. *The Desk Reference is a counselor resource, not a policy document and as such, does not require specific action. The bureau attempts to gather signatures as a strategy to document agreement, but neither the regulations, nor policy require a signature for plan review.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *NHVR is updating policy and training materials to assure staff have the information and resources to accurately identify and record the use of the annual review in the individualized plan for employment and in the case record. This work is targeted for completion by June 2021.*

- *The bureau released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, as we discuss in the Observation, NHVR lacked comprehensive controls and guidance for counselors to assess the customer's progress toward their employment outcome. NHVR's training document contradicts its assertion that amendments may be substituted for the annual review and actually distinguished the annual review as a separate meeting. Specifically:**

> ***Any plan that extends past 12 months will be reviewed. This review takes place with the participant to assure they are on track with the IPE goals and objectives. If they are not on track the review includes a specific action plan for moving forward. If changes in services are needed, the IPE will be amended or a new plan written to reflect these. (RECOMMEND - do this at the [annual review] meeting). [emphasis original]***

**In reference to Remark 2, NHVR is not limited to the requirements outlined in federal law and regulations. Internal policies and procedures are necessary within the organization to establish accountability, and ensure internal objectives are being met in compliance with federal and State laws and regulations. The *Desk Reference* is a procedural manual that directs counselors how to undertake their duties and responsibilities as a vocational rehabilitation counselor for areas including eligibility, IPEs, case monitoring, and closure. NHVR has also implemented some internal controls, and began monitoring whether these controls were met, based on certain requirements in the *Desk Reference*. Further, there are items the *Desk Reference* describes as "required" with the word "required" used 84 times and "must" used 11 times.**

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## CHAPTER 6: AUTHORIZATIONS AND PAYMENTS FOR SERVICES

New Hampshire Bureau of Vocational Rehabilitation (NHVR) staff were generally required to initiate and monitor financial activities pertaining to cases. Counselors were responsible for determining the party financially responsible to pay for services, assisting the customer to select a vendor, issuing authorizations to vendors performing services for customers, monitoring whether customers received the services authorized, and initiating payments to vendors. In cases where the customer was determined to have the means to contribute to their rehabilitation, counselors also determined how the customer would pay for their portion of the services.

An authorization was a documented instruction from NHVR to a vendor granting the authority to provide a service for a specific customer, within a certain time period, and within a certain amount of money. With the exception of assessments needed to determine eligibility or to develop an individualized plan for employment (IPE), services were required to be on a customer's IPE before an authorization could be issued in the electronic case management system. Depending on the counselor's signature authority, the authorization could require supervisory review or be directly issued to the vendor.

Effective controls over the authorization and payment of goods and services would have ensured these financial transactions were necessary and appropriate. However, we found gaps in the control structure that resulted in numerous weaknesses including authorizations issued for services not included on the current IPE and authorizations issued after the service had started. We also found inconsistencies in the financial needs assessment (FNA) process, limited oversight of NHVR's tracking of payments from customers who contributed to the cost of the rehabilitation, control weaknesses related to payments made directly to customers and over goods purchased for customers, and limited monitoring of vendors.

**Observation No. 28**

### Evaluate Gaps In Authorization Control Structure

NHVR did not have an adequate internal control structure to mitigate vulnerabilities in its two primary methods for managing expenditures: developing an IPE and issuing authorizations for services. NHVR counselors first drafted an IPE outlining the services and resources needed to achieve an employment goal and then issued an authorization linked to the services designated on an effective IPE. This system allowed two layers of review before committing financial resources. After identifying a potential fiscal crisis resulting in the need to implement an order of selection (OOS) in May 2018, management required all IPEs and authorizations be reviewed by supervisors and used these two activities as the primary method to review programmatic costs at the service delivery-level. However, we found the design of these controls and other practices allowed management oversight to be avoided.

**Services Did Not Need To Be Included On A Current IPE To Be Authorized**

Federal regulations required the IPE include all rehabilitation services a customer needed to achieve their employment goal. According to NHVR management, its electronic case management system was designed to only allow authorizations for services to be issued when the service was already included on an IPE. However, NHVR designed this control to allow an authorization to match a service on *any* IPE, including, for example, expired IPEs or IPEs developed to reflect a new employment goal. NHVR staff stated the reason they allow an authorization to be issued from any IPE was because their understanding of federal regulations allowed all IPEs in the case record to remain effective until the case closed. NHVR's practice seemed inappropriate because, while certain vocational rehabilitation (VR) services may be useful for multiple employment goals (e.g., job search and job development), other services may only be beneficial for specific jobs or only applicable to overcoming certain barriers (e.g., college training).

IPEs provided NHVR an opportunity to plan services, control cost, and incorporate management oversight. However, by allowing authorizations to be issued for *any* IPE the customer had on file, regardless of whether it was current, NHVR undermined the effectiveness of this mechanism designed to help control costs and manage program services as the customer's case progressed. Allowing services to be authorized from any IPE, regardless of how long ago the service was added, potentially allowed duplicate services or services not connected to the customer's current employment goal to be provided. In our review of 88 cases with an effective IPE, we found seven cases (eight percent) where an authorization was issued for a service linked to an expired IPE or one that was not the most recent IPE in effect. The following are examples in which the potential for an ineffective management control structure was created by not requiring authorizations be limited to only the most recent IPE:

- Customer Employment Goal And Planned Services Changed, But Authorizations Were Issued For Services Under A Prior IPE – When a customer's employment goal changed, NHVR required a new IPE be developed. In some instances, the change in employment goal and services needed to achieve the new goal were drastically different. For example, a customer receiving college training for a career in computer science under an initial IPE changed their employment goal ten years later to a career not requiring post-secondary training. However, the case management system would have allowed the original expense for college to be authorized after the employment goal changed. We found two additional customers changed their employment goals resulting in new IPEs. However, authorizations were issued, and NHVR paid, for services associated with a prior employment goal under an IPE that did not reflect the current employment goal.
- Services Were At Risk Of Being Duplicated And Paid – Allowing services to remain available for authorization until case closure increased the risk a service already authorized and paid for under one IPE could be authorized again in error. In one case we reviewed, a customer received two assessments under an IPE that was active at the time. However, nearly a year later those exact same services were authorized, and paid for again, even though the IPE in effect at the time did not include those services. The second authorization for those assessments potentially resulted in a duplicate payment, as we could not find evidence in the file the additional assessments occurred.

- Authorizations Could Be Issued For Any IPE A Customer Had On File – Cases spanning several years typically resulted in the development of multiple IPEs. Each iteration of an IPE with new services expanded the number of services which could potentially be authorized by NHVR. For example, one customer whose case spanned 15 years, had 18 IPEs. Resume development, which was included in the 15th IPE, was authorized while the 17th IPE was effective; the 17th IPE did not include resume development. Another customer's IPE had a technology equipment which was included in the third IPE. However, the purchase was not authorized and paid for until the fourth IPE was effective. It was purchased and paid for again when the seventh IPE - with a new employment goal - was effective. Consequently, no documentation existed on how the technology equipment related to the achievement of the most current employment goal.
- Non-Expiring IPEs Allowed Services To Continue Past Estimated End Dates – NHVR put an estimated end date on each IPE, but the end date did not stop services from being authorized. Additionally, NHVR did not require a new IPE be drafted to authorize services from the expired IPE when the end date passed. In two cases we found services provided under an IPE which had been expired for two months. In a third case, NHVR provided $24,600 in services between five and ten months after the IPE had expired.

**Authorizations Were Issued Retroactively**

Vendors were required to receive an authorization before starting services. This process allowed NHVR to review the services being provided against the IPE and assess the appropriateness and need for the service *before* it was provided. However, we found authorizations in our file review were primarily issued retroactively, *after* the service was authorized to start. Of the 575 authorizations in our review issued during the audit period:

- 463 (81 percent) were issued at least one day after the service was authorized to start,
- 196 (34 percent) were issued at least 30 days after services were authorized to start, and
- 93 (16 percent) were issued at least 60 days after services were authorized to start.

While most retroactive authorizations were likely due to the slight delay caused by requiring management to review an authorization before issuance, vendors began service provisions without an official authorization approved and issued by NHVR. Therefore, when management was required to review an authorization, those reviews were partially ineffective, since services in some instances had already been initiated prior to management's input. Additionally, with over one-third of authorizations we reviewed retroactive by more than 30 days, NHVR's requirement that vendors received authorization before starting services was not consistently followed.

**Service Delivery Needs Were Prioritized Over Financial Control Structure**

NHVR management reported one of the challenges to upholding aspects of its control structure was disruption to service delivery. By allowing services under prior IPEs to be provided and authorizations to be issued retroactively, NHVR mitigated the risk services would be delayed due to approvals or administrative actions. However, weakening the controls for both IPEs and authorizations may have increased risk to other areas since the two controls were dependent upon each other to be effective. Therefore, a weakness in one control could have been mitigated by

stronger controls in the other area. For example, a retroactive authorization was at a lower risk of obligating resources to an unintended service if the service was recently approved in a current IPE. Additionally, a service from an outdated IPE had a lower risk of being provided when it was no longer needed if management had tighter controls over authorizations being issued. Therefore, allowing for weaknesses in both controls did not effectively mitigate the risk an unneeded or unplanned service would be authorized. While ensuring uninterrupted service delivery was at times in conflict with instituting stronger management controls, NHVR should balance these competing objectives and routinely assess these risks.

**Recommendation:**

**We recommend NHVR management reassess its internal controls over issuing authorizations to ensure the objectives to both manage expenditures and provide timely service delivery are achieved in a balanced and risk-based manner. The assessment should consider whether allowing authorizations to be issued for services not on the most current IPE and allowing vendors to start services before authorizations are issued is appropriate.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau has a fundamental disagreement with how the auditors viewed the use of multiple IPE's over the lifecycle of a case. It was explained to the auditors, that while the system allows for the use of multiple plans in the life of a case, in the view of the federal government, each case has one IPE and any changes made after that were amendments. The systematic grouping of plans assists the counselor and participant in managing that plan moving forward but nothing is stopping them from continuing to use a service that was already approved in the past. The goal of the bureau is to provide services as responsibly as possible while lessening the administrative burden on the customer. Services utilized from previous system plans still require the same level of approval by a qualified professional prior to authorization.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The Bureau agrees that authorizations for services should be reassessed to ensure a balance between providing customer services timely and programmatic approvals. This initial assessment will be completed by June of 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, throughout the audit, NHVR management stated an internal control it implemented to ensure that NHVR only authorized and paid for services the customer needed was that the service had to be included on the IPE. Services included in an IPE were required to be needed for the customer to achieve the employment goal listed on that IPE. As stated in the Observation, by allowing services to be authorized from *any* of the customer's IPE, regardless of how long ago the service was added to the IPE, potentially allowed services not connected to the customer's current employment goal or duplicate services to be provided. NHVR's response that "nothing is stopping them from continuing to use a service that was already approved in the past" without implementing a mechanism to ensure the service is still needed for the current employment goal, essentially renders the internal control in the electronic case management system ineffective.**

**Determining Customer Contribution Towards The Cost Of Their Rehabilitation**

Federal regulations did not require VR agencies to consider customers' financial need when providing VR services. However, if VR agencies chose to consider the financial needs of customers, it must maintain written policies and ensure these policies were applied consistently.

NHVR implemented a process to consider the customer's financial needs through administrative rules which required some customers receiving goods or specific services to financially contribute towards the cost. Before obligating funds for these specific services, NHVR staff was required to determine and document through the FNA process whether a customer was not required to contribute towards the cost of the service, or whether they were financially responsible for some of the cost. Federal regulations and NHVR's administrative rules also exempted customers from completing an FNA if they received benefits through certain titles of the Social Security Act. Common VR services, such as job placement and counseling, were also exempt from customer contribution. However, other services, including training and transportation required an FNA form be completed before the service was provided or added to an IPE. Additionally, all tangible goods purchased by NHVR required an FNA be completed and customers attending college or other training programs were required to complete a *Financial Aid Transmittal Form* (FATF) to determine the level of support NHVR would provide towards tuition.

Once a counselor determined a customer needed a nonexempt service or tangible good, the FNA process included six steps.

1. Identify the financially responsible individual – usually the customer; however, if the customer could be claimed as a dependent, parents were deemed the responsible party.
2. The financially responsible party reported net monthly income from all sources including spouse, parent or guardian, and others who contribute to the customer's financial needs.
3. The financially responsible party reported liquid assets which was divided over 12 months to determine a monthly total, which was added to the customer's monthly income to calculate total resources.

4. The financially responsible party was allowed a set deduction based on 250 percent of the federal poverty level, after considering the size of the family unit and certain deductions, such as disability related expenses.
5. Total deductions were compared to the customer's total resources and if resources exceeded deductions, the excess amount would be multiplied by 12 to represent the total the customer could contribute towards nonexempt services and tangible goods for the year.
6. All parties were required to sign the FNA.

We found NHVR's guidance regarding the FNA process was unclear, inconsistent, not comprehensive, and at times conflicted with itself and NHVR administrative rules. As a result, we found FNA forms were missing and, in some cases, services not exempt from an FNA were provided even though forms were not completed. Additionally, NHVR inconsistently determined the financially responsible party when customers had recently graduated from high school. Finally, we found NHVR generally exempted customers who were receiving benefits through public assistance programs not specifically exempted in its administrative rules.

**Observation No. 29**

**Improve The FNA Process**

NHVR did not have comprehensive, clear, and internally consistent policies to ensure customers able to contribute towards the cost of their VR services and goods shared the financial burden in a consistent manner. Federal regulations authorized VR agencies to adopt an FNA under the condition the process was: 1) able to determine a reasonable customer contribution amount; 2) maintained with written policies; and 3) consistent in application. While NHVR maintained written policies with the purpose of determining a customer's reasonable financial contribution, the policies were not always applied consistently.

**Conflicting Guidance On Exemptions From The FNA**

NHVR administrative rules and policies automatically exempted customers enrolled in certain financial benefit programs from contributing to the cost of NHVR services and goods. However, NHVR administrative rules, policies, and other guidance were internally inconsistent on which qualifying financial benefits program exempted a customer from having their financial needs assessed, as depicted in Table 11. Consequently, customers were inconsistently exempted from the FNA process. For example, we found one customer receiving retirement income from the Social Security Administration (SSA) appeared to be exempt from contributing towards services, according to NHVR administrative rules, but was required to contribute $900. Conversely, in another case, NHVR exempted a customer who was receiving survivors benefits from contributing toward the cost of services. However, the customer was a minor and their parent was reportedly holding liquid assets exceeding $1 million.

NHVR management was cognizant of the internal inconsistency between its rules and policies prior to the audit period. In 2015, NHVR refunded a customer over $40,000 after the customer's

parent argued administrative rules required it to exempt the customer from the FNA, and essentially from contributing towards the cost of services, based on their SSA survivors benefit.

**Table 11**

**Financial Needs Assessment Exemptions**

| Financial Benefits Program | NHVR Rules | NHVR Policy | FNA Form | Training Materials |
|---|---|---|---|---|
| SSA - Social Security Disability Insurance | Yes | Yes | Yes | Yes |
| SSA - Survivors Benefit | Yes | Yes | No | No |
| SSA - Retirement Income | Yes | Yes | No | No |
| SSA - Supplemental Security Income | Yes | Yes | Yes | Yes |
| Department Of Health And Human Services - Aid to the Permanently and Totally Disabled | No | Yes | Yes | Yes |
| Department Of Health And Human Services - Temporary Assistance for Needy Families | No | Yes | Yes | Yes |
| Department Of Labor - Worker's Compensation | No | No | No | Yes |

Source: LBA analysis of NHVR documents.

***Unclear Federal Regulations***

NHVR rules reflected, almost verbatim, the language from federal regulations which prohibited VR agencies from using an FNA or requiring customers to contribute towards the cost of services if the customer was eligible for benefits under specific titles of the federal *Social Security Act*. These titles included the SSA's survivor and retirement benefit programs.

NHVR management reported the desire to clarify policy to cease providing FNA exemptions to customers receiving SSA retirement or survivor benefits which were not based on the customer's disability. However, any amendments to NHVR administrative rules to restrict the conditions under which an exemption was applicable could make future amended rules noncompliant with federal regulations.

**Missing And Incomplete FNAs**

Since certain services were exempt from the FNA process, not all customers were required to complete the FNA. However, of the 21 customers in our file review who did not have an FNA on file, 12 customers (57 percent) had services that required an FNA on their IPE. Five of these 12 customers (42 percent) actually received the goods or nonexempt services. For one of these customers, NHVR substituted an FATF for the FNA; however, NHVR rules, policies, and training materials did not provide an exemption from completing the FNA.

Due to the common types of services exempt from the FNA process under both NHVR administrative rules and federal regulations, it may have been reasonable for NHVR to not require an FNA to accompany every IPE. Therefore, NHVR's policy and guidance materials only required a recent FNA when a nonexempt service or tangible good was added to an IPE. However, four of

nine customers not documented as exempt from the FNA process received tangible goods, such as clothing and computer equipment, without a current FNA on file during the audit period.

FNAs were sometimes incomplete when submitted. For example, 14 of 41 FNAs (34 percent) we reviewed did not contain the signature of both the customer and NHVR staff. Additionally, NHVR did not consistently require an individual qualifying for an exemption to produce documentation. Missing or incomplete FNAs may be due to the lack of monitoring and follow-up procedures. For example, neither the case management system nor the annual review processes reminded staff to complete an FNA when required.

**Inconsistencies In Applying The FNA To Customers Who Were Not Considered Dependents**

NHVR training materials instructed staff to apply an FNA to a customer's parents when the customer was a dependent. However, NHVR administrative rules, policies, and the FNA form did not further clarify or require counselors identify whether this applied to the customer. Consequently, we found younger NHVR customers and their families were treated inconsistently. For example, in one case a college student living at home, under the age of 20, and unemployed was not considered a dependent; therefore, their FNA had $0 listed for resources. In another case, a college student under the age of 20 was not initially considered a dependent, but was later required to include their parents' financial resources. Once the parents' resources were considered, it was determined the customer should have contributed towards the cost of services.

**Unclear How Customers Were Expected To Contribute Towards The Cost Of Services**

NHVR policy, the FNA form, and training materials were lacking and internally inconsistent on determining the amount customers should contribute towards services and when customers would provide payment for services. It also lacked a method for tracking how much and when customers paid towards services.

***Determining The Amount Of Customer Contribution***

The FNA form calculated the annual amount a customer could contribute towards the cost of their services. However, we found the amount customers were actually asked to contribute did not always reflect the amount calculated in the FNA. For example, we found one customer's FNA determined they could contribute over $20,000, but this customer was only requested to contribute approximately $10,500 towards over $100,000 in services that were not exempt from customer contribution. NHVR did not document why the customer was only required to pay approximately half of their annual contribution as calculated by the FNA. In another case, NHVR improperly required a customer to contribute $120 towards the cost of services without any documented explanation to support the contribution amount. The FNA showed the customer's deductions exceeded their resources, so the customer should not have been required to contribute.

***Inconsistent Payment Options***

NHVR policy required customers to contribute financially to services *prior* to NHVR expending funds. However, guidance materials instructed counselors to "negotiate with the customer as to

how many monthly payments the person will be contributing," which appeared to allow customers to contribute over several months *after* NHVR paid the vendor for the service. We found one customer was instructed to pay their entire contribution towards the first applicable service they received upon receipt, while two others were allowed to pay over multiple months.

***No System To Track Customer Contributions***

If a customer contributed towards the cost of services over a negotiated period, NHVR needed to track the amounts paid towards these services. However, NHVR did not have a system to accomplish this. We found one case where a customer was reportedly making monthly payments towards their $10,000 contribution, but the case record did not contain documentation to show the customer made all required payments. Therefore, we were only able to verify ten payments over a one-year timeframe totaling $2,000. A case note found in the file indicated the customer had consistently made payments varying in amount for over a four-year period and the customer's remaining balance was $800. The case record did not indicate when the other payments totaling $7,200 were made. Without an implemented tracking system, NHVR could not ensure customers contributed the amount calculated by the FNA towards the cost of services.

**Recommendations:**

**We recommend NHVR clarify with the Rehabilitation Services Administration whether customers receiving retirement and survivor benefits from the SSA are exempt from the FNA. Once clarified, we recommend NHVR management clearly define in its administrative rules, which financial benefits programs qualify customers for an exemption from the FNA process and align the FNA form, NHRV policy, and internal training materials with these rules.**

**We also recommend NHVR develop a mechanism to remind counselors to complete the FNA when applicable services are added to the IPE and a system to monitor that all customers who require an FNA complete one timely.**

**We further recommend NHVR management ensure the FNA is consistently applied by:**

- **ensuring administrative rules, the FNA form, policies, and training materials clearly outline the process for determining whether the customer is considered a dependent and, when applicable, identifying those financially responsible for the customer;**
- **developing and documenting a methodology to determine whether customer contribution towards the cost of services should be applied at once or over an extended period, and if applicable, the monthly contribution amount customers will contribute as well as the number of payments; and**
- **developing a method to track customer payments towards the cost of their services.**

*NHVR Response:*

*NHVR concurs with this recommendation.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau has sought clarification from the Rehabilitation Services Administration on whether customers receiving retirement and survivor benefits from the Social Security Administration are exempt from the FNA process. Upon response the bureau will amend administrative rules, policies, and procedures to clarify the process. The bureau will redevelop financial needs assessment forms and training by September 2021.*
- *The bureau will research the feasibility of an addition to the case management system to remind counselors when to complete an assessment. As previously addressed in observation 32 prior to seeking a tracking mechanism for customer payments the bureau is seeking guidance from the State's Attorney General's office on the allowability of cost recovery from customers. If allowable under the current structure the bureau will move forward with adopting administrative rules to clarify the repayment process and once approved implement internal policies and procedures. If determined not allowable the bureau will decide if statutory changes should be petitioned.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**Observation No. 30**

**Ensure Exemptions From The FNA Are Properly Documented**

Our file review found that during the audit period, NHVR exempted three customers from having to demonstrate financial need before some services were provided, even though it did not properly document customers qualified for the exemption. As a result, NHVR paid $3,750 for services benefiting customers who it did not verify had qualified for financial assistance. In one case, the services were provided while NHVR was in an OOS.

NHVR rules and policies exempted those receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) from contributing to the cost of rehabilitation by exempting them from the FNA. Verification of whether an applicant received SSI or SSDI benefits usually occurred during the eligibility determination process. Federal regulations required that applicants who were receiving these benefits should have been presumed eligible for services. During the IPE development process, customers who were determined eligible based on receiving SSI or SSDI were exempt from the FNA. Similar to the requirement in federal regulations, when determining eligibility, NHVR rules required verification of the applicant's eligibility for these federal benefits by contacting the SSA if the applicant could not provide an award letter. As part of the case record, the *NHVR Counselor Desk Reference (Desk Reference)* and *NH Vocational*

*Rehabilitation Policy Manual (Policy Manual)* required documentation, such as the award letter. Additionally, NHVR training materials indicated NHVR was responsible for obtaining verification of SSI or SSDI benefits.

**Case Files Did Not Always Contain Documentation Demonstrating Eligibility For An Exemption**

Our file review included 14 customers who submitted an application during the audit period and were identified by NHVR as receiving SSI or SSDI benefits. We found seven cases (50 percent) did not contain an award letter or other documentation verifying the customer received these benefits. Five of the cases missing documentation submitted an application after NHVR entered an OOS. Without the award letter or other verification, these customers should not have been exempted from the FNA process. Additionally, based on NHVR's practices, six cases should have undergone some level of review including review from a supervisor or when the case was closed or transferred.

***Required Supervisory Review Did Not Identify Missing Documentation***

When determining eligibility for NHVR services, the *Desk Reference* required certain documentation be present in the case file, including documentation that an individual was eligible for SSI or SSDI due to their disabling condition. The *Policy Manual* indicated this documentation should include the benefits award letter.

NHVR practice required a supervisor, which included a regional leader (RL), a vocational rehabilitation counselor (VRC) III with eligibility signature authority, or the Field Services Administrator, to review all eligibility recommendations made by a VRC I before they were effective. Of the seven files that did not contain documentation of the customer's SSI or SSDI benefits, a VRC I made eligibility determinations in six cases (86 percent); therefore, these cases should have been reviewed by a supervisor. While all six cases received supervisory review, neither NHVR policies nor procedures outlined the items RLs should consider when reviewing subordinates' files. However, RLs generally reported reviewing the electronic case file, including data pages, case notes, as well as medical and other supporting documentation.

NHVR managers reported all or most VRC IIs and VRC IIIs held eligibility signature authority prior to the implementation of an OOS on May 7, 2018. All remaining counselors' eligibility signature authority was reportedly rescinded. NHVR began restoring signature authority to VRC IIIs in October 2018. Cases processed by counselors with signature authority would not be subject to review to ensure required documentation was in the file until they were closed or transferred as we discuss below, posing the risk that cases closed without the required documentation remained noncompliant.

***Required Review Of Closed Or Transferred Cases Did Not Identify Missing Documentation***

When a case was closed or transferred, NHVR's internal *File Review Form* required the counselor initial a box indicating certain documentation, including documentation of SSI or SSDI benefit, was in the file. The form was developed to ensure federal compliance and was meant to

systematically review whether required case documentation was in the file. The form also required the counselor to initial a box indicating the FNA was attached in the electronic case file, whether the customer and counselor signed the FNA, or if the FNA was not applicable. The form also contained boxes in each of these areas for a supervisor to initial, indicating their review.

Of the seven files that did not contain documentation of the customer's SSI or SSDI benefits, six (86 percent) had been closed or transferred to another counselor at the time of our review; therefore, the *File Review Form* should have been completed by the counselor and reviewed by a supervisor. If the review was completed as designed, the counselor or the supervisor should have identified the missing documentation. Three of these cases also underwent a supervisory review as a VRC I made the eligibility recommendation, allowing two opportunities to identify the missing documentation.

While reviewing for required documentation before transferring a case may have enabled NHVR to identify and request missing documentation, a review of the case at closure would not likely have resulted in an opportunity to correct the deficiency. However, it would allow for providing feedback to counselors on the need to obtain the proper documents.

**Services Paid For Customers Without Documentation Of Eligibility For FNA Exemption**

Federal regulations and NHVR rules did not require customers to demonstrate financial need for services including: assessments used to determine eligibility, priority for services, or VR needs; counseling and guidance; job-related services such as job search and placement, job-retention, and follow-up services; referrals; personal assistance services; and interpreter or reader services. Generally, a customer completed the FNA before receiving services that were not listed as exempt from the FNA. During the audit period, our file review found NHVR paid $3,750 for services for three customers which required the customer to demonstrate financial need by completing the FNA. These services included: software, mileage and transportation fees, clothing, low vision aids, and assistance for tuition or other training.

For customers attending college or other post-secondary education programs, NHVR required a FATF. If the customer received SSI or SSDI, counselors were instructed to use $0 as the family contribution when calculating NHVR's contribution. One customer NHVR identified as being exempt from the FNA based on SSI or SSDI status received $2,750 in tuition assistance in August 2017, even though their benefits had not been verified. The customer received an additional $15,500 in tuition assistance between 2013 and 2016. FATFs from 2014, 2015, and 2017 used a family contribution of $0 based on the customer's self-reported federal disability benefits. Even though the customer received tuition assistance from January 2013 until August 2017, NHVR did not receive verification of benefits until July 2019. The award letter indicated the customer had been receiving benefits since December 2017. No verification was obtained for the entire period the customer was receiving tuition assistance.

**Other Exemptions To FNA Requirements**

NHVR also exempted customers who qualified for other State or federal programs based on needs test, such as Temporary Assistance to Needy Families and Aid to the Permanently and Totally

Disabled. As we discuss in Observation No. 29, NHVR rules did not allow this exemption. NHVR's practice allowed customers eligible for these programs to be exempt from the FNA. However, neither the *Desk Reference* nor the *Policy Manual* required that counselors verify the customer provided documentation of receiving benefits through these other programs, nor did NHVR provide guidance regarding the types of documentation counselors could accept. While we did not find any customers in our sample solely receiving benefits through these programs, the risk remained that the FNA could be inconsistently applied.

**Recommendations:**

**We recommend NHVR management strengthen its process for ensuring award letters or other evidence of SSI, SSDI, Temporary Assistance for Needy Families, or Aid to the Permanently and Totally Disabled eligibility are in customer files before paying for services which require the customer to demonstrate financial need. If customers cannot provide verification of SSI or SSDI, NHVR should ensure counselors verify eligibility directly with the Social Security Administration, as required by federal regulations and its own rules.**

**In improving its process, NHVR should:**

- **develop clear and comprehensive guidance regarding the types of documentation required for *each* type of program under which customers could qualify for an exemption from the FNA;**
- **assess the effectiveness of existing processes to verify required documentation that a customer demonstrates financial need before authorizing payment for services, and improve or develop processes as needed;**
- **consider requiring the *File Review Form* be reviewed by personnel in a different regional office than where the case was processed;**
- **continually monitor for compliance and ensure deficiencies are corrected timely; and**
- **provide additional training if monitoring efforts reveal continued noncompliance.**

*NHVR Response:*

*NHVR concurs with this recommendation.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The policy workgroup as of December 2020 has begun drafting changes to policies and procedures for financial need tests.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**Paying For Services And Vendor Management**

Once NHVR determined the customer needed a service or good to complete an assessment or achieve an employment goal on an IPE, the counselor and customer would consider the potential vendors able to provide the service or good. Depending on the cost and type of service, NHVR had different procurement procedures for selecting a vendor. For example, certain purchases required selecting the vendor with the lowest submitted quote while some purchases allowed the customer more choice over vendor selection. Managing vendors was primarily the responsibility of the central office, and any vendor receiving payment was required to be established in the case management system. Vendors providing standard and frequently used VR services, such as job development services, were categorized as community rehabilitation program (CRP) vendors. CRP vendors were vetted and monitored by the central office.

NHVR staff used four payment methods to purchase goods or services depending on the type, cost, and availability of the good or service. The payment methods included:

- Field Purchase Orders – Goods under $1,000 could be purchased using a field purchase order or a procurement credit card. NHVR policy required quotes for these services but allowed exemptions for certain items under $100.
- Purchase Orders – For goods over $1,000, the purchase order followed general State purchasing processes. Purchase orders not using a State-contracted vendor and service required three quotes or a documented justification for a sole source award.
- Contracted Services – Services provided under a State contract could be ordered without obtaining quotes. For example, the State had contracts with vendors for common technology purchases. Additionally, CRP vendors were paid for providing services according to a fixed price in their service agreement.
- Customer Payment – A direct payment to the customer either as an advance payment for services or by reimbursing the customer after obtaining proof of the purchase. According to NHVR policy, customer payments were appropriate for transportation expenses or when attempts to enroll the provider as a State vendor were unsuccessful.

We found NHVR did not have a consistent process for approving CRP vendors, did not accurately document the services each CRP vendor was authorized to provide, did not ensure all service agreements were signed and retained, and did not monitor CRP vendor performance. Additionally, NHVR did not have adequate controls over issuing payments to and obtaining payments from customers. NHVR implemented payment plans with customers to recover the costs of some services; however, it was unclear whether these plans were authorized by statute. NHVR had limited controls over payments made directly to customers and did not have formal controls over goods purchased for customers.

**Observation No. 31**

## Improve Vendor Management

NHVR did not have a system of controls to consistently ensure qualified CRP vendors delivered quality services to customers. To become a vendor, NHVR requested an application, a completed service agreement, relevant professional certification, and either previous experience with NHVR or training on being a CRP vendor. In practice, we found NHVR inconsistently imposed these requirements. Upon application approval, NHVR set up and maintained vendors in its case management system; however, it used incomplete service agreements and had an inefficient method of tracking vendors when ensuring only active vendors were authorized to receive payments. Lastly, we found CRP vendor monitoring systems did not include performance metrics, routine program review and analysis, or structured disciplinary and complaint procedures to protect customers.

### Inconsistent CRP Vendor Approval Process

NHVR inconsistently implemented requirements and procedures outlined in the *Community Rehabilitation Program Operational Handbook* (*CRP Handbook*) while reviewing CRP vendor applications. This inconsistency was likely due to the lack of a formal and enforceable CRP vendor vetting processes codified in administrative rules. Administrative rules ensure requirements are uniform and transparent, thereby improving consistency. For example, we found the following inconsistencies in how CRPs were vetted:

- Certifications – The *CRP Handbook* instructed potential vendors to provide a resume which should include specific vocational credentials, or a projected obtainment date, of applicable certifications they or their employees have attained. In practice, NHVR staff reported certifications were recommended but not required. Additionally, NHVR did not have a system to track which vendors had certifications, vendors that were pending certifications, or whether vendors kept their certifications current. It also did not have a process to update whether staff recently hired by a CRP vendor had the recommended certifications.
- Training – The *CRP Handbook* required CRP employees to participate in training conducted by NHVR. However, according to NHVR staff, this requirement was waived for CRP vendors with previous experience with NHVR or for vendors who were recently trained. NHVR had no written standards delineating the amount of experience required to be exempt from training or how recently a vendor needed to have attended training to be exempt. Additionally, NHVR did not have a system to document CRP vendors who completed the required training.
- Interview – While not included in the *CRP Handbook*, as part of the screening process, NHVR reported requesting prospective CRP vendors to participate in an in-person interview which could determine vendor application approval or denial. NHVR did not have criteria or policy to standardize the interview process or inform prospective CRP vendors an interview was required.

- Service Agreements For Institutions – NHVR did not provide guidance on how service agreements between NHVR and CRP vendors were to be completed for larger institutions with multiple employees. Therefore, service agreements were inconsistently submitted. For example, CRP vendors with multiple employees either provided the name of one employee, multiple employees, or no employees when completing the service agreement. These gaps in tracking large CRP vendors' staff reportedly allowed CRP employees to work with customers without being trained by NHVR for weeks.

**No Process To Ensure Those Working With Customers Had Background Checks**

NHVR's vetting process did not include any inquiry pertaining to the criminal or other background history of CRP employees working directly with customers. NHVR staff reported larger CRP vendors sometimes implemented internal background check procedures before hiring staff, but independent CRP vendors unattached to an institution may not have implemented similar procedures. Additionally, NHVR did not collect data on which CRP staff received a background check and the extent of the background check procedures used. In a 2012 report, the World Health Organization reported adults with disabilities were 1.5 times more likely to be the victim of violence compared to individuals without disabilities, and children with disabilities were 3.7 times more likely than their peers without disabilities. Without mitigating controls, this area could present a serious risk.

**Inconsistent Vendor Setup**

The final step of the vendor application process involved the receipt of the vendor service agreement. Once the service agreement was completed, NHVR business engagement staff sent an email to central office staff to set up the new vendor in the case management system. We found procedures to set up and track approved CRP vendors included control weaknesses and inefficiencies. For example:

- CRP Service Agreements Were Not Signed By Both Parties – Although the vendor service agreements were reportedly approved by NHVR, at no point did NHVR sign, stamp, or indicate approval of the service agreement and establish an effective date. Therefore, the arrangement between the CRP vendor and NHVR was unclear. For instance, we found prices and services appeared to be modified on two service agreements, possibly after submission. Notes on the agreements modified the services and prices on the document. Without a dated signature, it was unclear if NHVR officially accepted these changes to the condition of the agreement or approved the agreement at all.
- CRP Service Agreements On File Did Not Always Document Approved Services – Service agreements were intended to not only designate the vendor providing services, but also allow the CRP vendor to communicate the services they were approved to provide. However, seven of the 60 service agreements (12 percent) we reviewed did not include a completed list of services the CRP vendor was approved to provide and ten (17 percent) listed no services, although they were being paid for services rendered.
- Services In The Case Management System Inconsistently Matched Service Agreements – Since vendors were set up in the case management system via an email and not by

submitting the service agreement to central office staff, we found inconsistencies between the services presented on the service agreement and the services authorized in the case management system. All six service agreements we reviewed where the CRP vendor communicated restrictions on the services they could provide had a discrepancy between the services the CRP vendor agreed to provide and the services they were authorized to provide in the electronic case management system.

- The Use Of External Spreadsheets Allowed Outdated Vendors To Remain Active – CRP vendors were tracked and managed using multiple spreadsheets to document the vendor and contact information. In addition to the spreadsheets, NHVR's case management system kept a list of all CRP vendors authorized to provide services and included fields to store pertinent information, such as contact information. Keeping vendor data stored in two places was inefficient, since it required duplicate data entry. Additionally, managing a list of vendors independent of the case management system required NHVR to routinely reconcile both vendor lists and deactivate vendors not currently providing services. However, NHVR did not routinely reconcile the two vendor lists. We found 13 of 70 vendors (19 percent) recorded as active in the case management system as of April 2020 did not have a documented relationship with NHVR for at least ten years but were still eligible to receive authorizations for services in the case management system. NHVR staff confirmed some vendors were no longer active yet were not deactivated in the case management system.
- Limited Segregation of Duties – An employee tasked with setting up a CRP vendor was also given the authority to issue authorizations for payments. Therefore, one employee could both set up vendors without a completed service agreement and authorize the same vendor to receive payment for services, thereby creating incompatible duties assigned to one employee. While NHVR mitigated this risk by segregating the duties of those entering and issuing authorizations, vendor creation and authorizations were still incompatible responsibilities and control weaknesses over the active vendor list did not mitigate this risk.

**Inconsistent Vendor Performance Monitoring**

NHVR lacked formal processes to consistently monitor CRP vendors performance, ensure vendor reports were received before paying for services, and ensure accurate incentive program payments. Additionally, NHVR did not have structured disciplinary and complaint procedures.

***No CRP Vendor Performance Metrics***

Federal regulations required NHVR to provide customers outcome data on the success of CRP vendors. Our 2001 *Bureau of Vocational Rehabilitation And Service Delivery* (*2001 Audit Report)* recommended NHVR develop performance metrics for CRP vendors and share those metrics with customers. However, this finding remained unresolved through the current audit. NHVR reported implementing a CRP vendor report card in the past to communicate basic statistics on the effectiveness of a CRP vendor, but ceased this activity before the audit period. According to NHVR staff, the report card included the number of referrals each CRP vendor received, which indicated a CRP vendor was experienced and valued by NHVR staff and customers. However, the report card did not include any performance metrics that may have helped customers choose a

vendor, such as the number and percentage of successful job placements or the industries the vendor was most successful in placing customers.

NHVR staff made referrals to CRP vendors without any performance metrics for customers to make an informed decision about a CRP vendor. Instead, existing vendors were informally assessed by NHVR staff based on reputation within each regional office. For new CRP vendors, NHVR staff reported giving these CRP vendors an opportunity to introduce themselves to a regional office and provide a biography. While over time, individual NHVR staff developed professional relationships with CRP vendors they found dependable and effective, these insights were not formally quantified and documented for dissemination for NHVR staff and customers. Consequently, NHVR staff were at risk of developing a bias towards one CRP vendor over another without presenting neutral statistics to customers.

***Vendor Reports Not Always Collected And Reviewed***

The *CRP Handbook* required CRP vendors to produce reports documenting the services provided to each customer. These reports allowed NHVR to verify the service occurred, monitor the progress of the case, and assess the quality of the CRP vendor's work. However, NHVR did not consistently collect vendor reports. In our review of 92 CRP-provided services authorized and paid for during the audit period, NHVR did not receive a vendor report for 13 services (14 percent). Additionally, NHVR did not have a formal process to assess the quality of CRP vendor reports.

***Unanalyzed And Loosely Defined CRP Vendor Incentive Program***

Between State fiscal years (SFY) 2016 and 2018, NHVR spent an average of $75,000 a year on payments designed to incentivize CRP vendor performance. Until April 2019, the CRP incentive program provided CRP vendors a bonus payment for placing a customer into a job timely. For example, an incentive payment ranged from as high as $450 for a job placement within two months to as low as $150 for a placement within nine months. While the design of the incentive program was to presumably produce prompt job placements, no analysis was done to assess the degree to which incentive payments improved CRP vendor performance. In fact, in our review of 38 CRP vendors receiving incentive payments in SFYs 2016 and 2017, we found only 12 CRP vendors (32 percent) received an incentive payment in the subsequent SFY, indicating the incentive payment program may have had little to no impact on improving CRP vendor performance over time.

The design of the program did not include clear definitions on how the time elapsed until job placement would be measured. Therefore, NHVR staff reported conflicting methodologies for calculating an incentive payment and one RL reported depending on CRP vendors themselves to determine the correct incentive payment amount. In our review of a subjective sample of five cases with incentive payments during the audit period, we found four of the five cases we reviewed contained a duplicate incentive payment made to CRP vendors. Additionally, NHVR management reported incentive payments were calculated based on the elapsed time between the date the CRP vendor received a referral from NHVR and the date the customer was placed in a job. However, our review of the elapsed time between these two dates found the amount paid was incorrect in two out of five cases (40 percent). In one case, the CRP vendor was entitled to $250 for facilitating

a timely job placement but received $450. In the second case, the CRP vendor was entitled to $350 but requested and received $450.

In April 2019, NHVR started implementing a new incentive program based on the quality of the job obtained as opposed to the timeliness of the placement. For instance, a job placement offering health insurance benefits would result in an incentive payment. However, similar to the previous incentive payment program, the new program did not clearly define documentation standards to verify incentive payments were issued accurately. Consequently, one NHVR RL reported being unsure how to implement the new incentive program.

***Underdeveloped Complaint And Disciplinary Procedures***

During the audit period NHVR established procedures to report and investigate CRP vendor misconduct and for NHVR to take disciplinary action. However, the procedures did not ensure customers and NHVR staff were made aware of past CRP vendor misconduct, nor were codes of conduct codified in CRP service agreements. Prior to the audit period, NHVR staff reported two CRP vendors had been disciplined by NHVR. NHVR had no record of the disciplinary action on file; however, NHVR staff reported one of the two CRP vendors had deceived NHVR about the legitimacy of a job placement and the dishonesty had resulted in eligibility for an incentive placement bonus. In response, NHVR reportedly suspended this CRP vendor from providing services for a short period. However, these two CRP vendors were still actively providing services during the audit period.

NHVR reported recently establishing a committee to increase oversight of CRP vendors and improve policy. While the forming of the committee may have increased oversight, gaps in monitoring CRP vendors were likely due to the limited amount of data collected on CRP vendors and the missed opportunity to leverage existing data collected in the case management system.

**Recommendations:**

**We recommend NHVR management improve oversight and management of CRP vendor approval and setup processes by:**

- **developing policies and procedures and adopting administrative rules to ensure all requirements imposed on CRP vendors are consistently enforced, transparent and clearly defined, and tracked;**
- **revising the service agreements to include signatures for both parties and provide clear instructions for CRP vendors with multiple employees entering into a service agreement;**
- **modifying vendor setup procedures to be based on a completed service agreement and reassign vendor creation responsibilities to segregate incompatible duties; and**
- **exploring options to manage the list of active vendors from the electronic case management system instead of external spreadsheets.**

**We recommend NHVR management asses the risk associated with allowing vendors who have not received a background check to work directly with customers and develop**

**procedures to mitigate the risk a vendor with a questionable background is approved. In developing the process, we recommend NHVR management:**

- **research commonly implemented background check procedures for CRPs,**
- **contact CRP vendors already conducting background checks to determine their processes,**
- **explore incorporating similar procedures to ensure consistent vetting of CRP vendors, and**
- **establish a process to collect information on CRP vendors receiving background checks.**

**We also recommend NHVR management improve CRP vendor performance monitoring by:**

- **complying with federal regulations and developing CRP vendor performance metrics to be disseminated to both customers and NHVR staff;**
- **developing procedures to require CRP vendor reports prior to payment and a process to assess the quality of the reports provided;**
- **clearly defining the CRP vendor incentive program in policy and routinely analyzing the outcomes of vendors receiving incentive payments;**
- **incorporating complaint and disciplinary procedures in both administrative rule and services agreements; and**
- **disseminating the results of any disciplinary action taken against a CRP vendor when misconduct has been confirmed after performing an investigation.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *While CRP service agreements were not signed by both parties the bureau had a process in place such that any service prior to being changed in the case management system needed to come from the Program Specialist in charge of such services effectively approving the agreement for the bureau.*
2. *The bureau disagrees with the recommendation to further segregate duties for the staff member charged with adding vendors to the case management system. Prior to the addition of CRP's to the system, a request will come from the Program Specialist who approves them. The bureau believes the risk is mitigated as this staff member or any other staff member is unable to issue an authorization if they created the authorization. Further mitigation is provided that the person who issues the authorization is unable to complete a payment.*
3. *In the observation it is noted that 14% of services provided did not receive an associated vendor report. It may be true that those vendor reports were not included in the case file but all invoices for those services had a Rehabilitation Counselors initials on them certifying that the services were provided.*

4. *The audit report indicates, "NHVR's vetting process did not include any inquiry pertaining to the criminal or background history of CRP employees working directly with customers." There is no federal or state requirement for background checks.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *Effective immediately the staff member charged with adding vendors will not add them to the system until an agreement signed by both parties is received then subsequently attached to the case management system.*
- *The bureau will continue to update its Community Rehabilitation Program Operational Handbook and post it on the website for all CRP's by June 2021.*
- *The bureau will develop a request for proposal seeking a contractor to assist in evaluating the current system of Community Rehabilitation Provider (CRP) management, developing efficiency and quality assurance measures to the system, providing training and perform monitoring of revised internal controls.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*
- *The bureau as of February of 2019 redesigned the entire CRP menu of services that streamlined service provision and eliminated the referenced vendor incentive program and replaced it with a more clearly defined outcome payment model that more closely match federal indicators. By March of 2021 the bureau will begin to use the case management system to track all agreements with CRP's.*
- *The bureau will research the feasibility of background checks for all entities and their staff who have direct involvement with customers by consulting with other entities in the state who serve similar cliental as well as other vocational rehabilitation programs nationwide.*

**Observation No. 32**

**Improve Controls Over Customer Payments**

NHVR had underdeveloped internal controls over receiving payments from and issuing direct payments to customers. Consequently, we found NHVR's direct financial transactions with customers resulted in statutory noncompliance, inconsistent service delivery, risky payments, and the poor execution of informal financial agreements.

**Statute To Recover Some Costs Not Implemented**

Starting in June 1990, RSA 200-C:6-a required customers to repay the cost of their services under two conditions: 1) the customer received a settlement or an award from a liable third person or party related to the customer's disability which made them eligible for services; and 2) the repayment would be limited to the amount of the award or settlement. Statute also required funds recovered to either be fully credited to NHVR, or a portion be returned to the federal government

depending on when the settlement or award occurred, when services were delivered, and the source of funds allocated for services.

NHVR management reported not being familiar with this statutory requirement and NHVR administrative rules, policies, and procedures did not implement the requirement. NHVR collected information on Workers' Compensation and personal injury settlements and awards during customer intake and while performing the FNA. However, the information requested did not include the date the customer received the settlement or award, or information related to pending litigation which could result in an award or settlement. Additionally, once repayments were collected, no guidance existed to instruct staff regarding which funds were owed to the State or were required to be returned to the federal government.

**Statutory Authority For Repayment Plans Implemented By NHVR Was Unclear**

Even though statute only allowed NHVR to recover costs based on the customer receiving an award or settlement, NHVR appeared to recover costs by allowing customers who must contribute towards the cost of their rehabilitation to make payments over extended periods of time. NHVR practice and training materials, broadly allowed any customer required to financially contribute towards services to participate in a repayment plan where NHVR would pay the entire cost of the service, and customers could enter into a repayment plan to pay back a portion of the costs. In the one repayment plan we found during our file review, NHVR provided over $100,000 in services and reported collecting at least $9,000 over four years after services were rendered using a repayment plan based on the customer's FNA. However, statutory authority to recover costs from customers was narrowly confined to those with financial settlements or awards pertaining to their disabilities, and was silent on if cost could be recovered through repayment plans. Therefore, it appeared NHVR lacked the statutory authority to allow repayment plans to customers without qualifying awards or settlements. Consequently, NHVR may have risked State funds by offering interest-free loans for services to customers outside of NHVR's jurisdiction.

**Limited Controls Over Customer Repayments**

The repayment process implemented by NHVR lacked internal controls to ensure accurate payments. In our review of NHVR procedures and the implementation of one repayment plan in our file review, we found the following:

- Repayment Agreement Not Signed Or Completed – NHVR procedures instructed counselors to complete a form indicating the type of payment and the process by which payment should be submitted. Although the one repayment form included in our file review was signed by the counselor and a supervisor, the form did not contain the customer's signature and did not stipulate the total amount owed to NHVR.
- No System To Track Repayment Plans – NHVR's case management system did not appear to have the functionality to track repayment plans nor did procedures provide instructions on where to record repayment efforts. Consequently, the case file did not fully describe or accurately document whether the customer was upholding the informal repayment plan.

- No Recourse For A Defaulted Repayment Plan – NHVR lacked any policy or procedures on how gaps in repayments would be remedied. Additionally, statute only granted the State a specific right of action for legal recourse over repayment plans not paid according to statue. Therefore, NHVR's noncompliance with statute, and the incomplete agreement in the one case we reviewed, made legal action to receive repayments potentially less viable.

**Limited Controls Over Payments Issued Directly To Customers**

NHVR provided payments directly to customers as a mechanism to deliver some services. These direct payments occurred after services were rendered in the form of customer reimbursements or prior to services as advance payments. While NHVR had procedures related to customer payments, controls to deliver and verify direct payments to customers were lacking. For example, we found:

- Underdeveloped Advance Payment Procedures Risked Waste – The only criteria before issuing an advance payment was to attempt using a State vendor first. Procedures did not also instruct the counselor to assess if the service was amendable to reimbursement instead of an advance payment. We found the following cases where NHVR provided customers advance payments.
    - In one case, NHVR provided $426 to cover three pre-scheduled training sessions. However, we did not find any evidence in the case record the customer attended one of the sessions. We could not find evidence the advance payment associated with the third training session was returned to NHVR.
    - In a second case, NHVR advanced a customer $60 for training fees. However, NHVR did not receive verification the customer attended the training as the customer was not responsive to the counselor's attempts at contact and the case was closed.
    - In a third case, a customer was advanced $133 for a scooter; however, there was no indication the customer actually received the item.
- Large Customer Payments Appeared To Bypass Controls And State Vendor Process – One customer had a vehicle modification completed but had not gone through NHVR's vehicle modification process. The customer was offered the option to be reimbursed over $4,500 or to have NHVR establish the provider as a State vendor. After the customer was reimbursed, the customer continued to request and received an additional reimbursement for unplanned vehicle modifications totaling over $5,000. After paying the customer nearly $10,000 in reimbursements, NHVR management informed the customer NHVR would no longer provide reimbursement.
- Verification Procedures Were Inconsistently Completed – NHVR procedure instructed counselors to collect evidence the customer purchased the good or service before receiving a reimbursement. However, we found customers received reimbursement without submitting documentation the service was provided or the documentation was submitted after the reimbursement was issued. For example, in one instance NHVR directly paid a customer for services without documentation the service occurred and informed the customer receipts would be required for future reimbursements. In another case, the documentation submitted was illegible, but the customer was still reimbursed.

- Ambiguous Procedures Resulted In Inconsistency – In one case we reviewed, we found the payment method switched from advance payments to reimbursements after the case transferred to a different counselor. In another case, one counselor communicated to a customer that payment reimbursement was a last resort for service delivery which was in contrast with other counselors' practices. Without clear guidance, counselors were left interpreting the appropriateness of direct customer payments individually.

NHVR's limited controls in the area of direct customer payments may have been partially due to internally inconsistent procedures. For example, NHVR procedures stated only four types of customer payments were allowed: 1) payments relative to transportation expenditures, 2) advance payment for services, 3) reimbursement for services, and 4) payments issued to a financial advocate who purchased services for a customer. However, these were not mutually exclusive options, since a transportation and financial advocate payment could be either a reimbursement or an advance payment. Additionally, NHVR procedures only required evidence the service occurred for customer reimbursements and payments made to financial advocates. A chronological, defined, risk-based process which required documentation for all direct customer payments may have improved controls.

**Recommendations:**

**We recommend NHVR management implement the statutory requirement to recover costs from customers receiving awards or settlements related to their disabilities in administrative rules. These rules should include a process for identifying potential future awards and settlements, and a process for identifying State and federal portions of recovered costs.**

**In implementing the statutory requirements, NHVR management should determine whether payment plans are allowable under its existing statute. If not, NHVR should consider whether such authority should be granted, and petition the Legislature to amend its statute accordingly. If NHVR determines payment plans are allowable under its current statute, it should:**

- **adopt administrative rules to describe the repayment process and required forms;**
- **develop internal policies on when NHVR could take legal action against noncompliant customers; and**
- **develop a tracking system to record repayment efforts.**

**We also recommend NHVR management improve controls over payments made directly to customers by modifying its existing procedure to limit the amount of reimbursements and advance payments and require all payments include proper documentation prior to reimbursing customers.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau is seeking guidance from the State's Attorney General's office on the allowability of cost reimbursement from customers. If allowable under the current structure the bureau will move forward with adopting administrative rules to clarify the repayment process and once approved implement internal policies and procedures. If determined not allowable the bureau will decide if statutory changes should be petitioned.*
2. *The bureau will consult with the State of New Hampshire's Department of Labor about the feasibility and practicality of NH RSA 200-C:6-a Recovery of Costs; Right of Action. If no longer practical the bureau will petition the legislature for the removal of the Rehabilitation Services Administration. If determined practical the bureau will work with the Department of Labor to develop policies and procedures for the recoupment of settlements. This expectation is that this would be completed by December 2021.*
3. *The bureau has drafted policies and procedures to address the areas observed for direct reimbursements found in the audit and project to have this completed by June 2021. The bureau does have concern with the examples in the section "Limited Controls Over Payments Issued Directly To Customers" as upon review, the four customers noted, received services that were reasonable and allowable under the direction of a Certified Rehabilitation Counselor and in the case of the vehicle modification the Field Service Administrator. The bureau does monitor and track all payments including payments made directly to customers which in turn results in less than 5% of payments being made directly to customers.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau will develop a policy for cost reimbursement by June 2021.*
- *The bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 3, we do not dispute whether the services were reasonable and allowable. The issue presented in this Observation is that NHVR's internal controls did not ensure payments were appropriately made to customers or that the service NHVR paid for actually occurred.**

**Observation No. 33**

**Institute Controls Over Goods Purchased For Customers**

NHVR did not have controls to document customers received the goods purchased for them when tangible goods purchased for customers were delivered to a regional office. NHVR did not have

formal procedures to document the transfer of goods to customers. While NHVR had general practices to document the procurement and receipt of goods by NHVR staff, no policy required a signature from the customer or other documentation the good was transferred. Our review identified that, during the audit period, 25 goods were purchased for ten customers and shipped to an NHVR regional office. We found 18 goods (72 percent) did not contain documentation the customer received the good. Additionally, as part of its control structure, NHVR told the Department of Administrative Services it would validate with customers to confirm the goods purchased for them were received. However, we found 16 goods (64 percent) did not contain a case note or other formal documentation following up with the customer to confirm receipt.

Demonstrating the custody of an asset through documentation was a fundamental management control to properly safeguard resources. Under typical NHVR procedures, counselors authorized the purchase of goods for their customers and regional office support staff coordinated the transfer of the good to the customer. Separating these two roles improved segregation of duties, but the absence of customer acknowledgement that they received the goods remained an internal control weakness. For example, without documenting the good was transferred, a customer could report to the counselor they did not receive the good, or goods taken by NHVR staff could go undetected without documentation.

NHVR management reported customers not receiving the goods purchased for them was not a primary concern as they were confident staff would not steal. However, NHVR management reported terminating an employee prior to the audit period for stealing a good purchased for a customer. The risk of theft would not only jeopardize NHVR resources but would also deprive customers from using the goods needed to overcome barriers to employment and fully leverage NHVR services.

**Recommendation:**

**We recommend NHVR management improve controls over the transfer of tangible goods purchased for customers by developing policies and procedures requiring the transfer of goods is documented through customers acknowledging receipt of goods and follow-up conversations with customers are documented in case notes.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau agrees that strong controls over physical assets is imperative. The separation of duties, as the auditor points out, by which "counselors authorized the purchase of goods for their customers and regional office support staff coordinated the transfer of the good to the customer" provides an important segregation of duties. Additionally, the bureau does have a process whereby the Rehabilitation Technician in the local office confirms directly with the customer the receipt of goods and documents this on the invoice after speaking with them. Verification of the delivery is checked by multiple staff prior to*

*payment. The bureau informed Administrative Services on the validation method and there was never a concern with the process.*

2. *The bureau has concern with the statement that the auditors found 16 goods that did not contain formal documentation as there was no requirement for an additional level of documentation.*
3. *The fact that the bureau was able to catch the one individual who stole prior to audit period is an example of the bureau's control systems working as designed. Since the reported termination of the employee a new case management system has been implemented where additional layers of separation of duties have been added further removing that chance for the theft.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau agrees to develop and implement more detailed procedures by March 2021 to more formally document the receipt of goods.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

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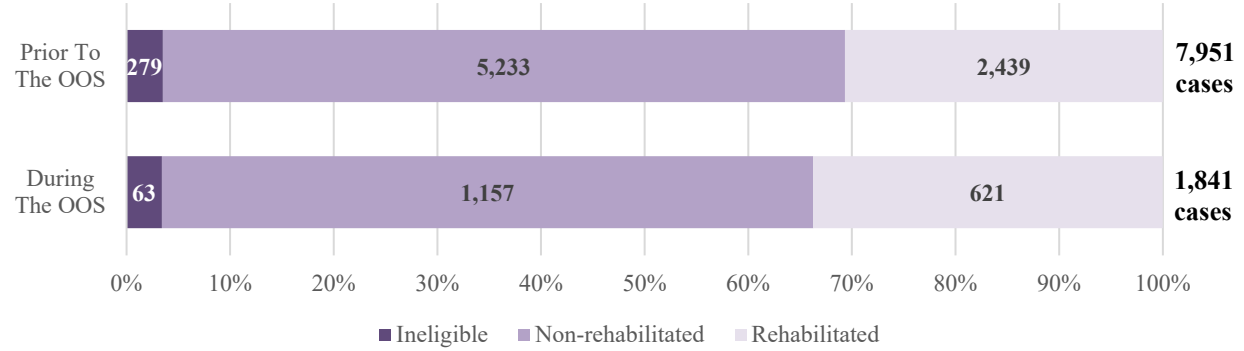
## CHAPTER 7: CASE CLOSURE

Under federal regulations, case records could be closed in one of three ways depending on the stage at which the individual was seeking services and if certain criteria were met: 1) an applicant or customer who did not meet eligibility requirements was determined ineligible, 2) a customer who successfully obtained and maintained competitive employment for at least 90 days was determined rehabilitated, or 3) a customer who was unable to obtain or maintain competitive employment under specific circumstances was determined non-rehabilitated. Figure 9 shows reasons for closure both prior to and during the order of selection (OOS), which was implemented in May 2018, indicating minimal changes between the two time periods.

**Figure 9**

**Number Of Case Closures By Reason, Prior To And During The OOS**




Source: LBA analysis of unaudited NHVR data on case closures between July 1, 2015, and June 30, 2019.

Cases being closed were federally required to include certain documentation within the case record describing and supporting the reason cited. State vocational rehabilitation (VR) agencies, in consultation with the State Rehabilitation Council, were responsible for determining what types of documentation would be maintained in the case record consistent with federal requirements. According to federal law and regulations, cases closed as rehabilitated were required to demonstrate the customer achieved the outcome specified in the IPE, and counselors verified the customer's wages and benefits. Additionally, federal regulations required rehabilitated cases demonstrate that services provided in the IPE contributed to the achievement of the employment outcome and that the customer maintained employment for at least 90 days to ensure stable employment without needing VR services. At the end of the stable period, federal regulations required the customer and counselor to agree the employment outcome was satisfactory and the customer was performing well. Finally, federal regulations required customers be informed of post-employment services (PES). If the case was closed, the individual would be required to reapply for a new determination of eligibility in order to receive future services, unless the case record was closed as rehabilitated and PES were needed.

Federal reporting requirements identified several reasons for closing a case as ineligible. These included if the applicant or customer: 1) had no impairment, 2) had no impediment to employment, 3) did not require services, and 4) had a disability that was too severe to benefit from services in terms of an employment outcome. Additionally, a customer could be determined ineligible if there was no long-term source of extended support services available. According to unaudited New Hampshire Bureau of Vocational Rehabilitation (NHVR) data, most ineligible closures occurred because the individual did not require services (224 of 342 cases, or 65 percent), or because the individual was too severely disabled to benefit from services (90 of 342 cases, or 26 percent).

The main purpose of VR programs was to provide services to individuals with disabilities so that they may prepare for and engage in competitive integrated employment and achieve economic self-sufficiency. Once customers achieved stable employment outcomes and certain other requirements were met, the NHVR could close the case as rehabilitated. If the customer obtained employment, VR agencies were required to inform them of the availability of PES, which were additional services, limited in scope and duration, necessary for a customer to maintain, regain, or advance in their employment. However, PES was not meant to substitute for extended or more comprehensive services which may have been necessary in certain instances to maintain consistent employment.

If customers did not achieve competitive integrated employment, or if rehabilitation requirements were not met, NHVR could close cases for non-rehabilitation. Federal guidance specified nine reasons for non-rehabilitated closures. According to unaudited NHVR data, most non-rehabilitated closures occurred because NHVR was unable to locate the customer after a move or contact the customer after repeated attempts (2,840 of 6,390 cases, or 44 percent), or because the customer refused services, either because they decided not to continue with VR or because their actions made it impossible to start or continue a VR program (2,528 of 6,390 cases, or 40 percent).

We found some cases were not adequately monitored to ensure they were closed timely. Even though NHVR management and staff reported periodically monitoring for cases that could potentially be closed, we found cases that remained on caseloads that had been inactive for months or years. Additionally, NHVR did not fully document all requirements were met when closing cases and did not ensure PES were only provided in specific circumstances.

**Observation No. 34**

**Improve Monitoring Of Cases For Timely Closure**

While management indicated caseloads should generally represent the number of active cases, we found many cases were inactive for lengthy periods of time and were not effectively monitored for lack of activity or timely closure. Management's decision-making about case allocation across counselors and when to release cases from the waitlist was negatively affected when inactive cases remained open and inflated caseloads. Additionally, counselors who repeatedly attempted to engage customers over a prolonged period, despite their non-responsiveness, diverted time that could have been better spent on active cases with customers who were engaged in the process to achieve their employment goals. The closure process for inactive cases was also inconsistent, even across a single counselor's caseload, potentially due to inadequate guidance.

**Prior Findings About Potentially Inactive Cases Remained Unresolved**

Our 2001 *Bureau Of Vocational Rehabilitation And Service Delivery Performance Audit Report (2001 LBA Audit)* identified potentially inactive cases that had not been closed out and were contributing to the appearance of higher caseloads. At the time of the audit, there were no federal requirements or NHVR policies on when to close inactive cases and the timing of closure was left to counselors' discretion. We recommended NHVR develop and implement policies on reviewing potentially inactive cases, and NHVR concurred. During our current audit, two central office managers indicated policies and procedures were clear about when cases should be closed. However, we found the *NH Vocational Rehabilitation Policy Manual (Policy Manual)* provided limited guidance to counselors on when to close potentially inactive cases, while the *NHVR Counselor Desk Reference (Desk Reference)* provided guidance only on when to close rehabilitated cases. Six of 25 counselors responding to our survey (24 percent) reported aspects of NHVR guidance, including rules, policies, procedures, and training, were unclear on case closures. Additionally, seven counselors (28 percent) reported case closure policies and procedures were inconsistently applied. Confusion and inconsistent monitoring likely contributed to ongoing issues with inactive cases and timely case closures.

**One-time Review Of Counselor Caseloads Was Ineffective**

The NHVR Director reported supervisors and counselors reviewed the status of all inactive cases when NHVR implemented its current case management system in July 2015. Counselors reportedly either re-established customer contact or closed out inactive cases as a result of the review. However, the review appeared ineffective, as inactive cases generally remained open and continued to be inactive.

We reviewed 66 cases that were open prior to July 2015 and managed by 23 counselors from our file and caseload reviews. We analyzed case notes and attachments in the electronic case management system for documentation of substantive customer contact that would have demonstrated engagement with rehabilitation and progress towards employment goals leading up to the one-time review. Almost half of the cases we reviewed (32 cases, or 49 percent) had no substantive contact with customers for at least four months prior to July 2015 but remained open, including ten cases with no contact for one to two years, and seven cases with no contact for between two and four years. Most of the 32 cases lacked evidence in the case record that counselors attempted to re-engage customers or initiate closure around the time the review was reportedly conducted. Twenty-two cases (69 percent) remained open but documented no substantive contact with customers for at least an additional four months, resulting in cases without contact for 16 to 76 months in total, despite the review. Examples of the five cases with the longest absence of contact are shown in Figure 10. Only one of the 32 cases (three percent) was closed in 2015, but not apparently as a result of the review. The electronic case file indicated the customer had been employed for more than 90 days without needing VR services when the case was closed in late September 2015.

**Figure 10**

**Months Without Substantive Customer Contact For Five Select Cases, Before And After July 1, 2015**


Source: LBA analysis of select NHVR electronic case files.

**Additional Controls Did Not Effectively Identify Cases For Timely Closure**

In addition to the one-time caseload review, management implemented ongoing controls to identify inactive cases or more timely close rehabilitated cases. NHVR training recommended counselors systematically review their cases and remove inactive cases. Although training materials did not provide guidance on how often to review caseloads or what criteria to use, most counselors responding to our survey (16 of 25 counselors, or 64 percent) reported reviewing their entire caseload for potential closures at least monthly, and management reported counselors and supervisors were aware of inactive cases. Additionally, management implemented limited monitoring of inactive and rehabilitated cases through the weekly case monitoring reports, beginning in September 2017. However, routine controls also appeared to be ineffective, and supervisors reported higher prioritization of active cases than inactive cases, inconsistent treatment of inactive cases, and inadequate monitoring tools in the electronic case management system.

We reviewed 329 cases, open between July 1, 2015, and October 24, 2019, managed by 56 counselors from all regional offices. These were comprised of 96 cases from our file review and 233 from two counselors' caseloads active on October 24, 2019. We found 183 cases (56 percent) were inactive at some point during this period and could have potentially been closed or closed sooner. We note it may be reasonable for some cases to be open for longer periods of time; however additional scrutiny may have helped to identify inactive cases. Additionally, we reviewed case activity for the two counselors' caseloads as of October 24, 2019, and found:

- The first counselor had a caseload of 69 cases, which included three cases on the waitlist. However, among the remaining 66 cases, more than two-thirds (45 cases, 68 percent) appeared to be inactive and could have potentially been closed.
- The second counselor had a caseload of 164 cases, which included 16 cases on the waitlist. However, among the remaining 148 cases, more than half (78 cases, 53 percent) appeared to be inactive and could have potentially been closed.

***Many Cases Where Customers Were Unavailable Could Have Been Closed Sooner***

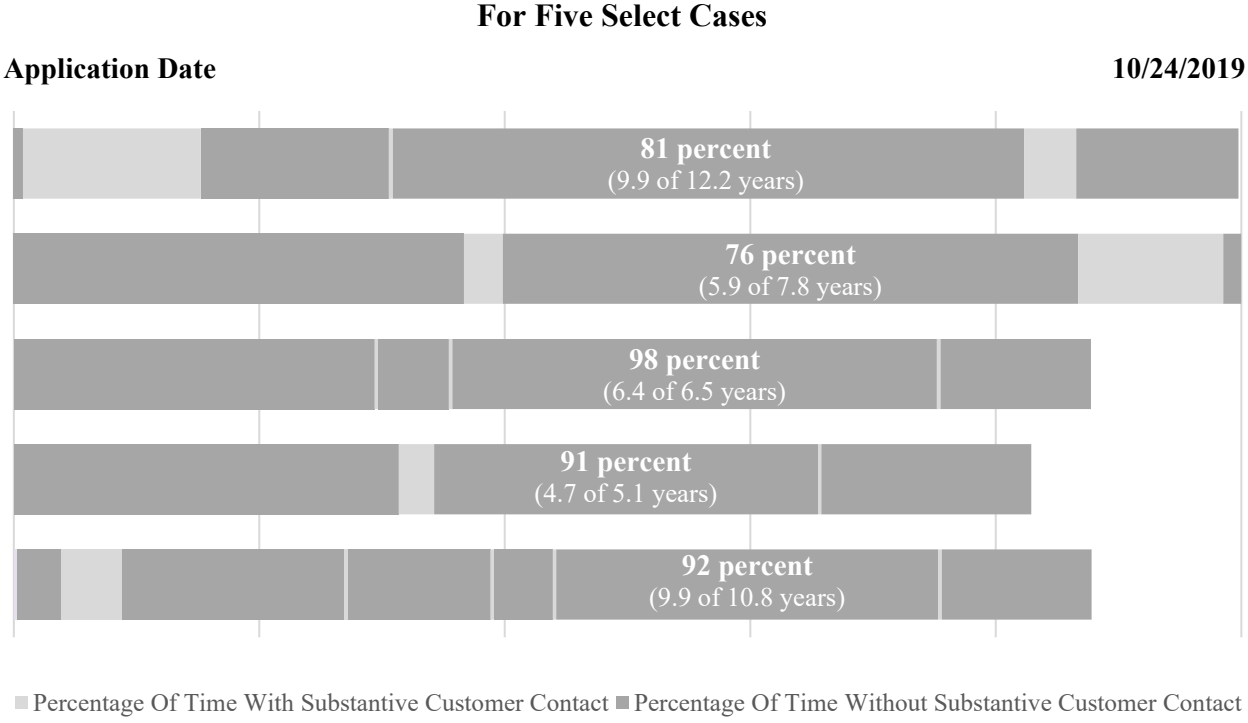
The *Policy Manual* specified counselors "may" close a case if an applicant or customer was "unavailable… for an extended period of time…" Neither the *Policy Manual*, procedures, nor training materials provided guidance on what constituted "an extended period of time." However, the *Desk Reference* required counselors to have "regular" customer contact at least every six to eight weeks, and more frequently in some circumstances. Counselors were required to document contact through case notes in the case management system. Additionally, supervisors pointed to potential indicators of inactive cases, including whether there had been case notes within the past 90 days, or whether IPEs had expired.

Designating a case as inactive was one way in which counselors could ensure inactive cases were easily identified. The *Policy Manual* specified counselors should place a case into the "services interrupted" status if a customer's VR services were interrupted, until the case could return to active status or was closed. However, a counselor could only designate a case as inactive if the customer needed to take a break, such as for a short-term injury, or if an additional assessment was needed to modify a customer's plan. Additionally, inactive cases still were required to document ongoing contact with the customer until the case was returned to active status or closed.

We reviewed case notes and attachments in the electronic case management system to identify the longest time span without documented, substantive customer contact and to determine whether cases documented ongoing, active customer engagement in the VR process, such as through vendor feedback or reports sent to the counselor. We focused our review on 302 cases that were open longer than six months. Among the 302 cases, 138 (46 percent) lacked substantive contact and evidence in the case record of active customer engagement for more than four months at some point, including 33 cases with no contact for one to two years and 16 cases with no contact for between two and six years. Some cases inactive for a long time also had limited customer contact over the entire duration of the case. Figure 11 shows the percentage of time without substantive contact, between application and October 24, 2019 when we reviewed the cases, for the five cases identified above with long absences of contact.

**Figure 11**

**Percentage Of Total Time Without Substantive Customer Contact For Five Select Cases**




Note: The four cases with 81 percent or more of the time without substantive contact contained periods where contact occurred on a single day, such as through a meeting or a phone conversation between the counselor and customer, and did not occur again until a later point in time.

Source: LBA analysis of select electronic case files.

We examined the two counselors' caseloads to identify how many inactive cases might be on a caseload at a given point in time. We focused our review on 214 cases that were not on the waitlist on October 24, 2019, and found 58 cases (27 percent) did not have documented, substantive contact and evidence of active customer engagement for four months or longer, including 11 cases with no substantive contact or active engagement for one to two years, and two cases with no substantive contact or active engagement for more than two years. Among these was one case that remained open even though the customer had moved and become a customer with another state's VR program. The customer reported moving in late June or early July 2019, although the counselor did not follow-up with the customer until mid-October 2019, at which time the counselor informed the customer their case would remain open "a little longer" to let the customer "fully settle in." However, the customer's case remained open with NHVR until April 2020.

Additionally, we identified some cases where customers appeared to only engage in the VR process when they reported needing assistive or other technology or restoration services, such as eyeglasses. For example, in one case, the customer had not been engaged in an active job search since 2017 and indicated in March 2018 that they did not want to work with NHVR. Although the customer refused services, the case was not closed at this time. The customer contacted their

counselor in June 2018 again indicating they were not interested in conducting a job search but asking for restoration services. Despite repeated indications that the customer was not interested in a job search, and lack of any action to conduct a job search, the case remained open through June 2020, and NHVR paid for restoration services in the amount of $727.

***Many Cases Where Customers Refused To Participate Could Have Been Closed Sooner***

The *Policy Manual* specified counselors may close a case if a customer refused to cooperate or "participate in a part of planning or service provision that [could] be demonstrated to be critical to success" and still refused to participate after advice from the counselor. While customer participation was necessary throughout the entire VR process, from eligibility to IPE development, service provision, and employment, neither the *Policy Manual*, procedures, nor training materials provided guidance on what constituted refusal to cooperate or participate. Supervisors pointed to various indicators, such as whether customers missed meetings, refused services, or were not working towards their employment goals. Additionally, supervisors reported customers may sometimes request counselors close their case.

We reviewed all 329 cases to determine whether customers had refused to cooperate or participate in their rehabilitation at some point between July 2015 and October 2019. Overall, half of cases (163 cases) documented non-cooperation, including customers who refused to participate in services or job searches; cancelled meetings with their counselor or vendors; or failed to timely return important documents upon request.

We examined the two counselors' caseloads to identify how many non-cooperative customers might be on a caseload at a given point in time. Of the 214 customers not on the waitlist, we found non-cooperation in 45 cases (21 percent). Among these was one case where the last substantive contact with the customer occurred in October 2018. Subsequently, the customer did not show up for a meeting scheduled for February 2019, nor did the customer inform the counselor they would be unable to make the appointment. The counselor attempted to contact the customer in July and October 2019, and despite the lack of contact, the case remained open through June 2020.

***Closure Of Unavailable And Non-cooperative Customers' Cases Was Not Always Timely***

The *Policy Manual* established a specific closure process when nonresponsive customers were released from the waitlist. NHVR required counselors to make several efforts to contact a customer. If the customer did not respond to initial attempts, the counselor was to send a letter on the third day without a response, scheduling an appointment. If the customer missed the appointment or did not respond to the letter by a certain date, the counselor was required to send a certified letter within three business days. Six supervisors reported using a broad closure process in all cases where customers were unavailable or nonresponsive. In practice, if customers were nonresponsive, the counselor sent a letter specifying the case could be closed if there was no contact within two weeks, followed by a second letter 30 days later specifying the case would be closed if there was no contact within ten days. Additionally, the *Policy Manual* required steps counselors took to contact customers be documented in the case management system.

However, there were inconsistencies in how the closure process was implemented. For example, one supervisor noted that if the counselor waited too long to send the second closure letter, they would need to start the process over and re-send the first closure letter. One central office manager reported counselors should attempt contact once more before re-sending an updated second closure letter, but reported there was no specific timeline for closure in the case of nonresponsive customers and noted sometimes counselors allowed too much time between attempts to contact a nonresponsive customer. Additionally, while each regional office had support staff, these staff performed different functions in each regional office, and there was no guidance on how to best utilize support staff during the closure process. Support staff in some regional offices supported counselors by sending out records requests and conducting follow up, reportedly allowing counselors to spend more time on other tasks.

Cases had no contact for varying lengths of time before counselors sent out the first of two notices of closure. Counselors documented zero to four attempts to contact customers prior to sending out the first notices after two to nine months without customer contact. Additionally, cases remained open for varying lengths of time.

- In one case, there was no documented contact with the customer for two-and-a-half years, from application in September 2017 through closure. The counselor documented attempted contact in February 2018 and sent out the first closure notice on the same day. A second and final closure notice was never sent, even though the customer did not respond in the requested timeframe. The counselor again attempted contact in June 2018, December 2018, March 2019, June 2019, and August 2019, before ultimately closing the case due to non-responsiveness in April 2020.
- In a second case, the customer had last contacted the counselor in March 2019, nine months prior to closure. The counselor attempted to contact the customer twice before sending a first notice in August 2019 and a second notice in November 2019, before ultimately closing the case in December 2019.

***Many Rehabilitated Cases Could Have Been Closed Sooner***

Federal regulations, the *Policy Manual*, and the *Desk Reference* required customers to maintain employment for no less than 90 days to ensure employment was stable and VR services were no longer needed. One central office manager noted counselors might keep cases open much longer than 90 days, but noted policy was clear on when to close these cases. Additionally, the *Desk Reference* required counselors to close PES cases once customers had achieved an outcome, whether rehabilitated or non-rehabilitated.

We reviewed 41 cases where the customer was recorded to be in stable employment between July 2015 and October 2019. Almost half of cases (19 cases, 46 percent) were stable for at least one month longer than required, including:

- five cases stable for an additional one to three months,
- eight cases stable for an additional three to six months,
- three cases stable for an additional six to nine months, and
- three cases stable for at least an additional nine months.

We then examined the two counselors' caseloads to determine whether customers with employment could have had their cases closed out sooner. There were no cases in stable employment or PES on October 24, 2019, in one counselor's caseload. Among the 66 cases on the other counselor's caseload:

- Eight cases (12 percent) were recorded in stable employment for 46 to 233 days longer than required, all without documented, substantive contact for between three months to almost two years. Among these was one case where the customer obtained employment in August 2017 and received no further services, although employment was not recorded as stable until March 2019. The counselor last spoke with the customer in February 2019 and attempted contact six additional times before eventually closing the case in January 2020.
- Five cases (eight percent) were open in PES but had not been closed as required. Among these was one case opened for PES in October 2018, with services paid for in February 2019, when the counselor also confirmed employment concerns were addressed. However, the case was not closed until March 2020.

**Recommendations:**

**We recommend NHVR management improve guidance on case closure timeliness by:**

- **developing, implementing, and refining rules, policies, procedures, and training on reviewing caseloads to identify potentially inactive cases and on closing cases deemed inactive, including criteria for "unavailable" and "non-cooperative" customers and timelines;**
- **identifying ways to assist counselors, such as through the use of support staff to timely send the second closure notice if no contact is made after the first closure notice is sent, and developing appropriate policies and procedures; and**
- **ensuring guidance on closures is comprehensive and consistent across rules, policies, procedures, and training;**

**We recommend NHVR management improve monitoring of case closure timeliness by:**

- **identifying data and information necessary for monitoring inactive cases, as well as developing, implementing, and continually improving processes to routinely collect, monitor, and analyze compliance data and information;**
- **routinely measuring staff compliance, such as through random review of a certain percentage of cases on a counselor's caseload, and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau notes concern with this observation as it appeared the auditor's did not value the impact of the unique situations, disabilities, and functional limitations of each customer which could make full engagement in the process difficult. For many individuals, the VR process assists them in engaging more over time, as disabilities can hinder this, and thus, positive outcomes. Because of this, the VR counselor may take longer to close a case because they are trying to continually engage to help the customers.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau will develop guidance and training to the counselors, support staff and supervisors on how to more effectively manage caseloads concentrating on customers who are not actively engaged in the process. As of December 2020 an updated policy on closures was in the process of being developed and is estimated to be implemented by February of 2021 to assist staff with consistency. The bureau will develop a data report to assist staff with the identification of cases that may not be fully engaged in the process by March 2021.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**As we state in the Observation, it may be reasonable for some cases to remain open for longer periods of time due to customers' barriers preventing them from fully engaging in the vocational rehabilitation process. We note that such barriers to full engagement are rarely documented in the case record and did not appear to explain most case inactivity we observed.**

**One case, presented in Figures 10 and 11, was open for five years, during which the counselor maintained contact with the customer for a handful of days over the course of the case. After limited contact when the case was first opened, there was no contact or activity during a three-and-a-half-year period, until the counselor sent a letter requesting contact. Subsequently, there was no contact or activity for an additional one-and-a-half-year period after the counselor's letter.**

**Observation No. 35**

**Improve Employment Verification**

NHVR was required to report employment and wage information to the Rehabilitation Services Administration, NHVR's federal oversight agency, to comply with performance measures and annual reporting requirements. Although NHVR was federally required to document verification of employment and wages in customer records, we found inconsistent supporting documentation

in case files. Further, if verification was not obtained, NHVR personnel's understanding of how cases should be categorized upon closure varied.

**Files Did Not Contain Formal Employment Verification**

- The Rehabilitation Services Administration provided examples of acceptable supporting documentation to be retained in the customer's file. Consistent with federal guidance, NHVR required counselors obtain employment verification through the following methods:

- paystub, initialed by the customer, identifying the customer's start date and rate of pay;
- form, to be filled out by the employer, documenting verification of employment and wages;
- if the customer obtained self-employment, a financial statement showing stability had been achieved within 180 days based on the level of income, revenue, and operating costs; or
- detailed case notes that included the job, employer, rate of pay, start date, and justification for not obtaining formal documentation.

NHVR management reported being aware of issues with employment verification. During a federal monitoring session in May 2019, federal reviewers reviewing a sample of NHVR's case files verbally commented that while case notes indicated the customer became employed, there was not always supporting documentation in the file such as a paystub or letter from the employer. Our file review of 12 rehabilitated cases showed only four cases (33 percent) containing formal documentation. Although four cases had a paystub provided to verify employment, none of the paystubs contained an employment start date and customer initials per NHVR requirements. None of the other eight cases contained detailed case notes with employment information and justification for not obtaining formal documentation.

Further, three of the four cases with a paystub had conflicting wage rates documented in the file. Specifically, the paystub contained an hourly wage different from the wage entered by the counselor into the case management system. In the event the customer did not provide their social security number, supplemental wage information entered into the case management system was used to report required federal performance metrics. When counselors entered conflicting wage data in its case management system, NHVR could not accurately report performance metrics for those customers who did not provide a social security number.

**Self-employment Was Not Verified**

Self-employed individuals were subject to additional verification before the case could be closed as rehabilitated. Counselors were required to obtain a financial statement or tax form after the business had been in operation for at least 180 days. NHVR management reported self-employment verification was inconsistent among counselors. Our file review contained one rehabilitated customer who was self-employed. However, the case was closed within 90-days of the self-employment date, which would not have met with 180-day stability requirement. Additionally, no documentation was provided to verify revenue equaled or exceeded the business' operating costs, as required in NHVR policy. Within five days of rehabilitated case closure, the

customer informed the counselor the business was not as successful as reported and the customer was not satisfied with their employment outcome.

**Closure Procedures Were Unclear If Employment Verification Not Obtained**

Although NHVR management reported discussing employment verification guidance since at least calendar year 2017, NHVR personnel reported different understandings of case closure procedures if counselors were unable to obtain any employment information. For example, during our interviews with some NHVR staff:

- four regional leaders (RL) and one counselor reported the case could be closed as rehabilitated without employment verification;
- one RL and one counselor reported the case could not be closed as rehabilitated without employment verification; and
- one counselor reported being unsure how to close a case without employment verification.

Additionally, in our survey of counselors, four counselors indicated a case note was sufficient to verify employment instead of seeking formal documentation, and one counselor reported they did not verify employment. NHVR could not ensure it was fulfilling its programmatic purpose if employment was not being verified consistently.

**Recommendations:**

**We recommend NHVR management ensure counselors verify a customer's employment and obtain documentation required by federal requirements. As part of its process, NHVR should ensure:**

- **hourly wages are accurately captured and reported,**
- **all personnel understand the criteria for what should be closed as a rehabilitation, and**
- **written policy and procedures include how supervisors should verify this information is being collected.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The Rehabilitation Services Administration did not require nor train VR staff on formal employment documentation until 2018, nearly halfway into the audit period. It should be clarified that the customer was employed but the case documentation did not follow the guidance case guidance completely or the case was closed prior to the bureau or the government providing guidance in this area.*
2. *The section, "Closure Procedures Were Unclear If Employment Verification Not Obtained" and survey questions asked to staff are misleading as cases can be closed without employment verification through a detailed case note documenting the attempts to acquire formal verification.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau has drafted policies and procedures that detail required employment verification that is projected to be implemented to the field and trained by June of 2021. By December 2021 the bureau projects having a functioning quality assurance unit that will use a statistical based quality control process to assess staff compliance with the observation.*
- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, federal guidance was released in March 2017. However, the federal requirement for verifying a customer is earning wages at or above the minimum wage and benefits are comparable to those paid to other employees for similar work has been in place since at least 2010.**

**In a report encompassing FFYs 2016 through 2018, and released in late 2020, the Rehabilitation Services Administration, NHVR's federal oversight agency, also identified issues with employment verification. Federal reviewers noted that there was inadequate documentation verifying customers' employment outcome in two cases they reviewed (ten percent) and inadequate documentation supporting hourly wages in three cases (15 percent). They also found hourly wages documented in performance reports and customer records did not match in two cases (ten percent).**

**In reference to Remark 2, the responses from NHVR staff and management were not limited to survey questions. As the Observation notes, we also interviewed RLs and counselors. While NHVR purports questions to staff were misleading, the questions open-ended, unbiased, and were reviewed internally to ensure objectivity to allow RLs and counselors to fully explain their understanding of closure processes.**

**Reasons For Case Closure**

The main purpose of VR programs was to provide services to individuals with disabilities so that they may prepare for and engage in competitive integrated employment. However, according to unaudited NHVR data, approximately two-thirds of cases closed during our audit period were closed for non-rehabilitation and ineligibility.

It was important to maintain accurate and reliable information on case closures so that both NHVR management and external stakeholders could assess performance relative to customer outcomes. Although NHVR's internal reporting focused on rehabilitated closures, the Rehabilitation Services

Administration required NHVR to report information on all closure reasons, and reviewed this information as part of its monitoring process.

Additionally, accurate and reliable information could have assisted management in prioritizing process improvements intended to increase the number and proportion of customers achieving rehabilitated outcomes. As stewards of public resources, NHVR was responsible for ensuring federal and State funds were used efficiently and effectively. A substantial portion of spending was on cases closed for non-rehabilitation or ineligibility. Unaudited NHVR data showed spending of $10.7 million on total costs for cases closed for non-rehabilitation or ineligibility during the audit period, and spending of $11.6 million on total costs for cases closed as rehabilitated. Accurate information on the specific reasons for closures could help prioritize process improvements in areas with high spending over which NHVR had some control.

**Observation No. 36**

**Ensure Closures For Rehabilitation Are Supported By All Required Documentation**

The Rehabilitation Services Administration assessed NHVR's performance, in part, through information on the number of customers who achieved an employment outcome after receiving services. Our *2001 LBA Audit* found NHVR had a relatively high rehabilitation rate compared to other states, a trend supported by data from FFYs 2009 through 2013.

Accurate reporting of rehabilitated cases was important for performance assessment and achievement of program objectives. However, during our current audit, we found cases closed as rehabilitated did not always meet federal requirements or NHVR specifications. Inaccurate closures or those not fully supported by required documentation affected NHVR's ability to assist individuals with disabilities in obtaining competitive employment, as well as management's decision-making and ability to accurately evaluate agency performance.

**Rehabilitation Closures Were Not Always Supported By Required Case Documentation**

To determine whether rehabilitation closures were supported by all required documentation, we analyzed 12 cases closed as rehabilitated between July 2016 and August 2019 from our file review of 97 cases. However, none of the 12 cases contained all documentation required by federal regulations and NHVR administrative rules for rehabilitated closures, nor did any case contain all documentation required by internal NHVR guidance. NHVR spent a total of $764,863 on the 12 cases, averaging five years from application to closure per case. If closures for rehabilitation were recorded only when supported by all required documentation, management could have improved decision-making and processes related to closures.

***Some Cases Did Not Verify Employment Was Achieved***

An employment outcome involved a customer entering or retaining full-time or part-time competitive integrated employment or achieving an outcome such as self-employment. Each customer's intended outcome was specified in their IPE. Federal regulations and NHVR administrative rules required rehabilitated closures demonstrate that the customer achieved the

outcome specified in the IPE, and wages and benefits were verified. NHVR recorded all 12 cases as achieving the employment outcome identified on the customer's most recent IPE. However, none of the cases fully verified customers' wages and benefits as required by federal regulations, NHVR administrative rules, and the *Policy Manual*.

***Some Cases Did Not Document That VR Services Contributed To The Employment Outcome***

Federal regulations and NHVR administrative rules required rehabilitated cases demonstrate that services provided under IPEs contributed to the achievement of employment outcomes. The *Policy Manual* and training materials also required documentation that guidance and counseling had been provided, that appropriate and substantial VR services had been provided in accordance with the customer's IPE, and the services had contributed to the achievement of an employment outcome.

In seven of the 12 cases (58 percent), the customer first obtained employment and an IPE was later developed with a corresponding employment goal before closure. This practice appeared to make it difficult for NHVR to meet requirements regarding service provision, as not all customers required or received services that contributed to their employment outcome.

- In one case closed after we formally reviewed the file, the customer, who was classified as MSD, obtained employment before IPE development began. The customer reported applying for a position and being hired, without assistance from NHVR. An IPE was developed to reflect the customer's employment, with only guidance and counseling listed as a service. After IPE development, the counselor attempted contact at least four times over five months before reaching the customer, who reported employment was going well. The counselor reached the customer twice more before closure, asking about employment. During the 11 months the case was open, it did not appear guidance and counseling contributed to the achievement of the customer's employment outcome or the customer's ability to maintain that employment.
- In one case closed after we formally reviewed the file, the customer, who was classified as SD, began services with an employment goal in a healthcare field, changed their employment goal to accountant, but eventually obtained employment as a cashier. Upon closure, the counselor reported the customer received guidance and counseling and job placement services from NHVR, as well as informational interviewing services from a CRP vendor. However, the customer obtained the cashier position one year before case closure, without NHVR assistance, and had limited contact with the counselor in the three years the case was open, including multiple requests for contact and notices of closure. Additionally, informational interviewing was provided as a job exploration activity prior to IPE development, to select the initial healthcare employment goal. This service was unrelated to the customer's employment as an accountant or as a cashier. Case notes also did not document how NHVR provided job placement services or that guidance and counseling contributed to the customer's employment as a cashier.

    - An initial plan was developed with a healthcare position employment goal. No services were provided, and after 15 months of limited contact between the customer and NHVR the customer reported obtaining employment as an accountant, without NHVR assistance.

  - After the customer obtained employment as an accountant, a second IPE was developed to reflect "accountant" as the employment goal. The customer later reported losing this employment and subsequently obtaining employment as a cashier, without NHVR assistance, while still working towards an employment goal of "accountant."
  - The counselor informed the customer that if they wanted "cashier" to be their goal, they would need a new IPE and verification of employment, and a third plan was developed. However, no services were provided to maintain the employment goal. The case was closed as rehabilitated with the customer obtaining employment as a cashier.

- In one case closed prior to the OOS, the customer had an employment goal pertaining to computers for more than ten years, before obtaining employment in the educational field and developing a new plan. There was a nearly three-year gap in documented communication between the customer and counselor, at which time the customer reported they had been working for an educational institution for the past five months. A second plan was developed three months later, which did not reflect any additional services to be provided or paid for by NHVR to assist the customer in maintaining stable employment. NHVR paid $13,250 for services supporting the customer's original employment goal. However, no services were paid for, and guidance and counseling was not provided in relation to the customer's new employment goal.
- In one case closed during the OOS, the customer had an employment goal of teacher for nine years before obtaining seasonal employment performing data entry. There was a seven-month gap in communications, at which time the customer reported they would be working in another state for four to six months. Although employment was seasonal, the customer repeatedly reported wanting to stay in the position over a period of one-and-a-half years, after which a new plan was developed with an employment goal related to data entry. While NHVR paid $109,107 for services supporting the customer's original employment goal, including tuition to obtain a master's degree, no services were paid for, and guidance and counseling was not provided, in relation to the customer's new employment goal.

***Some Cases Did Not Document Employment Was Stable And Maintained Without Services***

Federal regulations required a customer maintain employment for an appropriate period of time, no less than 90 days, to ensure employment stability without needing VR services. These requirements were also included in the *Policy Manual* and the *Desk Reference*. However, in six of 12 cases (50 percent), there was documentation the customer received VR services past the recorded stable date, and four of the six cases (67 percent) documented the customer was employed, without receiving services, for less than 90 days before closure.

- In one case closed prior to the OOS, the counselor recorded a stable date in July 2016, with closure 90 days later, in October 2016. However, the counselor reported providing guidance and counseling and services costing $4,788, including vehicle modification and consultation, through August 2016, 34 days before closure.

- In one case closed during the OOS, the counselor recorded a stable date in September 2018, with closure 91 days later, in December 2018. However, according to case notes, the counselor reported providing guidance and counseling through December 2018, six days before closure.

The *Desk Reference* also required confirmation employment was expected to continue for at least one year. However, nine of 12 cases (75 percent) did not document expected employment length.

***Some Cases Did Not Document The Outcome Was Considered Satisfactory***

Federal regulations required the customer and a qualified rehabilitation counselor, at the end of the stable period, to consider the employment outcome satisfactory and agree the customer was performing well in employment. These requirements were also specified in the *Policy Manual* and training materials. However, in six of the 12 cases (50 percent) this information was not documented, including three cases that were ultimately closed by support staff not considered to be "qualified rehabilitation counselors" under federal law. An additional four cases (33 percent) contained unclear documentation. In one case closed during the OOS, a rehabilitation technician completed closure. The counselor last documented contact with the customer two-and-a-half months prior to closure, indicating the customer's case was "due to be closed with NHVR as [they had] been working for ninety days." However, it was the rehabilitation technician who completed the closure case note and reported the customer "has maintained suitable employment" and "possesses acceptable skills to perform the work satisfactorily."

We found five of 12 cases (42 percent) did not document that the customer considered their employment outcome to be satisfactory or the customer thought they were performing well. One of the five cases also documented counselor concerns about the customer's employment. In one case closed during the OOS, the counselor and the customer expressed concerns about the employment outcome. Throughout the case, the counselor reported being "very concerned" about the customer pursuing self-employment, given their disabilities, and noted the customer chose self-employment "without NHVR's support." The counselor appeared to close the case without customer consultation or agreement. Less than two weeks after closure, the customer indicated they did not know if they would consider themselves "gainfully employed," indicated they would "not call this a complete success just yet," and requested their case remain open.

The *Policy Manual* and training materials required documentation that the customer had an opportunity for involvement in the closure decision. However, six of 12 cases (50 percent) did not document that the customer was involved in the closure decision, while an additional case contained unclear documentation. In one case closed prior to the OOS, the customer did not appear to be involved in the closure decision. The last meeting with the customer was three months prior to closure, during which the customer reported enjoying her job. However, the customer reported "struggling" due to ongoing mental health issues, the counselor and customer had developed a plan for the customer to obtain assistance, and the counselor indicated they would continue to provide guidance and counseling to the customer. Subsequent to that meeting, there was no contact, and the counselor reported the customer's phone was disconnected.

Additionally, the *Desk Reference* required confirmation that the customer agreed with case closure. However, seven cases (58 percent) did not document that the customer agreed with closure, while an additional case contained unclear documentation. In one case closed during the OOS, there was no documentation indicating the customer agreed with the closure decision. In the month prior to closure, a rehabilitation technician had been communicating with the customer about the case. The technician asked whether the customer was still working and requested employment verification. After the customer noted a potential issue, the technician asked if the customer was okay with closing their case, which the customer was reluctant to do. The technician noted the case could be re-opened to obtain PES. However, there was no documented response from the customer.

***Some Cases Did Not Document Customers Were Informed Of PES***

Federal regulations and NHVR administrative rules required customers be informed of the availability of PES. However, eight of 12 cases (67 percent) did not document that the customer had been informed of the availability of PES, while an additional two cases contained unclear documentation (17 percent).

**Monitoring Of Rehabilitated Closures Was Inadequate**

NHVR monitoring of rehabilitated closures was limited to oversight of one internal NHVR requirement; that the customer agreed with the closure. Management did not timely or consistently address noncompliance and did not ensure staff were compliant with federal and NHVR requirements. NHVR monitored all closures through the *File Review* Form, which required the counselor to initial a checklist and note that the closure form was signed and dated by the counselor and customer. An RL was required to sign off once the file was closed, but the review happened after a case had already been closed, leaving no opportunity to proactively correct noncompliance. However, monitoring did not provide oversight of compliance with federal regulations and NHVR administrative rules, which likely contributed to noncompliance among all 12 cases we reviewed. NHVR management could have potentially used supervisory review to provide oversight of proposed closures for rehabilitation. Such oversight would have also ensured compliance with the federal requirement that a qualified rehabilitation counselor consider the employment outcome satisfactory and agree the customer was performing well in employment.

**Recommendations:**

**We recommend NHVR management ensure all cases closed as rehabilitated contain all documentation required by federal regulations and its own requirements. In ensuring this, management should provide additional guidance through administrative rules, policy, procedure, and training materials on the requirements that must be met before closure.**

**We also recommend management develop a process to monitor compliance by:**

- **identifying data and information necessary for monitoring rehabilitated closures and associated documentation requirements;**
- **developing, implementing, and refining processes to routinely collect, verify, and monitor compliance data and information;**

- **routinely assessing staff compliance and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations:*

1. *The audit report states, "Rehabilitation Closures Were Not Always Supported By Required Case Documentation" and "Some Cases Did Not Verify Employment Was Achieved". The bureau disagrees with this section of the observation as employment verification required for closing a case successful was not standardized by the U.S. Department of Education until 2017 and then implemented by the bureau until 2018. All cases closed successful contained information about the nature and scope of the closure just not the more detailed guidance put out after the cases in questioned were closed.*
2. *The audit report states, "Some Cases Did Not Document That VR Services Contributed To The Employment Outcome". The bureau disagrees with the first example provided in the observation, as upon review, the bureau provided the guidance and counseling as well as follow up to assure that the customer did not need any additional services, that they were able to navigate the employment situation satisfactorily and that the employment situation met their needs.*
3. *The audit report states, "Some Cases Did Not Document That VR Services Contributed To The Employment Outcome". The bureau disagrees with the second example about the employment goal in a healthcare field, as assessment and exploration services are important in the process to assist a customer to identify additional information about jobs and job environments they would like to pursue, or decide not to pursue. Sometimes due to disability and circumstances, it is difficult to maintain contact with participants. The bureau also works with where the customer is, helping to assess if there are any specific concerns or issues in the areas of employment they explore and ultimately succeed in.*
4. *The audit report states, "Some Cases Did Not Document That VR Services Contributed To The Employment Outcome". The bureau disagrees with the third example related to the employment goal pertaining to computers as the services provided throughout the entirely of the plan including changes in job goal are all part of the services that lead to an individual's ultimate success. The services and experiences the participant received throughout the case lead them to their employment opportunity and success at that position. A rehabilitation plan is the entire plan from initial plan through the last plan. These are not separate entities and should not be evaluated as such.*
5. *The audit report states, "Some Cases Did Not Document That VR Services Contributed To The Employment Outcome". The bureau disagrees with the fourth example related to the employment goal of a teacher, similarly to the above disagreement. This case was closed as an Educational Administrator after the customer successfully gaining their Master's degree. This is a success story and the services, including investment of the Rehabilitation Counselor's time all contributed to supporting the customer along their journey.*
6. *The audit report states, "Some Cases Did Not Document Employment Was Stable And*

*Maintained Without Services". In the example, the audit notes that guidance and counseling was provided during the stable period which is allowable as this service includes placement follow up which is necessary in a successful closure. The expenditures were not directly related to a service provided to an individual but were in relation to a consultant being brought in to assure that the vehicle modifications were complete and to assist the bureau in determining a reimbursement strategy. The Agency agrees that additional time could have been taken past the expenditure, however, the participant received that services and was using these successfully at closure.*

7. *The audit report states, "Some Cases Did Not Document Customers Were Informed Of PES". The bureau disagrees with this as this information is provided to customers on their plans for employment and reinforced at closure. It is included as part of the written documentation that is provided to all participants at closure.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring will be developed and implemented for the VR program. It is the expectation that this work will be developed and implemented by December 2021.*
- *The bureau is in the process of updating policies and procedures related to closure to ensure documentation for successful closures is standardized across the bureau. It is the expectation that this work will be developed and implemented by June 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, we note federal regulations related to rehabilitated case closures have been in place since at least July 2010. Requirements in NHVR administrative rules dated back to at least January 2012, when rules were last updated. Requirements in the *Policy Manual* date back to at least June 2007 and requirements in the *Desk Reference* date back to at least March 2018.**

**In reference to Remark 2 through Remark 5, case closures for rehabilitated customers must be in accordance with federal law and regulations, as outlined in this Observation. Federal regulations required services contribute to the employment outcome and that, to be closed as rehabilitated, the case record must contain documentation that demonstrates the services provided under an IPE contributed to the achievement of the employment outcome. The *Policy Manual* also states, "Services must lead *directly* to employment goals..." [emphasis added] In all examples we provided, the customer first obtained employment and an IPE was later developed with a corresponding employment goal before case closure. There was no documentation that the services identified in the Observation contributed directly to the employment outcome.**

**We note, this is a similar issue identified in other states' audits of VR agencies. Audits of the Wisconsin Division Of Vocational Rehabilitation (December 2015) and West Virginia Division Of Rehabilitation Services (January 2018) found that cases were closed as**

**rehabilitated when the employment outcome did not meet the documented IPE goal, and the employment outcome was not what the customer received services for. Both audits specifically stated these were inaccurate case closures.**

**In reference to Remark 6, NHVR did not provide documentation demonstrating that guidance and counseling was an "allowable" exemption to federal requirements. Further, federal regulations, which define VR services as including guidance and counseling, did not provide for such an exemption.**

**In reference to Remark 7, as stipulated in federal regulations, NHVR is required to *document* that the applicant "is informed through appropriate modes of communication of the availability of post-employment services." Without a case note or other record demonstrating this information was provided to the customer, the requirement was not met.**

**Observation No. 37**

## Ensure Closure Reasons For Cases That Are Not Rehabilitated Are Used Accurately

The *Policy Manual* specified counselors should close cases at any point during the VR process if they determined individuals were not eligible, unavailable for services, chose not to participate, or were rehabilitated. Accurate reporting of cases closed for non-rehabilitated reasons was important for performance assessment and achievement of program objectives. Inaccurate closures affected NHVR's ability to assist individuals with disabilities by providing services designed to obtain competitive employment, as well as management's decision-making and ability to accurately evaluate agency performance.

### Inaccurate Non-rehabilitated Closures

We reviewed nine cases closed for ineligibility and 19 cases closed for non-rehabilitation from our file review of 97 cases, and found in 15 of the 28 cases (54 percent), the reason for closure appeared inaccurate. Federal regulations required NHVR to justify determinations that customers were ineligible for services because they did not meet at least one of the four eligibility requirements, and to justify closing an individual's case for non-rehabilitation. Having an accurate understanding of which cases were closed for what reasons could have potentially helped management improve case closure or customer retention processes, as well as service provision.

#### *Ineligible Closures*

Of the 28 cases we reviewed, NHVR reported nine (32 percent) had been closed because the applicant or customer was determined to be ineligible. Federal reporting requirements identified seven reasons for an ineligible closure, with which NHVR management reported agreement. We found all nine ineligible cases had been closed for a reason different than the one provided in the electronic case file. Seven of the nine cases had been closed as ineligible but should have been closed as non-rehabilitated.

- One case was closed by a supervisor during the OOS as "does not require VR services," which was to be used when a customer was ineligible and did not require VR services to prepare for, enter into, or retain gainful employment. However, one year prior to closure, the customer obtained employment as a cashier with the assistance of CRP services paid for by NHVR and maintained employment with the assistance of guidance and counseling provided by NHVR. A former supervisor intended to update the customer's IPE to reflect their new employment goal, but the update never happened. Upon closure, the customer reported being satisfied with employment and unable to identify additional services needed. Consequently, the case should have been closed as "refused services or no further services needed," as the customer actively chose not to continue their case. However, if the IPE had been updated, the case – with payments totaling $34,369 – could have potentially been closed as rehabilitated.
- Another case was closed during the OOS as "does not require VR services." However, at the time of closure, the counselor reported the customer was no longer interested in employment and had not pursued employment in many years, despite requesting the case remain open. The counselor had found the customer initially eligible for services, meaning the customer did require services to obtain or maintain employment. The case – on which NHVR spent $22,538 – should have been closed as "refused services or no further services needed," since the customer actively chose not to continue their case.

In addition to federal requirements, the *Desk Reference* required consultation with the office's RL prior to closure for "disability too significant to benefit from service." However, among the four cases recorded as closed for that reason, only one documented consultation with a RL. For example, one case was closed prior to the OOS as "disability too severe to benefit from service," which was to be used either during an eligibility determination or later, if a customer acquired additional disabilities or functional limitations that were so significant, they could not continue to benefit from services. NHVR spent $17,499 on the case, although $2,149 was spent after the customer reported going on a one-year medical leave, starting in August 2015. When the counselor next reached out for a status update in December 2016, the customer reported going on disability. However, no medical documentation was provided by the customer, the counselor did not update the customer's eligibility assessment to determine the extent to which medical issues affected the customer's functional limitations or ability to benefit from services, and no trial work experience was conducted. The case file did not document a request to close the case, nor did it document that a supervisor had been consulted prior to closure.

Finally, we found in two of the 28 cases (seven percent), applicants were documented as ineligible, although both should have been closed for a different ineligibility reason than the one recorded. One case was closed by a VRC I during the OOS as "ineligible (after a determination of eligibility)," which was to be used when a customer was initially determined eligible but later found to not meet eligibility requirements. However, the applicant was never found eligible. The counselor reported NHVR was unable to obtain medical documentation demonstrating the applicant was eligible. Consequently, the case should have been closed as "no impairment," as the applicant did not have a demonstrable physical or mental impairment. There was no indication the determination was reviewed by a supervisor.

### *Non-rehabilitated Closures*

We found six of 19 non-rehabilitated cases (32 percent) appeared to be closed for an inaccurate reason. Federal requirements identified specific non-rehabilitation closure reasons. NHVR guidance on closures did not define non-rehabilitated closure reasons, and some non-rehabilitated closure reasons used by NHVR appeared to differ slightly from federal closure reasons, which may have contributed to confusion among counselors as to which closure reasons to use.

Of the 28 cases we reviewed, NHVR reported three cases (11 percent) had been closed because the customer "refused services," but we identified 16 cases (57 percent) where this reason likely should have been recorded as the closure reason. In total, NHVR spent $357,360 on these 16 cases where customers ultimately requested their case be closed and refused further services, including eight cases with spending ranging between $15,000 to more than $100,000.

Additionally, NHVR reported 14 of the 28 cases (50 percent) had been closed because the customer could not be located or contacted, but we identified ten cases (36 percent) where this reason should have been recorded as the closure reason. In three of the other four cases, customers moved, or were planning to move, immediately prior to closure. These cases were recorded as closed because the customer was "unable to locate, contact, or moved." However, these closure reasons were to be used if customers relocated without leaving a forwarding address. We found all three customers had requested or indicated their cases be closed prior to moving. Consequently, the cases should have been closed as "refused services or no further services needed." In one of the three cases, the customer reported they would pursue VR services through other states. If NHVR had provided referral information to the other VR agency on behalf of the customer, to facilitate provision of services, NHVR could have potentially closed the case as "transferred." However, no documentation indicated NHVR took such actions. In total, NHVR spent $53,645 on these ten cases where they were ultimately unable to locate customers, or where customers did not respond to repeated attempted to contact them, including one case with spending exceeding $25,000.

### *Customer Acknowledgement Of Closure*

In addition to federal requirements, the *Policy Manual* specified non-rehabilitation closures required written notification of the closure and documentation of an IPE amendment, where an IPE had been developed, in cases where the customer was available. Training materials indicated either an IPE amendment or a closure letter were necessary, describing the closure and signed and dated by the counselor and, when feasible, the customer. The *Desk Reference* required case closure forms be scanned and attached to the electronic case file. However, we found none of the 18 cases where the customer was available at closure included a scanned form where the customer acknowledged the closure.

## Monitoring Of Non-rehabilitated Closures Was Limited

NHVR monitoring of non-rehabilitated closures was limited to oversight of one internal NHVR requirement; that the customer agree with the closure. Management did not adequately monitor for or timely or consistently address noncompliance, and did not ensure all federal and NHVR requirements were met. NHVR monitored all closures through the *File Review Form*, which

required the counselor to initial a checklist and note that the closure form was signed and dated by the counselor and customer. An RL was required to sign off once the file was closed, but the review happened after a case had already been closed, leaving limited opportunities to proactively correct noncompliance. However, monitoring did not provide oversight of compliance with federal regulations and NHVR administrative rules, which likely contributed to noncompliance. NHVR management could have potentially used supervisory review to provide oversight of proposed closures for non-rehabilitation.

**Recommendations:**

**We recommend NHVR management ensure cases are appropriately closed as non-rehabilitated and contain all documentation required by federal regulations and its own requirements. In ensuring this, management should provide additional guidance on ineligible and non-rehabilitated closure by defining closure reasons in its administrative rules, policy, procedure, and training materials on the requirements that must be met before closure.**

**We also recommend NHVR management develop a process to monitor compliance by:**

- **identifying data and information necessary for monitoring non-rehabilitated closures and associated documentation requirements;**
- **developing, implementing, and refining processes to routinely collect, verify, and monitor compliance data and information;**
- **routinely assessing staff compliance and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed.**

*NHVR Response:*

*NHVR concurs with the recommendations put forth by the audit report.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *In July 2020 to ensure cases are appropriately closed the bureau implemented changes to the case management system requiring supervisor approval prior to closing a case ineligible. In areas where the incorrect closures were used frequently names were changed to highlight nuances. In October 2020 closure types were added to a supervisor report to assist management in identifying trends and potential issues with compliance. By December 2021 the bureau projects having a functioning quality assurance unit that will use a statistical based quality control process to assess staff compliance and recommend additional training. Policy and procedure changes that will assist staff and customers for closure requirements are currently drafted and are projected to be implemented by March 2021.*

- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**Observation No. 38**

**Ensure Compliance With PES Requirements**

At times, NHVR provided PES contrary to federal or NHVR requirements, and NHVR administrative rules contained limited information on the PES process. None of the 94 PES cases we reviewed followed all federal and NHVR requirements. Consequently, in some situations, services provided as PES:

- should have been provided during the original case to ensure employment stability before closure;
- were not necessary to maintain employment and should not have been provided at all; or
- were not limited in scope or duration, so NHVR should have opened a new case.

**PES Appeared To Be Improperly Initiated In Some Cases**

We found some cases were closed as rehabilitated, then opened for PES without meeting federal or NHVR requirements. We reviewed 94 cases opened for PES. Our review was comprehensive, including all 90 cases originally closed between July 2015 and June 2019 and re-opened for post-employment, as well as four additional cases open for post-employment during October 2019. Our review included a total of 108 PES plans, as some cases were opened more than once or had plan extensions. Eighty-five cases had one PES plan, six cases had two plans, one case had three plans, and two cases had four plans.

***Issues With Timeliness Of PES Following Original Closures***

When NHVR implemented an OOS on May 7, 2018, it updated the *Policy Manual* to require PES be initiated within 12 months of a rehabilitated closure. Twenty cases were opened for PES during the OOS, with one case opened four times, resulting in 23 PES plans. Among the 23 plans, 12 (52 percent) started more than 12 months after the original case was closed as rehabilitated.

- Three plans represented the *first* PES opening and, on average, started 29 months. One was opened 47 months – nearly four years – after the original closure.
- Six plans represented the *second* PES opening, and, on average, started 46 months. One started 67 months – more than five-and-a-half years – after the original closure.
- Two of the 12 plans represented the *third* and *fourth* PES opening. These two plans started 65 months and 74 months after the original closure, respectively.

### *Some Cases Should Not Have Been Opened For PES*

Federal regulations specified PES were to be provided subsequent to the achievement of an employment outcome. However, it did not appear some cases should have been closed as rehabilitated when they were, directly affecting the need for them to be opened for PES in the first place. We found at least 30 of the 94 cases (32 percent) were originally closed as rehabilitated, but the customer had not achieved stable employment for at least 90 days, had not agreed with closure, was still requesting services, or the vendors not yet been paid.

Federal regulations required a customer maintain employment for no less than 90 days, to ensure employment stability without needing additional VR services. However, at least 19 cases opened for PES had not been stable long enough when they were originally closed. Among these, ten cases were opened for PES within what should have been the 90-day stable period.

The *Policy Manual* also required customers have an opportunity for involvement in the closure decision, and the *Desk Reference* required customers agree with closure. However, six cases opened for PES did not document customer agreement with case closure. All six cases were opened within 30 days of the original closure date. For example, in one case, the counselor implied the customer was in agreement with the original closure on June 17, 2019, noting the customer was "quite satisfied with the new position" and that PES had "been explained but [were] not needed at this time." However, PES case notes demonstrated the counselor had not actually obtained agreement. One week *after* closure, the counselor emailed the customer to check in, noting, "I am getting ready to close your case" and requested employment verification to meet federal requirements. The customer requested several services related to low vision, "before closing my [case]," and noted, the case could be closed after receiving those services. The case was opened for PES three days later to provide the requested services.

Additionally, we found two cases where NHVR had not paid for all services prior to closure and re-opened them under PES to make payments for services provided under the original case. In both cases, counselors did not pay the retention incentive bonus to the community rehabilitation program vendor that helped the customer to find employment and reported they "neglected" to authorize and pay the bonus prior to the original closure. There was no indication customers were aware their cases had been opened under PES, and both cases were closed as successful post-employment cases.

### Services Were Provided Without Clear Documentation Of Customer Agreement

Federal regulations required PES be provided under an amended IPE, which NHVR referred to as a post-employment services plan. The *Desk Reference* required the PES plan to be signed and dated by the counselor and customer. Additionally, the *Desk Reference* permitted counselors to extend a PES plan by closing an active plan and opening a new plan to cover the extended period of time and new services needed. The new plan was also required to be signed and dated by the counselor and customer. The *Desk Reference* required any amendments to a customer's IPE, which included the PES plan, to be scanned into the electronic case file. However, we did not find all PES plans were signed by both parties or scanned into the case management system. It would have

been labor-intensive for management to verify whether PES plans were valid without scanned copies to review. Among the 108 PES plans on which NHVR spent $63,037 in PES services:

- 106 plans (98 percent) were not scanned into the electronic case management system, including one with just the signature page; and
- 105 plans (97 percent) were not signed by both the counselor and customer.

**Various Issues With PES**

Federal regulations specified PES must be necessary for a customer to maintain, regain, or advance in employment, and provided examples of situations in which services could be provided under post-employment. For example, a customer might need mental health services and counseling to maintain employment if their position was jeopardized due to conflicts with supervisors or co-workers, or job placement services to regain employment if their position had been eliminated during a reorganization. PES were available if customers did not need complex and comprehensive services, and federal regulations required services be limited in scope and duration. We found some PES plans initiated by NHVR did not meet all these requirements.

***Inadequate Documentation Of The Necessity Of Some Services***

Counselors documented which services were needed through customers' PES plans. For both initial PES plans and plan extensions, NHVR required counselors' case notes document *why* those services were needed to maintain employment. We found 24 of 108 plans (22 percent) had case notes explaining how PES were needed to help customers maintain employment. For example, one customer was "written up" by their employer for working too slowly, so NHVR paid for a barrier intervention to identify the customer's obstacles to working at an appropriate pace. However, case notes related to the remaining 84 plans (78 percent) either did not connect service needs to employment at all, or did not clearly connect services to the need to *maintain* employment. Of the 108 plans, we found:

- Case notes in 50 plans (46 percent) did not document services were needed to maintain employment, or even connected to the customer's employment. For example, one case opened during the OOS indicated the customer was having "computer issues" but did not specify that the issues prevented the customer from maintaining employment or even that the computer was used for employment.
- Case notes in 34 plans (31 percent) connected services to customers' employment or benefits, but did not explain how services were needed to *maintain* employment. For example, one case opened during the OOS indicated the customer needed computer training "to better track inventory and financial data" but did not indicate how the absence of services would jeopardize the customer's employment.

Additionally, NHVR required counselors to complete regular case notes documenting progress on each plan, including vendor notes and ongoing customer contact. However, among the 108 plans:

- 31 plans (29 percent) did not have substantive or, in some cases, any case notes;
- 82 plans (76 percent) did not document ongoing contact with the customer; and

- 64 plans (59 percent) did not document vendor notes, reports, or related analysis.

***Some Plans Did Not Appear To Be Limited In Duration***

Federal regulations required PES be limited in duration. NHVR did not establish guidance on the overall duration of PES plans, instead establishing guidance and requirements related to specific aspects of service provision. When it implemented the OOS, NHVR updated the *Policy Manual* to specify that related authorizations should generally not exceed three months from the planned start of PES. Twenty-two plans had their most recent authorization during the OOS. The most recent authorization for ten plans (45 percent) exceeded the three-month timeframe, occurring an average of 12 months, and as long as 34 months – or nearly three years – after the plan started.

When it implemented the OOS, NHVR also updated the *Policy Manual* to require PES necessary to maintain or advance in employment be limited to those that could be provided within 90 days. Twenty-one plans had their most recent service during the OOS. The most recent service for 11 of the 21 plans (52 percent) was provided beyond the 90-day timeframe, occurring an average of 312 days and as long as 1,023 days, or nearly three years, after the plan started. Additionally, NHVR estimated an end date for PES plans past which services should not be provided without an extended plan with services provided. However, 15 of the 95 plans (16 percent) had services provided past the plan's expected end by as much as two years afterwards.

***Some Plans Did Not Appear To Be Limited In Scope***

Federal regulations required PES be limited in scope. PES was available to meet customers' rehabilitation needs when the customer did not require complex and comprehensive services. NHVR only provided services through 95 of the 108 plans developed. Based on our observation of the estimated number of services and plans costs, it appeared counselors did not expect some plans to be limited in scope. NHVR did not establish specific limits on the number or total cost of services to be provided, leaving decisions to counselors' discretion. We found:

- In 36 plans (38 percent), customers were expected to receive services in three or more categories, including seven plans with six or more categories and one plan with ten.
- In 42 plans (44 percent), customers were expected to receive services costing $500 or more, including 14 plans estimated at $1,000 or more and one plan estimated at $5,000.

The *Policy Manual* required post-employment support services be provided only in conjunction with a *primary* VR service. Training materials indicated primary services were those necessary to prepare a customer for employment, such as guidance and counseling, training, and job placement, while support services included maintenance, transportation, interpreter services, and occupational licenses, tools, or equipment. There were 17 plans where the customer received support services. Six of the 17 plans (35 percent) provided support services without also providing primary services. NHVR paid $2,493 for these support services that were not connected to a primary service.

When it implemented the OOS, NHVR updated the *Policy Manual* to require services necessary to maintain or advance in employment be limited to team, community, and support services that were readily available, easy to arrange, and routine. However, it did not provide any guidance on

which services were considered team or community services, or how counselors should determine whether services were readily available, easy to arrange, or routine. We did identify informal guidance provided in one case to one counselor on the appropriateness of vehicle modifications for PES, but this guidance was not formalized in policy, procedures, or training.

While federal regulations indicated counselors should consider opening a new case if customers needed more comprehensive services, the *Policy Manual* required customers complete a new application if substantial services – long-term, extensive, multiple services – were needed. However, no guidance was provided as to how counselors should determine whether services were considered long-term or extensive.

***PES Should Not Be Used To Support A New Employment Goal***

When NHVR implemented the OOS, it updated the *Policy Manual* to require PES be initiated only for the specific employment goal documented in the case file. We found one case where PES was provided to support a new employment goal. The customer originally obtained employment in a library, and their original case was closed as rehabilitated. The customer later lost that position, and NHVR opened a PES case, even though the customer was looking to obtain employment in a different field. NHVR paid $1,801 for related benefits counseling, training, books, and job search services through the PES case.

**Untimely Case Closure**

Once a customer had achieved an outcome, whether rehabilitated or non-rehabilitated, the *Desk Reference* required the counselor to close the case. However, even after all services had been provided, some PES plans remained open. Among the 95 plans where services were provided:

- 15 (16 percent) were closed or remained open three to six months after services were provided,
- 16 (17 percent) were closed or remained open six to 12 months after, and
- 19 (20 percent) were closed or remained open 12 months after.

In one PES plan, NHVR ordered clothing needed by the customer and informed the customer in October 2019 that the clothing was available to be picked up. The counselor made two subsequent attempts to contact the customer, with no response. The plan remained open through April 2020, five months after the clothing was purchased and 26 months after the plan started. In a second plan, NHVR paid for the customer to have an eye examination, which took place in May 2014. There were no case notes documenting contact with the customer, whether other services were considered, or how employment was affected by the examination. However, the counselor did document attempted contact with the customer in October 2015, almost one-and-a-half years after the examination, and in May 2017, three years after the examination. The case remained open until September 2017, 40 months after the examination and four months after the last attempted contact.

NHVR did not provide services to maintain or retain customers' employment under 13 of 108 PES plans (12 percent). However, despite not providing services, 11 plans remained open for an average

of four months, and as long as 19 months, after they started, while another two plans contained inadequate information to know how long they were open.

**Limited Documentation Of Case Closure**

If a customer maintained or regained employment, the *Desk Reference* required counselors to document information about the customer's employment and closure. NHVR reported 83 of the 108 plans were closed because customers maintained or regained employment.

- NHVR required the counselor to document confirmation that employment was stable and expected to continue for at least one year. However, only one of the 83 plans (one percent) contained documentation of the counselor's agreement that employment was stable and expected to continue for at least one year, while nine plans (11 percent) contained documentation of the customer's agreement that employment was stable and expected to continue for at least one year.
- NHVR required the counselor to document the customer's agreement with case closure, although only 12 of the 83 plans (14 percent) contained documentation.

**Recommendations:**

**We recommend NHVR management improve compliance with PES requirements and ensure appropriate use by:**

- **ensuring administrative rules incorporate post-employment processes;**
- **ensuring guidance on post-employment in administrative rules, policy, procedures, and training materials is comprehensive, including how to determine when service needs are too complex or comprehensive for post-employment;**
- **developing guidance to ensure cases originally closed as rehabilitated are appropriately opened to provide PES and implementing monitoring of original closures to ensure vendors have been paid prior to closure; and**
- **developing policies and procedures to ensure cases opened for PES contain all required documentation to support the necessity of services and to support closure.**

**We also recommend NHVR management improve its monitoring of post-employment, including case progression and timeliness of closure, by:**

- **identifying data and information necessary for monitoring post-employment, as well as developing, implementing, and continually improving processes to routinely collect, monitor, and analyze compliance data and information;**
- **implementing controls in the case management system or developing a report to monitor when PES cases open, to ensure PES cases are opened timely after the original rehabilitation closure;**
- **implementing controls in the electronic case management system or developing a report to monitor how long PES cases have been open, to ensure services are provided in a timely manner;**

- **routinely measuring staff compliance, such as through inclusion of post-employment service compliance on the weekly case monitoring report or the purposeful selection of PES cases for inclusion in a routine internal audit process, and analyzing information to identify trends and potential issues with compliance; and**
- **remediating deficiencies, by addressing noncompliance in a timely, formal, and consistent manner and refining processes as needed.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *According to the audit report, "Additionally, we found two cases where NHVR had not paid for all services prior to closure and re-opened them under PES to make payments for services provided under the original case. In both cases, counselors did not pay the retention incentive bonus to the community rehabilitation program vendor that helped the customer to find employment and reported they "neglected" to authorize and pay the bonus prior to the original closure. There was no indication customers were aware their cases had been opened under PES, and both cases were closed as successful post-employment cases." Upon review of this, it was discovered this is a training issue. The case should not have been opened in PES, it could have just been re-opened to pay the bills. This type of error will be corrected in the future.*
2. *The observation states it did not find all PES plans were signed by both parties or scanned into the case management system. There was no requirement until as recently as October 2020 that all documents be scanned into the system as part of the electronic case record.*
3. *The observation states, "PES Should Not Be Used To Support A New Employment Goal," which is inaccurate as the U.S. Department of Education regulation states in 34 CFR Part 361.5(41) that such plans can be "provided subsequent to the achievement of an employment outcome and that are necessary for an individual to maintain, regain, or advance in employment, consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice." As the audit report indicates, "There was no indication customers were aware their cases had been opened under PES, and both cases were closed as successful post-employment cases." This is a training issue and clearly should not have been opened in PES.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau is in the process of drafting further policies and procedures on post-employment services to address areas of concern in the observation. The bureau will as part of an internal quality assurance program ensure to include the length and scope of Post-Employment plans in the review set to ensure compliance with new policies and procedures. This program will be fully implemented by December 2021. To assist supervisors with the review of these cases the length of time such cases have been open will be added to a weekly report by February 2021.*

- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 2, as stated in the Observation, the *Desk Reference* required any amendments to a customer's IPE, which included the PES plan, to be scanned into the electronic case file. NHVR provided the *Desk Reference* in response to our request for internal policies and procedures effective during the audit period (July 2016 to June 2019). We note the document provided by NHVR was modified in March 2018.**

**In reference to Remark 3, we note NHVR is not limited to the requirements outlined in federal law and regulations. As stated in the Observation, "When NHVR implemented the OOS, it updated the *Policy Manual* to require PES be initiated only for the specific employment goal documented in the case file."**

## CHAPTER 8: PROGRAM MANAGEMENT

Through its ongoing operations, management was responsible for improving accountability in achieving the agency's mission. A critical factor for NHVR to achieve its mission was incorporating an effective internal control system into daily activities which would help the agency adapt to changing environments, evolving demands, changing risks, and new priorities. An agency must integrate cohesive components of the internal control system consistent with the regulatory environment in which it operates.

Components of an effective internal control system included properly designed and implemented: 1) policies and procedures to respond to risk within the control and information systems; 2) quality information necessary to achieve objectives and the processes to communicate identified quality information; and 3) an organizational structure with regular performance evaluations to identify gaps in training, continually develop skills, and hold individuals accountable for assigned responsibilities. As changes occur, such as through regulatory or policy changes, it was necessary for management to continually monitor and evaluate the internal control system so it remained effective. Monitoring was also necessary to identify deficiencies and improve operations. When implemented correctly, controls facilitate achievement of desired results through effective stewardship of public resources in compliance with applicable laws and regulations.

During the audit period, New Hampshire Vocational Rehabilitation (NHVR) program operations faced many challenges. New challenges associated with implementing an order of selection (OOS) in May 2018, a Department-wide reorganization, staff reductions, changes to staff roles and authority, and limitations on program spending likely contributed to deficiencies in internal controls. Some deficiencies were longstanding, dating back as far as our 2001 *Bureau of Vocational Rehabilitation and Service Delivery* (*2001 LBA Audit*) performance audit. These deficiencies included limited and unclear administrative rules, policies, procedures, and training documents, which did not contain some processes used in the field, were disconnected and not contained in one location, and sometimes contradicted each other. In addition to the lack of formal guidance, we found some program records were missing and data used for decision-making were sometimes not reliable, affecting everything from basic program management to counselor performance management.

### Administrative Rules, Policies, And Procedures

As a State agency implementing a federally funded and regulated program, NHVR operated in a multi-layered regulatory environment including federal laws and regulations, a federally required state plan, and State laws. Any State program interacting with New Hampshire residents needed to comply with the *Administrative Procedure Act* unless specifically exempt. The *Administrative Procedure Act* promotes transparency and due process by mandating any requirement or policy imposed on the public was properly codified and approved under the administrative rules process. Administrative rules create clear guidelines for the public to follow, provide NHVR with the legal authority to enforce program standards not codified in State law, and facilitate the equal and consistent treatment of the public. Once adopted, administrative rules detailed the program

requirements and standards, while internal policies and procedures further specified how to implement and apply the requirements set by federal and State policy makers.

We found NHVR administrative rules needed to be updated, as they were inconsistent with practices in the field; some processes which should have been adopted in administrative rules were not; and forms required to be used by those outside of NHVR were not adopted into rules. Additionally, policies and procedures were not comprehensive and, at times, updated informally, were not clearly communicated and implemented, and not monitored for compliance.

**Observation No. 39**

**Update Administrative Rules**

RSA 21-N:9, I(k) required the Board of Education adopt rules for vocational rehabilitation (VR) services. In practice, NHVR had developed, implemented, and updated these rules. We found NHVR's administrative rules, adopted in January 2012, were not consistent with some of its practices; not comprehensive, resulting in some ad hoc requirements; and did not reflect updated federal requirements. RSA 541-A, the *Administrative Procedure Act*, required agencies adopt rules to: 1) implement, interpret, or make specific a statute enforced or administered by an agency; and 2) prescribe or interpret an agency policy, procedure, or practice requirement binding on persons outside the agency, whether members of the general public or personnel in other agencies.

The *New Hampshire Drafting And Procedure Manual For Administrative Rules*, published by the Office of Legislative Services and was required to be followed by all State agencies, stated in determining whether an agency policy or procedure should be in rule, agencies must pay special attention to whether the policy affected private rights or changed the substance of another rule binding on the public. Without clear and comprehensive administrative rules, there may be confusion regarding program requirements and the responsibilities of all parties involved in the VR process.

**Some Practices Were Inconsistent With Rules**

Rules have the force of law and were binding on persons they affect. We found some practices observed in the field did not align with rules. Specifically:

- Change In Criteria For Assigning Priority Categories – To be categorized in the highest priority category, most significant disability (MSD), rules required an individual to have two or more serious functional limitations and need two or more services. When NHVR implemented the OOS, it required an individual have *three* or more serious functional limitations and need *three* or more services to qualify as MSD. NHVR's *VR Portion of WIOA State Plan For the State of New Hampshire (State Plan)*, *NH Vocational Rehabilitation Policy Manual (Policy Manual)*, and training materials reflected this change; however, NHVR rules did not. Consequently, customers with two or more serious functional limitations needing two or more services were categorized as significant disability (SD), contrary to rules, and placed on the waitlist. Of 50 customers we reviewed who were categorized by NHVR as SD on the waitlist, 30 customers (60 percent) had two

or more serious functional limitations and required two or more services, and should have been categorized as MSD under NHVR rules.

- Financial Needs Assessment (FNA) – NHVR implemented an FNA to determine whether customers had financial resources to contribute to the cost of their rehabilitation. Ed 1008.02(b) exempted individuals receiving benefits under Titles II or XVI of the *Social Security Act* from the FNA. Title II encompassed federal old-age, survivors, and disability insurance, while Title XVI encompassed Supplemental Security Income (SSI) for the aged, blind, and disabled. NHVR automatically qualified individuals for financial assistance if they received Title II or Title XVI benefits if it was related to their disability. It also exempted individuals receiving Temporary Assistance for Needy Families and Aid to the Permanently and Totally Disabled from completing the FNA, which was not specified in its rules.

**Processes Not Adopted In Rules**

Rules were meant to supplement statutory requirements by describing how those requirements would be implemented. Rules had the force of law and no rule was valid or effective, nor could it be enforced by an agency, until it was properly adopted. NHVR augmented some existing rules by imposing additional requirements without formally incorporating them in rules, or created requirements in the absence of rules, imposing ad hoc requirements. We found some processes that imposed requirements on applicants, customers, and vendors were not codified in rules. For example, we found:

- No Timeframe For Eligibility Extension – Federal regulations allowed an extension under certain circumstances if eligibility could not be determined within 60 days. While NHVR's rules addressed some reasons allowable for eligibility extensions, rules did not include NHVR's practice of limiting each extension to a maximum of 60 days.
- Extension For Developing An IPE – Federal regulations allowed an extension of the 90-day deadline for developing an IPE if the agency and the customer "agree to an extension of that deadline to a specific date by which the [IPE] must be completed." NHVR's rules did not address IPE development extensions. However, NHVR's practice required counselors fill out a form documenting the reason for the extension; the actions needed before the plan could be completed; and customer, counselor, and supervisor signatures and date. Additionally, NHVR's practice limited each extension to a maximum of 90 days.
- IPE Amendment Required Before Providing Post-employment Services (PES) – Starting in July 2017, federal regulations required an IPE be amended to include any PES and providers necessary for the customer to maintain, advance, or regain employment. NHVR rules did not incorporate this requirement.
- Community Rehabilitation Program (CRP) Vendor – NHVR did not have rules addressing the process for becoming a CRP vendor. However, the *Community Rehabilitation Program Operational Handbook* required providers interested in becoming a CRP vendor to fill out specific forms as well as provide a letter of intent, a guide for customers on job placement services, resumes including credentials or the projected date for receiving credentials, and a professional biography or profile. It also required CRP staff to participate in NHVR-

conducted training and CRP vendors submit certain reports and invoices within specific timeframes. None of these requirements were adopted in rule.

**No Rules For Some Programs Required By State Law**

RSA 200-C required NHVR to establish, administer, and adopt rules for certain programs. NHVR rules did not address the following programs:

- RSA 200-C:7 required NHVR to develop a program to make special telecommunications equipment available to deaf, hard of hearing, and speech impaired individuals. It required the program to develop criteria for assigning priorities to various persons requiring special telecommunications equipment. It also required rules be developed for disbursing program funds; determining the types of equipment available; assigning priority to individuals seeking equipment; and purchasing, maintaining, and repairing equipment.
- RSA 200-C:10 required NHVR to establish a workers' personal care assistance program for persons with severe physical disabilities. It required rules to address subsidies towards the cost of personal care assistants and eligibility standards for program participation.

According to the NHVR Director, NHVR no longer implemented these programs.

**Forms Not Adopted As Required**

Statute required forms be established in rules. RSA 541-A:1, VII-a defined a form as a document required for persons outside the agency to provide information, or the format in which the information must be submitted. The *New Hampshire Drafting And Procedure Manual For Administrative Rules* further clarified a document requiring certain information be submitted, specifying how that information should be submitted, or containing a mandatory list of information to be submitted met the definition of a rule. Forms could be adopted by either writing out the requirements in rules or by incorporating the form by reference. We found NHVR required applicants, customers, and vendors to submit specific forms, or provide certain information through forms; however, the requirements of these forms were not written and adopted in NHVR's rules, nor were they incorporated by reference. Specifically:

- *Application For Vocational Rehabilitation Services* – NHVR's application form required applicants to provide personal information, as well as a description of their disability and their social security number. By signing the form, the applicant agreed to and authorized release of information to certain entities. It also included a statement that the applicant certified they received a copy of the form. According to the *New Hampshire Drafting And Procedure Manual For Administrative Rules*, certification must be incorporated by reference or be quoted verbatim or paraphrased in an agency's rules, as the requirement imposed in the certification are themselves rules.
- *Personal Information Form* – Applicants were required to complete, sign, and date a nine-page form which collected, among other things, the applicant's social security number, citizenship status, criminal court record, and information on medications. The *Personal*

*Information Form* also required certification the information provided was true, accurate, and complete to the best of the applicant's knowledge.

- *Progress Appraisal Form* – NHVR used the form for various purposes, including for the customer to acknowledge case closure. Once a customer was employed for 90 days, counselors generally sent the form to the customer citing employment as the reason for case closure. The customer was required to indicate their agreement or disagreement with the decision, sign and date the form, and return it to NHVR.

***CRP Provider Forms***

NHVR required CRPs to complete the following forms, none of which were adopted in rules:

- The *Vendor Application* form – required the CRP vendor to provide business information, certify accuracy of the information, and grant the State the right to investigate the facts contained.
- The *Assurance Of Compliance With Federal Laws* form – required the CRP vendor assure it would comply with certain federal regulations, guidelines, and standards.
- The *Accessibility Assurance* form – required the CRP vendor to ensure compliance with the *Americans with Disabilities Act*.
- The *CRP Service Agreement* form – outlined the services the CRP vendor would provide.

***Other Forms***

NHVR also required applicants sign and date the following forms, none of which were codified in rules or incorporated by reference:

- The *Financial Aid Transmittal Form* for customers pursuing post-secondary education,
- The *Eligibility Determination Extension* form,
- The *Trial Work Experiences Plan* form,
- The *Individualized Plan For Employment* form,
- The *Amendment - Individualized Plan For Employment* form, and
- The *Plan Development Extension* form.

**Some Rules Did Not Reflect Current Federal Regulations**

NHVR last updated its rules in January 2012, before the federal *Workforce Innovation and Opportunity Act* (WIOA) became effective in 2014, and before the final federal WIOA regulations were issued in 2016. These federal amendments specifically emphasized achievement of competitive integrated employment, required VR agencies to make pre-employment transition services (Pre-ETS) available to students with disabilities, and to allot at least 15 percent of federal funding to provide Pre-ETS. While NHVR's rule cited the federal definition of competitive employment, that definition was removed from federal regulations in 2017 and no longer existed. Additionally, NHVR rules did not address or define Pre-ETS, nor did it describe the types of services available, the population eligible for these services, or how students qualified for services.

We also noted the following:

- Incorrect Federal References – NHVR rules established definitions referencing subsections of federal regulations. For example, Ed 1002.25 cited an "individual with a significant disability as defined in 34 CFR 361.5(b)(31)." However, there are no subsections in the most current version of §361.5(b) and definitions were moved to §361.5(c).
- No Timeframe For Developing An Individualized Plan For Employment (IPE) – Beginning in July 1, 2017, federal regulations required IPEs be developed as soon as possible but no later than 90 days from the date of the eligibility determination. Prior to this, federal regulations only required IPEs be developed and implemented in a timely manner. Rules required IPEs to be "developed and implemented in a timely manner" but did not incorporate the federal timeframe of 90 days.
- Incorrect Citation Of Federal Laws – NHVR rules referenced the *Workforce Investment Act of 1998*, which was replaced by WIOA in 2014.
- Extended Evaluation – NHVR rules allowed an extension for determining eligibility if NHVR needed to conduct an extended evaluation and described the process for conducting such an evaluation. However, extended evaluations were removed from federal regulations in 2017.

Finally, some sections of rules appear to have been copied directly from federal regulations, without expanding on the federal regulation as required. For example, Ed 1010.12(f) stated, "The designated state unit shall establish and implement standards for the prompt development of individualized plan for employment for the individuals identified under Ed 1010.12(a), including timelines that take into consideration the needs of the individuals." This language, which seemed to require states establish their own standard of "prompt" IPE development, appeared to have been copied directly from 2011 regulations and NHVR did not establish its own standard as required.

**Recommendations:**

**We recommend NHVR management ensure it promulgates adequate rules for all:**

- **activities under its authority as outlined in RSA 200-C,**
- **any requirements it imposes on persons external to its own personnel including applicants, customers, and CRP vendors, and**
- **forms it requires applicants, customers, and CRP vendors to use to provide information.**

**As part of the rulemaking process, NHVR management should conduct a comprehensive assessment of its current rules and determine whether they adequately reflect all current federal laws and regulations, as well as align with and address all its current practices.**

**The Department Of Education (DOE) should consider seeking legislation to move rulemaking authority for all VR services administered by NHVR from the Board of Education to the Commissioner. This would more clearly link the authority and responsibilities for operating the VR program to one entity.**

**Finally, NHVR should ensure it implements all requirements RSA 200-C and implement a program to provide telecommunication equipment and subsidies for personal care services, and adopt corresponding administrative rules. If NHVR determines the programs are not needed, it should petition the Legislature to amend this statute.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *NHVR agrees that modified criteria established in the order of selection that were approved by Rehabilitation Services Administration should have immediately been implemented using an emergency rule. Beyond this, the bureau will implement rules where statutorily required, pursuant to RSA 541-A and where rule clarity would be needed.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau introduced a full edit of its rules to the State Board of Education in December 2020. These rules will go through a further evaluation over the ensuing months as processes are updated in response to the audit report and, where needed, additional rule modification necessary to ensure consistency between practice and rule will be proposed.*

**Observation No. 40**

## Improve Policies And Procedures

One of the core components to an internal control system is management establishing activities through policies, procedures, and processes which, if sufficiently structured and followed, can help ensure program objectives are achieved efficiently, effectively, and lawfully. NHVR policies and procedures were: 1) in need of updates, 2) missing critical components of certain NHVR services and administrative operations, 3) ineffectively communicated and retained, and 4) inconsistently implemented in practice. Documenting established control activities through formally adopted policies and procedures is essential to implementing and overseeing an effective internal control system as it provides consistency and transparency in decision-making.

### Policies And Procedures Informally Updated

Federal law and regulations stipulated requirements for state VR programs related to the development of policies and procedures including:

- conducting public meetings to provide the opportunity for public comment, as well as consider the views of certain stakeholders prior to adopting any policies or procedures governing the provision of VR services;

- consulting with the State Rehabilitation Council on a regular basis regarding the development, implementation, and amendment of policies and procedures pertaining to the provision of VR services; and
- transmitting all written policies, practices, and procedures of general applicability provided to or used by rehabilitation personnel to the State Rehabilitation Council.

NHVR management issued guidance letters, informal directives, and amended policies and procedures which added to or changed existing practices in at least 22 instances during the audit period. During the same time period, the State Rehabilitation Council held 14 meetings. We found evidence that the State Rehabilitation Council discussed the need to update certain policies from the *Policy Manual* at five of these meetings. While NHVR management reported the State Rehabilitation Council helped develop policies, we did not find evidence in State Rehabilitation Council minutes that any new or amended policies were reviewed or developed during these meetings, nor did we find evidence that any other written policies, practices, or procedures were transmitted to the State Rehabilitation Council. Additionally, with the exception of meeting to enter an OOS in May 2018, no public comment meetings were held during the audit period for the purpose of considering the views of stakeholders prior to the adoption of policies and procedures governing the provision of services.

**Formal Policies And Procedures Were Not Comprehensive Nor Periodically Monitored**

Limited formal and comprehensive policies, procedures, and periodic monitoring hindered NHVR from making timely and necessary changes to implement effective internal controls and resulted in noncompliance with certain federal requirements. NHVR management stated formal policies had not been thoroughly reviewed and updated since 2007 citing few changes occurred until NHVR entered the OOS in 2018. An effective internal control system provides a means to retain organizational knowledge by documenting policies and procedures in appropriate detail allowing management to monitor and evaluate control activities. Management must periodically review policies, procedures, and related control activities to identify, analyze, and respond to changes and ensure processes retain relevance and effectiveness.

From State fiscal years (SFY) 2007 through 2019, at least 16 federal directives were issued which would have impacted NHVR policies or procedures including discontinuing obsolete policies and requirements, changes to required data collection and performance reporting, and implementation of new federal program requirements. NHVR also issued and implemented at least 28 informal changes to policies or procedures during the same time period. Federal regulations required VR agencies maintain written policies covering the nature and scope of each service it provided and the criteria under which it was provided. During a federal monitoring session in May 2019, federal reviewers noted NHVR did not have policies and procedures in several areas including:

- pre-employment transition services, as they were in draft format since at least 2018;
- prior federal approval for certain expenses, which was a federal requirement since 2014;
- financial internal controls, data collection, and reporting; and
- process for periodic review of policies and procedures.

NHVR management also acknowledged the need to update and develop other formal policies and procedures related to topics such as vehicle modifications, fair hearings, supported employment, home modifications, FNAs, applicant intake and processing, and measurable skills gains performance metrics. Further, while we did not conduct an analysis to identify all existing policy and procedure gaps, we discuss deficiencies with certain policies and procedures in other observations throughout the audit report. Additionally, we found NHVR implemented additional practices without written policies or procedures in at least the following areas:

- revoking counselor signature authority and requiring supervisory review to approve eligibility, IPEs, and authorizations;
- seeking waivers to NHVR policy, procedure, or practice;
- requiring supervisory review for IPE and amendment costs above certain thresholds; and
- circumstances in which counselors meet with customers at locations other than NHVR offices.

**Policies And Procedures Were Not Effectively Communicated And Implemented**

NHVR management regularly issued guidance letters, directives, and informally amended policies and procedures which added or changed existing practices. However, NHVR did not formally update existing policies or procedures consistently or timely. While documentation of internal controls can be through management directives, policies, or operating manuals, the documentation must be readily available, properly managed, and maintained in order to be effective. NHVR changes to policies, procedures, and practices were reportedly communicated through leadership meetings, emails, or phone calls and were inconsistently documented. Additionally, guidance letters, manuals, emails, and other written practices were not retained centrally, which led to unclear understanding and inconsistent implementation of policies and procedures amongst management and personnel.

***Communication And Document Retention***

Effective policies and procedures document responsibilities for a process' objectives, design, and implementation, while management is responsible for communicating policies and procedures so that personnel can implement the control activities for their assigned responsibilities. In March 2007, NHVR began issuing guidance letters to "advise staff on implementation of policy; to provide clarification and support for policy and procedures; and to communicate other information that is to be complied with and implemented by NHVR staff." The guidance letter, which implemented the system, noted information regarding policies and procedures were previously communicated using a variety of methods resulting in confusion and misunderstandings due to staff inconsistently receiving information and a lack of a central location for referencing guidance materials.

However, the guidance letter system was not incorporated into policies or procedures, nor provided procedures for retaining documentation in a central location. Instead, guidance letters were sent via email and personnel were responsible for printing those emails and retaining the information within their individual copy of the *Policy Manual.* Further, NHVR management continued to communicate policies and procedures through a variety of methods, including at least one regional

office developing an informal policy guidance manual independent of the central office, supplementing it with clarification they received from NHVR upper management via email or other methods, thereby perpetuating ineffective communication and lack of centrally retained documentation through the audit period.

Federal reviewers also commented in May 2019 that all policies, procedures, and other guidance documents should be collated into one document for ease of access as well as develop a process to review the document to delete or add processes as needed. Regardless, NHVR management continued to develop additional companion guidance materials for existing policies and procedures as of January 2020.

***Inconsistent Interpretation And Implementation***

Federal regulations required assurance NHVR could identify, upon request, regulations and policies relating to the administration and operations of the program including State interpretations of any federal law, regulation, or guidelines. NHVR training materials also specified personnel should practice consistent and equitable application of all policies and procedures in the delivery of services to customers. Regardless of federal requirements and NHVR training materials, the *Policy Manual* made numerous references to waivers and at least one regional leader (RL) reported that RLs could waive *any* policy. We also found evidence in the case record of RLs waiving policy in practice. For example, policy allowed customers to be reimbursed for transportation in certain instances. In one case, the RL approved an advanced payment to the customer without acquiring documentation services were received, while also acknowledging the payment was contrary to policy. Further, waivers were not executed through a formal process nor was there an actual waiver form. Internal controls cannot operate effectively if they are not designed properly and implemented consistently. Informally waiving policies and procedures caused any written interpretation of federal laws, regulations, and guidance to be subjective, and did not ensure consistent implementation.

Additionally, although management and counselors reported there were areas in policies and procedures which could benefit from more clarification, management assured it was always available to provide guidance. At least one manager also stated making policy too specific would not allow enough flexibility in customers' cases. However, subjective interpretation resulted in conflicting understanding among management and personnel as to the appropriate policies, procedures, and practices. For example, when we inquired with management about which cost threshold amounts required supervisory review, management and personnel reported varying amounts between $5,000 and $20,000. In addition, management and personnel were unsure as to whether the review was prompted based on total case estimates, individual IPE estimates, actual money spent, or authorizations. Management was also unable to provide consistent responses regarding the processes for completing eligibility extensions, determining eligibility and disability priority based on medical documentation availability, verifying employment, closing cases, and implementing trial work experiences.

**Recommendations:**

**We recommend NHVR management improve policies and procedures by:**

- **formally updating the *Policy Manual* with all policies which govern the provision of rehabilitation services;**
- **ensuring all existing policies, procedures, guidance, and practices which do not govern the provision of rehabilitation services are converted into more manageable documentation that is comprehensive, centrally located, and easily accessible for personnel;**
- **only issuing additional guidance to personnel for clarifying policies, procedures, and practices which have already been appropriately adopted and formalized;**
- **ensuring policies and procedures are subjected to the required public comment process and input from the State Rehabilitation Council;**
- **transmitting all policies, procedures, guidance, and written practices provided to or used by rehabilitation personnel to the State Rehabilitation Council;**
- **incorporating a periodic review process to ensure internal controls remain relevant;**
- **developing formal communication processes in policy to ensure directives are issued and retained efficiently and effectively;**
- **complying with federal requirements by documenting interpretations of federal law, regulations, and guidelines; and**
- **implementing policies and procedures consistently and objectively.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As the audit report states, "NHVR management issued guidance letters, informal directives, and amended policies and procedures which added to or changed existing practices in at least 22 instances during the audit period." Guidance documents and informal directives are not policy and do not need to go through the same review and public comment process. As occurred with the Order of Selection Policy in 2018, all policy must go through the State Rehabilitation Council and public comment.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *As of December 2020, the bureau has updated much of the current policy manual with the assistance of an internal workgroup, these policy updates have been enhanced by reviewing them with the State Rehabilitation Council (SRC) Policy Committee and they will be moved to the full SRC at the January meeting, with public comment occurring in early 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace*

*the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**We agree guidance documents and informal directives are generally not policy documents. However, the manner in which NHVR utilized guidance documents and informal directives were in actuality, changes to policies and procedures, not as additional guidance on existing policies and procedures. Additionally, the 22 instances included other documentation such as the 2018 *Vehicle Modification Guide*, which specifically changed requirements imposed on customers to receive vehicle modifications. Under federal regulations, these 22 changes were subject to the public comment process, or at a minimum, required transmission to the State Rehabilitation Council.**

### Waivers To NHVR Policies

Waiver procedures are necessary when a requirement or prohibition did not apply to an individual under particular circumstances. Waivers were individual petitions to avoid a specific policy based on a predefined criteria and process. Therefore, waivers were designed to address exceptions to a policy and not act as common practice. NHVR allowed broad aspects of its policies and procedures to be waived. However, it did not establish a standardized process to approve waivers, nor did it outline circumstances under which waivers would be considered.

### Observation No. 41

### Develop And Adopt Standardized Waivers

NHVR administrative rules lacked a standardized waiver process with clear criteria and procedures. NHVR granted waivers for college funding and enrollment status, purchases of hardware and software, and exemptions from the waitlist. Consequently, we found NHVR waivers were granted to customers inconsistently, did not contain proper authority and documentation, and undermined existing policies and procedures.

### Waiver Process Not Established In NHVR Rules As Required

Statute required agencies to establish a waiver process in their rules before they can grant a waiver of any rule requirement. However, NHVR did not have waiver processes in its rules. Additionally, rules did not codify many of its requirements, including those it imposed on applicants and customers and had the possibility of being waived. As a result, NHVR generally provided waivers to its policies and procedures without a process explaining how customers could obtain these waivers. By establishing waivers in policy and procedures and not in administrative rule, NHVR risked waiving a rule directly, or a policy required to be included in rules, in a manner statute or federal requirements prohibited.

**No Standardized Method For Obtaining Waivers Or Documenting Approvals**

NHVR did not have a standardized method for petitioning, documenting, and approving a waiver of its policies and procedures. Additionally, it did not establish guidelines for the type of documentation that needed to be retained in case files. According to NHVR management, case notes were the primary tool for documenting case activity. However, documenting a waiver request in a case note did not ensure the customer properly petitioned for the waiver or the proper approval took place.

- No Waiver Application – NHVR did not have a waiver application form, so waivers required NHVR staff to initiate the process, not the customer. Additionally, the process to obtain a waiver did not appear to be clearly communicated to customers. One customer in our file review was only informed about the ability to obtain a waiver after expressing dissatisfaction with NHVR policy. Once informed of the ability to obtain a waiver, the customer requested and successfully received one.
- No Formal Process To Document Management Approvals – NHVR did not have requirements for retaining documentation associated with waiver requests and case notes alone did not ensure approvals were properly documented. For example, one counselor waived the amount of tuition assistance NHVR could provide based on the customer's financial need, allowing the customer more financial assistance from NHVR to attend college. However, the only documentation in the file was a case note written by the counselor stating NHVR management approved the deviation. No documentation was retained in the file indicating that management actually approved the waiver request.

**No Clear Criteria For When A Waiver Could Be Warranted**

Any waiver process should contain criteria to ensure the deviation from existing policies and procedures was justified. NHVR did not establish clear criteria to guide its counselors or managers on the types of deviations which could warrant a waiver. As a result, we found inconsistencies in how waivers were granted.

- Obtaining Technology – To obtain technology goods such as hardware or software, NHVR required a recommendation from a professional who had evaluated the customer, stating a specific technology product was needed. However, we found one customer received a computer without the required assessment and another customer received computer software although a consultant's assessment found it was unnecessary. We did not find documentation in the case record explaining why these customers were not required to follow established policy.
- Exemption From The Waitlist – NHVR policy allowed a customer to bypass the waitlist if they were in "immediate danger of job loss." However, NHVR policy did not define what qualified as "immediate danger of a job loss." One customer in our file review was categorized as having a less significant disability (L-SD) and should have been placed on the waitlist. The customer received a waiver based on a letter from their employer stating the employer was "not sure how long [the customer] would be able to remain in [their] current position." However, there was no indication of whether the customer would

immediately lose their position, or if the customer would lose their employment or only their current position. Not establishing clear criteria may have resulted in some customers taking the spot of another customer in a higher priority category on the waitlist. Defined criteria to assess the validity of the waiver process ensured consistent treatment of all customers.

**Universal Waivers Of Any Cost Measure**

Policy allowed for any cost measure imposed by NHVR to be waived if the cost could prevent the customer from receiving a necessary service. Although NHVR already had a FNA process to determine a customer's ability to contribute towards the cost of services, the FNA process was not incorporated into the cost measure waiver procedure. For example, two customers received more in college funding than they should have received because of their financial circumstances. However, NHVR did not review whether the customers could contribute financially without the waiver. A more effective and robust FNA process incorporated into a standardized waiver process could have provided a fair and consistent method for waiving cost measures. Consequently, some waivers of cost measures may have been arbitrary and reinforced the inconsistent application of the FNA process which was prohibited under federal regulations and NHVR administrative rules.

**Recommendations:**

**We recommend NHVR management develop and adopt, in administrative rules, a consistent and standardized process for customers to request a waiver from requirements imposed by NHVR. The process should include:**

- **an application form for customers to formally petition for a waiver;**
- **requirements for how waiver requests should be documented, including what records should be retained in the customer's files, the outcome of the waiver request, and who reviewed the request;**
- **clear and specific criteria for circumstances which may warrant a waiver; and**
- **requirements to demonstrate criteria was applied consistently and approved by management.**

**We also recommend better integrating the FNA process into the waiver process when considering waivers associated with customer costs.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *As the audit report states, "No Formal Process To Document Management Approvals – NHVR did not have requirements for retaining documentation associated with waiver requests and case notes alone did not ensure approvals were properly documented." When a waiver is requested for hearing aids, a very complete and documented process occurs. Namely, a waiver calculator is completed to determine the amount of funding requested to*

*be waived. A waiver case note is created and when an activity due is approved by the Director, an indication of this is noted in the activity due.*

2. *As the audit report states, "Exemption From The OOS Waitlist – NHVR policy allowed a customer to bypass the OOS waitlist if they were in "immediate danger of job loss." However, NHVR policy did not define what qualified as "immediate danger of a job loss." The bureau believes we have clarity on this process and utilized it in appropriate ways during the OOS when a customer met the appropriate criteria developed in bureau guidance.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau has drafted a waiver policy and will vet the policy with the internal agency policy committee and the SRC policy committee to be included in new policy updates during 2021.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**NHVR's response in Remark 1 provides an example of a practice used for one type of waiver. NHVR has formal and informal practices to grant waivers for multiple policies. During our file review, we did not consistently find waivers were requested, documented in case notes, and approved by management.**

**Counselor Authority And Performance**

Management was responsible for establishing the organizational structure, roles and responsibilities, and reporting lines to ensure organizational objectives are met. To accomplish this, management must delegate authority to key roles within the organization but only to the extent required to achieve an objective. Management must also maintain responsibility over an organization's control structure and delegate authority to operationalize designed control activities. In addition to assisting an organization in accomplishing program objectives, clearly defined delegation of authority allows management to better safeguard assets against fraud, waste, and abuse by segregating incompatible duties.

After management assigns roles, responsibilities, and authority to positions throughout the organization, it must recruit and retain qualified and competent staff to fill those positions. It must also ensure staff possess the necessary knowledge and skills to perform those roles effectively. Management must design a training program to further develop, maintain, and reinforce staff competences throughout the organization and tailor training for specific roles.

NHVR management delegated authority to counselors and RLs on a graduated spectrum, with RLs being granted the most authority and vocational rehabilitation counselor (VRC) Is the least. NHVR management delegated signature authority for three activities: determining eligibility and assigning disability priority categories for NHVR services, developing IPEs, and issuing authorizations for purchasing goods and services for customers. NHVR controlled signature authority through its electronic case management system, by allowing only counselors with authority to finalize certain data pages. Counselors without signature authority required supervisory review and approval.

- VRC Is did not have a master's degree and required supervisory review and approval for all decisions both prior to and during the OOS.
- All VRC IIs had a master's degree and most held signature authority prior to the OOS, only needing supervisory review for IPEs meeting or exceeding the $10,000 estimated cost threshold. With the implementation of the OOS, all counselors' signature authority was rescinded, requiring supervisory review for all decisions. Management began restoring IPE and authorization signature authority for some VRC IIs on a case-by-case basis starting in January 2019.
- All VRC IIIs had a master's degree and held signature authority prior to the OOS, only needing supervisory review for IPEs meeting or exceeding the $20,000 estimated cost threshold. With the implementation of the OOS, VRC IIIs' signature authority was rescinded, requiring supervisory review for all decisions. Management began restoring eligibility, IPE, and authorization signature authority for some VRC IIIs on a case-by-case basis beginning in October 2018.

We found weaknesses in the signature authority structure, which could benefit from a formal review. NHVR also did not ensure counselors were held to the education requirement established in its *State Plan* and counselor performance was not adequately measured or monitored. To further exacerbate the issue, counselor training was not comprehensive, and training materials were not complete or were outdated.

**Observation No. 42**

**Review Signature Authority Structure**

Prior to the OOS, most VRC IIs and VRC IIIs had full signature authority with limited oversight during a time when NHVR had high levels of program spending. Immediately after implementing an OOS, NHVR management rescinded signature authority of VRC IIs and VRC IIIs for all activities and required RL review and approval. However, as NHVR progressed further into the OOS, it began restoring signature authority for some VRC IIs and VRC IIIs on a case-by-case basis, partially readopting the authority structure in place before the OOS. Additionally, signature authority was not documented or monitored, and NHVR did not conduct a formal evaluation to determine the impact of rescinding or restoring signature authority. As a result, NHVR implemented substantial signature authority changes in response to entering the OOS without fully considering how these changes would affect management and counselor responsibilities.

**Strict Supervisory Review Requirements Implemented After OOS Declined By June 2019**

Signature authority was an internal control intended to ensure supervisors reviewed activities for VRC Is and certain activities performed by other counselors to achieve compliance and consistency with requirements. NHVR delegated signature authority allowing counselors to finalize decisions without supervisory review. NHVR substantially changed its signature authority structure during the audit period which occurred as follows: prior to the OOS, during the OOS until October 2018, and October 2018 to June 2019.

***Signature Authority Prior To The OOS***

Prior to implementing an OOS in May 2018, most VRC IIs and VRC IIIs reportedly held signature authority for all activities, allowing them a substantial amount of autonomy. Specifically, NHVR allowed counselors with signature authority to determine eligibility and assign customers to a priority category, finalize IPEs estimated to cost under a specific threshold, and issue authorizations without requiring supervisory review. All activities performed by VRC Is required supervisory review before becoming effective. We reviewed all activities completed in June 2017. We were unable to determine whether activities completed by VRC IIs or VRC IIIs prior to the OOS required supervisory review, as management did not document which counselors had authority during that time. We found at least the following proportion of each activity conducted by VRC Is required supervisory review:

- 38 percent (75 of 198) of eligibility determinations,
- 32 percent (42 of 130) of IPEs developed, and
- 24 percent (226 of 929) of authorizations issued.

***Signature Authority During The OOS Until October 2018***

After implementing the OOS in May 2018, NHVR reportedly rescinded all counselors' signature authority and required all activities be reviewed by an RL or the Field Services Administrator. The only activities not required to be reviewed were those performed by RLs, except finalizing IPEs estimated to cost $20,000 or more, which required approval from the VR Director or the Field Services Administrator. This increased oversight remained in effect until October 12, 2018, when management began restoring signature authority to VRC IIs and VRC IIIs on a case-by-case basis. We reviewed all activities completed in June 2018. We found the following proportion of each activity required supervisory review:

- 96 percent (112 of 117) of eligibility determinations, and
- 95 percent (414 of 438) of authorizations issued.

We note no IPEs were developed during June 2018 since customers were not released from the waitlist until September 2018. From September 2018 to October 11, 2018, 96 percent (22 of 23) of IPEs required supervisory review.

***Signature Authority From October 2018 To June 2019***

By June 2019, NHVR had restored signature authority for certain activities to some counselors. All four VRC IIIs had authorization signature authority, three had IPE signature authority, and one had eligibility signature authority. Of the 11 VRC IIs, eight had authorization signature authority, seven had IPE signature authority, and none had eligibility signature authority. We reviewed all activities completed in June 2019. We found the following proportion of each activity required supervisory review:

- 94 percent (91 of 97) of eligibility determinations,
- 65 percent (46 of 71) of IPEs developed, and
- 42 percent (152 of 360) of authorizations issued.

NHVR continued to restore signature authority to counselors on a case-by-case basis after June 2019. Consequently, the percentage of IPEs and authorizations, activities which involved costs, were completed by those with signature authority was trending towards the level of review in place before implementing the OOS, when scrutinizing costs was not a primary focus.

**Increased Signature Authority Decreased Management Oversight**

The number of cases without activities being reviewed was increasing as management restored signature authority to VRC IIs and VRC IIIs. For example, allowing VRC IIIs to determine eligibility, develop IPEs, and issue authorizations meant they had substantial control over all aspects of case without receiving additional review or oversight. This meant in some cases, one counselor could:

- determine an applicant eligible without all required documentation,
- develop an IPE with services not agreed to and signed by the customer that may not have been needed for the employment goal, and
- issue authorizations for services not agreed to or may not be needed by the customers.

Without a process for periodic supervisory review, NHVR could not ensure counselors were applying all requirements consistently. While more experienced counselors may not require frequent review, as we discuss in Observations No. 3 and No. 14, we identified activities that were finalized without supervisory review but contained issues related to consistency and compliance. Management oversight could have increased the likelihood these activities would be completed consistently and in compliance with requirements. Additionally, management oversight could mitigate the risk of error, misuse, and waste.

**Signature Authority Did Not Consistently Consider An Activity's Risk**

Management delegates authority for a specific activity to mitigate the risk an agency objective will not be achieved. Therefore, management delegates less authority throughout the organization in areas involving higher risk or a level of complexity management is best suited to address. Conversely, management delegates more authority and restricts direct oversight when an activity can be easily standardized and poses less risk to the organization's mission. NHVR assigned

signature authority primarily based on each individual and their position within the organization instead of an analysis of the specific activity and its associated risk.

### *Management Delegated Authority For Complex And Higher Risk Activities*

Counselors performed a variety of activities ranging in complexity. One of the more complex and higher risk activities performed was determining an individual's eligibility and prioritization for services. NHVR made efforts to standardize eligibility determination and disability priority assignments by creating a worksheet to help counselors consider eligibility requirements and disability priority criteria. However, parsing through potentially complex medical documentation and applying unclear and limited guidance on the requirements made this activity inherently more complicated than other activities assigned to NHVR staff. Additionally, determining whether an applicant was eligible or ineligible without documentation supporting the decision posed a significant risk to NHVR by either denying an eligible customer services or wasting resources on an ineligible customer. However, NHVR historically delegated VRC IIs and VRC IIIs the authority to determine eligibility and prioritization for services without requiring any form of periodic review when eligibility decisions were made, for example, a review from RLs, other VRC IIIs, or upper management.

### *Less Complex Activities Could Be Reviewed By Counselors With Authority*

Eligibility decisions and finalizing IPEs were more complex activities and posed a higher risk. Reviewing authorizations required fewer technical skills specific to rehabilitating customers but required a general understanding of NHVR financial policies and practices. If management implemented more stringent controls over the eligibility and IPE processes, it could potentially accept more risk over the process of issuing authorizations. Although a less complex activity, issuing authorizations still benefited from periodic review for compliance and validity. If consistent and effective controls were put in place prior to the authorization process, RLs could focus on higher risk activities and allow lower risk activities to be reviewed by other counselors with signature authority.

## Changes Made To The Organizational Structure Without Formal Assessment

NHVR was in the process of changing its signature authority structure in the midst of two crises which created conflicting challenges for NHVR: 1) a pending budgetary shortfall increased the risk of spending federal appropriations too quickly; and 2) the OOS and adoption of a waitlist for services increased the risk customers would not receive VR services timely. NHVR may have temporarily benefited from adopting a stringent authority structure to address a pending budget shortfall and reverting back to a more lenient structure to timely address the waitlist, but these two divergent authority structures were likely not sustainable for a balanced approached. The use of a formal assessment to analyze the NHVR delegation of authority structure would have facilitated NHVR in focusing on increased periodic oversight for certain activities, assessing risk and task complexity, and prioritizing senior management's time. Additionally, delegating authority requires management to accept a certain amount of risk, which could decrease the costs of controls and improve operational efficiencies if overall effectiveness was maintained.

**Recommendations:**

**We recommend NHVR management reevaluate its signature authority structure and review process by conducting a formal assessment of responsibilities delegated to counselors and RLs. The formal assessment should consider:**

- **the risks associated with increasing the proportion of activities that do not receive review;**
- **the complexity of each delegated activity; and**
- **opportunities to prioritize upper management's role in higher risk activities and delegate further responsibilities for lower risk activities.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The auditor report states, "NHVR did not conduct a formal evaluation to determine the impact of rescinding or restoring signature authority." This is an incorrect understanding of the action taken in May 2018 when NHVR implemented an order of selection. At that time, approval authority was rescinded for all but the most experienced counselors to allow NHVR to effectively manage during a period of uncertain financial stability. Between that time and October, as the financial stability of the organization improved through greater visibility, rescinded authorizations were incrementally restored. The auditors assert that the restoration should have been based on transaction complexity. While we concur that complexity is certainly one of the considerations in the restoration of approval authority, we also considered the experience of the personnel to whom additional authority was restored, as the experience level of staff plays an important role in the correct execution of a transaction.*
2. *The bureau has 30 VR counselors. Although the bureau had no formal policy on signature authority prior to the audit, the bureau's approach to authorization could be discerned by the system level access granted to an individual counselor. If a counselor was a counselor I they did not have signature authority and all activities had to be reviewed and approved by a III or a Supervisor. If a counselor was a II they met the "qualified counselor" criteria and were allowed to sign their own documents. In addition, if a counselor was a III they could review and approve VR counselor I and II work, as well as signing their own documents. VR counselor IIs and IIIs have a Master's degree and have substantial training and practice before they are allowed to have signature authority. The bureau trusts these counselors and reviews their work through case review procedures.*
3. *The case management system will not allow a VR counselor who does not have signature authority to approve any actions in the case management system.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau has developed, since the audit, a signature authority structure that manually tracks authorizations outside of the system, in addition to the system. The bureau reviews this structure periodically and makes changes accordingly.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, NHVR provided no formal evaluation to demonstrate it assessed the risks associated with revoking all signature authority and the risks associated with restoring signature authority. In fact, NHVR had no formal policy on the process of revoking or restoring signature authority. A formal evaluation of the signature authority structure likely would have identified the need for a formal policy and process to delegate and monitor signature authority.**

**In reference to Remark 2, while it may have been appropriate for counselors with advanced degrees to be delegated additional authority, a Master's degree did not fully mitigate all risks associated with treating individuals with disabilities consistently. In fact, NHVR's response to Observation No. 43 states, "There is not empirical data to suggest that the quality of work from someone coming out of a master's program is higher quality than an experienced counselor with effective training." Regardless of the degree held by staff, management is still responsible for monitoring the effectiveness of its authority structure and responding appropriately.**

**Observation No. 43**

## Clarify Counselor Performance Expectations

Federal regulations required VR programs to develop a system of staff development, particularly with respect to assessment, vocational counseling, job placement, and rehabilitation technology. However, management had limited processes to ensure counselors met qualification requirements and to determine whether they were working efficiently, effectively, and in support of NHVR's goals and mission.

### Counselor Education Requirements Were Not Always Met

Federal regulations required NHVR to establish and maintain a comprehensive system of personnel development, including education and experience requirements. These requirements were intended to ensure qualified counselors could "work effectively with individuals with disabilities to assist them to achieve competitive integrated employment." Counselors were expected to help counselors through a knowledge of disabilities and vocational implications of

functional limitations on employment, counseling skills, case management, caseload management, and the use of labor market information.

Federal regulations limited certain actions to "qualified counselors," including:

- determining applicants required VR services, necessary for eligibility determinations;
- assisting customers with developing IPEs, necessary to identify needed services;
- approving and signing IPEs and amendments, necessary to provide services;
- reviewing IPEs, necessary to assess progress towards employment outcomes; and
- determining employment was satisfactory, necessary for cases to be closed as rehabilitated.

Federal law required NHVR to establish policies and procedures to ensure staff were appropriately and adequately prepared and qualified, including establishing education requirements. NHVR was permitted to select its own education requirements for qualified counselors: *either* a bachelor's degree *or* a master's degree in fields related to VR. NHVR management elected to require counselors have a master's degree and indicated such requirements "provide an opportunity to increase the knowledge, skills, and abilities of rehabilitation counselors, thereby enhancing the provision of services and the quality of employment outcomes." However, NHVR did not ensure education requirements were met for all counselors, instead hiring VRC Is without Master's Degrees, not developing and monitoring action plans to ensure VRC Is eventually met education requirements, and not providing guidance for supervisors on review of VRC I decisions.

***Inability To Meet Education Requirements A Longstanding Issue***

Our *2001 LBA Audit Report* identified NHVR's inability to meet education requirements as an issue. NHVR's education requirement was implemented in June 2000, and all counselors were required to have a master's degree by July 2005. At the time, NHVR reported concern with its ability to recruit and retain qualified counselors. We suggested management plan accordingly and monitor counselors' progress to meet the deadline. NHVR acknowledged its ability to meet the selected education standard remained an issue, reporting in its 2016 *State Plan*, "while it is the intent of NHVR to hire and retain employees who meet the [education] standard, in some instances we are unable" to do so.

NHVR's hiring practices for VRC Is did not conform with the education standard it had selected in its *State Plan*, as VRC Is were only required to have a bachelor's degree. However, without a master's degree, VRC Is could not be considered "qualified" counselors, according to NHVR's education standard. Within six months of hire, VRC Is were supposed to be "immediately" placed into a plan that would allow them to obtain a master's degree within seven years.

One RL reported an inaccurate understanding of the education requirements, indicating there was "no hard deadline" by when VRC Is needed to obtain a master's degree and that federal regulations did not require counselors to have a master's degree.

### *Limited Mechanisms To Enforce Education Requirements*

Despite NHVR's requirement that VRC Is be "immediately" placed into a plan to obtain a master's degree within seven years of hire, there were limited processes in place to monitor plans, gauge progress, or generally enforce education requirements. The NHVR Director and one RL reported VRC Is' plans were not written and instead consisted of verbal agreements with supervisors. Some RLs reported they did not track the progress of VRC Is in their office towards the education requirement and were unsure how or whether the central office monitored progress, noting there was no centralized list of VRC Is who were on a plan.

There appeared to be a well-known lack of enforcement, contributing to further noncompliance. One central office manager reported some VRC Is did not want to pursue a master's degree, while one RL noted there had been several instances where VRC Is did not obtain a master's degree in the required timeframe but faced no consequences. We identified two counselors who remained in a VRC I position for longer than seven years, one for nine years and one for at least ten years. One RL expressed concerns about longevity and consistency within NHVR if management did not have a plan to ensure VRC Is obtained the necessary credentials for promotion.

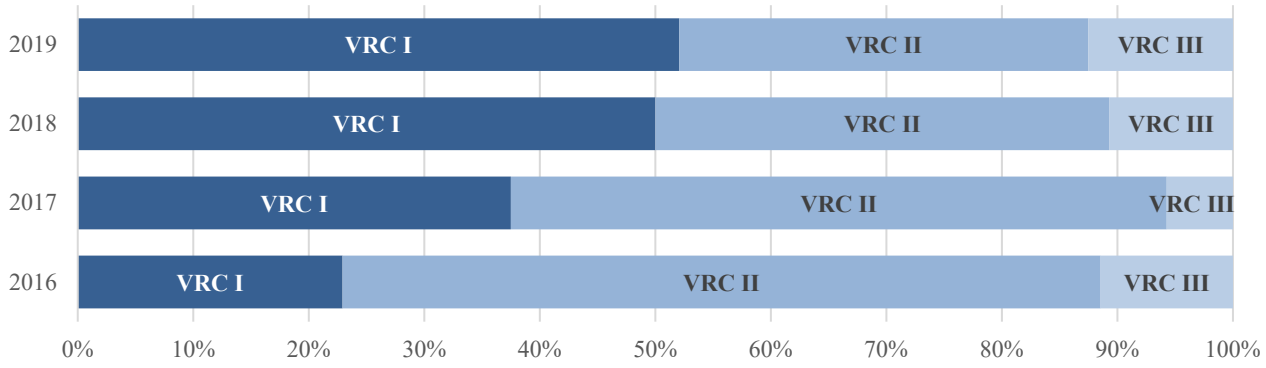
### *VRC Is Made An Increasing Proportion Of Decisions*

NHVR did not provide signature authority to VRC Is. However, a growing proportion of rehabilitation counselors were VRC Is without master's degrees, increasing from 33 percent of counselors in 2016 to 52 percent by September 2019.

We reviewed unaudited NHVR data on all eligibility decisions, IPEs, and authorizations finalized in June 2016, June 2017, June 2018, and June 2019, and found a growing proportion of all counselor decisions required supervisory review. Figure 12 shows an increase in the proportion of eligibility determinations on VRC Is' caseloads, all of which required supervisory review.

**Figure 12**

**VRC Is Handled A Growing Proportion Of Eligibility Determinations, Based On Case Assignments As Of July 2019**




Source: LBA analysis of unaudited NHVR data on eligibility determinations made in June 2016, June 2017, June 2018, and June 2019, and personnel information on staff classifications.

Without guidance from NHVR management as to what documents and information to review or how thoroughly, it was unclear whether supervisors were spending a sufficient amount of time on review and approval of VRC Is' decisions. Management would have been unable to assess how much time supervisors spent on review, as that information did not appear to be tracked, and supervisors were unsure how much time they spent reviewing counselors' decisions.

**Caseload Management And Counselor Performance Measures Were Limited And Not Focused On Outcomes**

NHVR training materials emphasized the importance of caseload management to ensure "a more fluid flow to objectives," for counselors, and to ensure services were "delivered in a prompt, professional and understandable manner leading to successful employment," for customers. NHVR's caseload management guidance and counselor performance measures focused primarily on the quantity and speed of work being performed, to ensure customers were "moving through" the VR process. However, this focus minimized the importance of quality caseload management and customer outcomes. One central office manager noted concerns with existing performance measures, reporting that counselors will do what management measures. However, management also conducted limited monitoring and enforcement of counselors' performance relative to NHVR targets and federal requirements.

***Caseload Management And Performance Measurement Focused On Work Quantity And Speed***

The *NHVR Counselor Desk Reference (Desk Reference)* established minimum expectations of performance, or performance targets, to ensure customers were moving through the VR process. Performance targets generally focused on the expected number of activities counselors should perform each month and the expected length of time it should take to complete activities. The *Desk Reference* indicated new counselors should be meeting performance targets within six months of hire, or a plan developed to ensure targets were met within another three to six months. Counselors with more than one year of experience were expected to be "working at or above" performance targets. Management indicated meeting performance expectations would help counselors "maintain fluid caseload movement." Performance measures covered the entire VR process, from application to closure, and included:

- Application – NHVR required counselors to intake at least eight applicants monthly.
- Eligibility – Federal law required eligibility decisions be made within 60 days of application. NHVR required counselors to make at least six eligibility decisions monthly.
- IPEs – Federal law required IPEs be developed within 90 days of eligibility. NHVR required counselors to implement four IPEs monthly. Counselors were responsible for ensuring all customers were in an active IPE and for reviewing all IPEs at least annually.
- Case Progress – NHVR established requirements counselors maintain "regular and ongoing contact" with customers at least every six to eight weeks and include at least one case note every 90 days to document case progress.
- Rehabilitation And Closure – Federal law indicated counselors could close a case as rehabilitated if a customer maintained competitive integrated employment, without

needing VR services, for at least 90 days. NHVR required counselors have two rehabilitated customers monthly.

The *Desk Reference* stated counselors should be held accountable for "those performance areas for which they have control." However, one central office manager acknowledged measures were not always within counselors' control. For example, counselors might have more applicants needing intakes or eligibility determinations, depending on which day of the week they were scheduled to handle intake appointments.

Central office managers and RLs reported that *Desk Reference* performance measures were put aside once the OOS was implemented. One manager reported that once operations were "back to normal," management would place more focus on counselor performance.

***Limited Monitoring And Enforcement Of Performance Expectations***

Management relied upon two primary reports to monitor counselor performance against caseload and performance targets: the quarterly *Movement Report* and the weekly case monitoring report. RLs were reportedly able to generate similar reports from the case management system for their review. The NHVR Director reported repeated mistakes were occurring without resolution, and supervisors needed to hold counselors more accountable for their performance. However, management also did not appear to use the reports to comprehensively address performance that did not meet targets and requirements.

The *Movement Report*, last generated in 2018, compared counselor performance against monthly targets to move customers from one status to the next, such as from application to eligibility. Reports indicated few counselors met these targets. For example, the report issued on March 3, 2018, showed, among the 40 counselors actively working on cases between October 2017 and February 2018:

- four (10 percent) averaged eight or more applications and intakes,
- 11 (28 percent) averaged six or more eligibility determinations,
- 13 (33 percent) averaged four or more IPEs,
- 15 (38 percent) averaged at least two rehabilitated customers, and
- two (five percent) met all four performance targets, on average.

The weekly case monitoring reports tracked additional performance measures since September 2017, including federal time limits, eligibility and IPE measures, and case progress. However, reports monitored performance *after* federal requirements had passed or targets had been missed. For example, the weekly case monitoring report issued on June 7, 2019, identified:

- six cases past the 60-day limit for eligibility, including two past by 20 days or more;
- 21 cases with expired eligibility extensions, including ten expired by 60 days or more;
- nine cases past the 90-day limit for developing an IPE, including one past by 50 days; and
- five cases with expired IPE extensions, including three expired by 60 days or more.

The weekly case monitoring reports also tracked some performance measures without providing additional context to demonstrate the magnitude of the issue. For example, the report issued on June 7, 2019, identified 170 cases with expired IPEs and 142 cases past the 90-day target for a case note. But the report did not indicate which IPEs had been expired or for how long, or how long it had been since a case note had been written.

Additionally, there was no process to ensure noncompliant cases appearing on weekly case monitoring reports were addressed in a timely manner. Some counselors repeatedly had multiple cases appearing on the weekly case monitoring reports, and some cases appeared on numerous reports without being resolved. For example, the report issued on June 7, 2019, identified three counselors responsible for over half of noncompliant cases on the report (220 of 387 cases, 57 percent). We also found one case with an eligibility extension that had been expired by ten months and appeared on 40 prior reports without resolution.

Not all established performance expectations were monitored by management, such as an internal target to maintain ongoing and regular customer contact at least every six to eight weeks or a federal requirement IPEs be reviewed at least annually. Others were not monitored as minimum expectations, such as the federal expectation to close a rehabilitated case after at least 90 days of stability. Instead, NHVR's weekly case monitoring report tracked whether counselors closed rehabilitated cases after at least 120 days of stability.

***Caseload Expectations Focused On Caseload Size***

The *Desk Reference* established expectations for caseload sizes, indicating counselors should maintain an average caseload between 125 and 150 cases. Counselors with fewer than 125 cases should have a plan to increase the number of referrals and new customers until their caseload was "within expectations." Conversely, counselors with more than 200 cases should have a plan to reduce the number of cases "to a manageable workload." However, the *Desk Reference* specifically noted VRC IIIs should have a caseload of 50 percent of expectations, or around 75 cases. RLs reported smaller caseloads were related to VRC IIIs' supervisory responsibilities, which included attending supervisor meetings, mentoring other counselors, and assisting RLs with approving eligibility decisions, IPEs, and authorizations for other counselors without signature authority.

Management previously identified caseload sizes on the quarterly *Movement Report*. New counselors were expected to be meeting caseload targets within six months of hire. The *Movement Report* issued on March 3, 2018, identified four VRC Is with less than six months' experience maintained an average caseload of 57 cases. Counselors with more than one year of experience were expected to be "working at or above" targets. However, the *Movement Report* indicated few counselors met these caseload size targets. For example, the *Movement Report* issued on March 3, 2018, identified:

- one of five VRC IIIs (20 percent) maintained a caseload below expectations of 60 cases, and one VRC III (20 percent) maintained a caseload above expectations of 121 cases; and
- 28 of 31 VRC IIs and VRC Is with more than six months' experience (90 percent) maintained caseloads below expectations (ranging from 55 to 123 cases).

This information appeared to indicate NHVR was overstaffed prior to the OOS, which several central office managers later acknowledged.

NHVR provided no formal guidance to RLs on making caseload assignments, and as a result, RLs used various processes to assign new cases to counselors. Two RLs reported new applicants were generally assigned to counselors responsible for intake interviews on specific days of the week, one reported assignments were based on geographic area and one reported reviewing existing caseloads and considering each counselor's experience, familiarity with certain types of disabilities, and other responsibilities. Two RLs noted some counselors in their regional office maintained "specialty" caseloads, such as customers who were deaf or hard of hearing or customers with mental health impairments. Regional office-specific specialty caseloads were in addition to agency-wide specialty caseloads maintained by three counselors assigned to cases with blind or visually impaired customers.

Counselors with specialty caseloads tended to have smaller caseloads, although formal NHVR performance expectations did not acknowledge this or other case-related criteria that might necessitate a reduced caseload. A measure of case complexity – combined with a holistic performance management system – might have allowed management to assess whether variations in caseloads were appropriate, given counselor knowledge, skills, and abilities. Management could then anticipate the amount of work that cases of differing complexity might involve when making assignments or contemplating releases off the waitlist.

***Inadequate Monitoring Of Transferred Cases***

Cases were frequently transferred across multiple counselors, particularly cases of longer duration or cases active after the implementation of the OOS. Two examples where customers were transferred multiple times included:

- one case in which the electronic case management system listed six counselors with responsibility for the case over a period of more than six years, and
- another case in which five counselors had responsibility for the case over a period of 18 months, primarily during the OOS.

NHVR provided no formal guidance on caseload transfers, and transfers were not specifically monitored by the RLs or the central office to ensure they were appropriately handled. Consequently, during our file and caseload reviews, we identified:

- Transfers Not Addressed Timely – In one case, two staff did not timely engage with the customer once the case was transferred to their caseloads. The customer applied for services in May 2017. The original counselor determined eligibility in July 2017 but had no further contact with the customer. An RL was assigned the case six months later but engaged in no activity. A second counselor was assigned the case two months later, sent two notices of closure to the customer, and ultimately learned the customer had moved. The case was transferred to a third counselor covering that geographic area 14 months later, who engaged in no activity until ten months after the transfer. At that time, the case was placed into an inactive status due to customer medical issues.

- Inadequate Initial Case Management Affected Case Management After Transfer – In one case, inadequate documentation negatively affected later case management. The customer applied for services in June 2012. The RL took over the case four years later, at which time the RL noted college tuition authorizations were not "making any sense" and indicated the file was "missing a lot of necessary paperwork," including a signed IPE. As a result, the RL expressed confusion about how the original counselor paid for college tuition two months prior and was unable to answer customer questions, needing to request substantial documentation from the customer to understand how to proceed. The case was transferred to a second counselor two months later, then transferred back to the RL after 14 months. A CRP vendor contacted the RL and reported the second counselor changed the customer's employment goal, noting a signed IPE "somewhere" reflected the change. The RL was unable to find an updated IPE in either the electronic or hardcopy files and requested the customer either provide a copy or come to the regional office to sign a new IPE.

**Recommendations:**

**We recommend NHVR management improve compliance with counselor education requirements by:**

- **reviewing whether current educational requirements are appropriate, especially given NHVR's long-standing practice of hiring candidates with bachelor's degrees;**
- **ensuring its educational requirements are met by all counselors upon hire; and**
- **ensuring any requirements to obtain a graduate degree in order to retain employment or be promoted is monitored and enforced.**

**We recommend NHVR management improve caseload management and performance measurement by:**

- **developing, implementing, and refining objective, quantifiable performance expectations, and acceptable ranges of performance that are clearly linked to NHVR goals and objectives and clearly communicated to staff;**
- **developing a measure of case complexity and use that information to more appropriately allocate caseloads across counselors;**
- **routinely measuring staff performance against expectations and analyzing information to identify trends, potential issues with performance expectations, and deviations from acceptable performance levels; and**
- **developing, implementing, and refining systems to identify staff noncompliance with federal law, federal regulations, rules, policies, procedures, and other performance expectations and address noncompliance in a timely and equitable manner.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *According to the audit report in the section titled, "Caseload Management And Counselor Performance Measures Were Limited And Not Focused On Outcomes" the counselor expectations currently in place are very focused on outcomes. The bureau has two sets of outcomes the counselors have as expectations. The first involves expected numbers of referrals, completed applications, completed eligibility determinations, completed plans and completed closures. In addition to expectations that move cases through the VR system, the bureau has the federal performance accountability measures. These measures include: the percent of their caseload that are working second and fourth quarter after exit from the program, the number of cases that are in a training program that will result in a recognized credential and the number of cases they have that achieve a measureable skills gain during the year. In addition to these expectations we have the state plan goals that globally drive the outcomes of the program.*
2. *According to the audit report, "Additionally, there was no process to ensure noncompliant cases appearing on weekly case monitoring reports were addressed in a timely manner. Some counselors repeatedly had multiple cases appearing on the weekly case monitoring reports, and some cases appeared on numerous reports without being resolved." The audit team fail to mention that these reports are reviewed on a weekly basis and some cases that are noncompliant are due to the customer's unwillingness to either assist with eligibility determination paperwork or completing a plan or creating an extension. The system of compliance is based on two factors: 1) the counselor having necessary info to complete a document, and 2) the customer being willing to complete their portion of this action. Without both being accomplished, the case is non-compliant but to say the bureau has no process for these reports is untrue.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau will reevaluate and modify its plan if necessary, relative to the requirement that all counselors progress towards a master's degree. There is not empirical data to suggest that the quality of work from someone coming out of a master's program is higher quality than an experienced counselor with effective training.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 1, NHVR is confusing output and outcome measures. The first set of performance expectations noted in NHVR's response are also identified and described in the Observation. NHVR states these include "expected numbers of referrals, completed applications, completed eligibility determinations, completed plans and completed closures." These are all outputs – the amount being produced by counselors (work quantity), and not outcomes – the results of services. Other counselor-specific performance measures in use during the audit period, such as compliance with the 60- and 90-day time limits and**

**compliance with extension requirements, likewise focused on outputs, including timeliness (speed), and not outcomes. The second set of performance expectations noted in NHVR's response were not fully implemented until September 2019, according to the Rehabilitation Services Administration. No documentation was provided by NHVR to demonstrate that these agency-wide performance measures were also being used to evaluate individual counselor performance.**

**In reference to Remark 2, the Observation clearly states that the case monitoring reports are a weekly monitoring tool. If customers are unwilling to participate in their vocational rehabilitation process, NHVR has the ability to assess whether those cases should be closed, as stipulated in its internal guidance and discussed in Observation No. 34.**

**We note that a system of compliance is based on effective monitoring and enforcement controls designed to ensure staff accountability and consistent treatment of applicants and customers, as well as proper case management. The results of our review of cases appearing on multiple weekly case monitoring reports – discussed in Observations No. 6 and No. 7 – demonstrate the necessity of these two components. One case appeared on 40 case monitoring reports because eligibility had not been determined by the eligibility extension end date. There was no documented activity on the case between the application date and its first appearance on a weekly case monitoring report, three months later. After the first appearance on a monitoring report, there was no documented activity for an additional seven months, until the counselor sent the first notice of closure. The following month, the counselor sent the second notice of closure and left a message for the applicant. There was no documented activity on the case for an additional two months, until the case was closed.**

**Observation No. 44**

## Develop A Strategic Training Program

NHVR did not have a training program strategically linking agency goals to skills and competencies needed for the agency to perform effectively. Training programs undertaken as an integral part of the agency's strategic planning were important for improving staff development and retention, agency performance, provision of services, and resource management. Staff needed to possess a wide range of knowledge, including an understanding of the rehabilitation process, assessments, vocational counseling, job placement, and rehabilitation technology, as well as compliance with laws, regulations, rules, and internal guidance. Additionally, strategic training program could help management:

- identify gaps in employee knowledge, skills, and abilities and operational performance;
- ensure staff expertise and knowledge remained current;
- focus on developing a productive and skilled workforce that was capable of meeting existing and future organizational responsibilities; and
- address competencies and processes with the greatest impact on performance.

Training sessions occurred for new counselors, and to address significant programmatic and operational changes. However, training alone does not produce desired outcomes, instead it

requires adequate preparation, resources, and continuous evaluation to identify improvements. Management and staff reported quality and effectiveness of training began to decline during the audit period. Specifically, personnel reported concerns about the ineffectiveness of new counselor training, lack of continued staff development, and improvised training sessions. We also found staff resources were insufficient to effectively implement training activities, NHVR did not update or establish certain federally required training policies, and training materials and related documents were not comprehensively evaluated or updated. Sufficient and adequate training could have improved existing operations and helped management identify areas in which revisions, additions, or changes to rules, policies, procedures, and other internal guidance were warranted.

**Limited Resources To Support Training**

Reportedly, NHVR used to have a dedicated unit with five full-time equivalent positions responsible for policies, procedures, updating the *State Plan*, performance monitoring, and personnel training. By April 2018, one person was tasked with all these responsibilities in addition to overseeing the Concord regional office as the RL. Based on supplemental job descriptions provided by NHVR, this person's workload equated to the responsibilities of at least three full-time equivalent positions. In May 2019, federal reviewers specifically commented that it was a lot of responsibility for one person.

A Concord RL was eventually hired and began working in the position at the end of November 2019. However, expected job duties for the new Concord RL still included overseeing the NHVR training program. This was disproportionate to the responsibilities of other RL positions. Additionally, managing the Concord regional office during this time period required more staff oversight than other regional offices. The Concord regional office had the largest average caseload per counselor and consisted of only VRC Is who were required to receive review and approval from the RL for all eligibility, disability priority, IPE, and authorization finalizations. During the same time period, some VRC IIs and VRC IIIs began receiving signature authority to complete their own approvals and certain VRC IIIs were permitted to review and approve the work of other counselors. According to supplemental job descriptions, VRC IIIs were also expected to provide supervision for the regional office in the absence of the RL. Therefore, other field offices with VRC IIs and VRC IIIs potentially alleviated some RL supervision responsibilities. By not evaluating training resources and needs, staffing resources were constrained, which contributed to NHVR's inability to address deficiencies and develop a strategic training program. A comparison of staffing and average caseload per counselor by regional office is provided in Table 12.

**Table 12**

**Number Of Counselors By Location And Caseloads As Of October 2019**

| Regional Office | VRC I | VRC II | VRC III | Total Cases[1] | Average Caseload Per Counselor |
|---|---|---|---|---|---|
| Concord | 4 | 0 | 0 | 594 | 149 |
| Manchester/Nashua[2] | 6 | 1 | 1 | 916 | 115 |
| Berlin | 0 | 3 | 1 | 448 | 112 |
| Portsmouth | 2 | 1 | 1 | 418 | 105 |
| Keene | 2 | 2 | 1 | 449 | 90 |

Notes:
[1] Includes applicants, waitlist customers, and customers who were eligible for, or were already receiving services.
[2] Manchester and Nashua regional offices merged in calendar year 2018 and was overseen by one RL.

Source: LBA analysis of unaudited NHVR data.

**Policies And Procedures Were Incomplete And Outdated**

Federal law and regulations specified the *State Plan* must include the policies and procedures NHVR will undertake to ensure professionals will carry out standards and are adequately trained. Federal regulations required NHVR include adequate training procedures specifically related to:

- WIOA and other amendments to federal regulations;
- the requirements of related federal laws and programs such as the *Americans with Disabilities Act, Individuals with Disabilities Education Act*, Social Security work incentive programs, Ticket to Work, and *Work Incentives Improvement Act of 1999*;
- informed choice; and
- recruitment, development, and retention of qualified rehabilitation personnel.

The current *State Plan* was submitted in calendar year 2015 and updated in May 2018 after NHVR implemented the OOS. However, the *State Plan* did not include required training activities related to all federal laws and programs, amendments to federal regulations, or informed choice. Further, while the *State Plan* referenced certain training procedures and activities, federally required documentation of those activities in the *State Plan* were incomplete and outdated. Several training activities were included in the initial *State Plan*, but were not updated to accurately reflect NHVR training.

- Several references were made to the responsibility of the NHVR Training Officer, but a dedicated position no longer existed.
- Training activities related to personnel development and retention reflected anticipated staff and customer needs based on calendar year 2015 staffing levels and no changes to service delivery. OOS impacted the delivery of services and reduced staff resources which

would necessitate a reevaluation of how to effectively and efficiently train qualified personnel and meet customer needs.

- Training procedures for WIOA included in the *State Plan* were limited to, "providing training on activities occurring across the state as a result of implementation of WIOA."

Additionally, although referenced in the *State Plan*, there were no policies and procedures related to staff training in NHVR's policy.

**Training Gaps And Materials**

NHVR training materials and resources were not comprehensively evaluated and updated, contributing to improvised training and to the retention of obsolete documentation. Evaluation of training and development programs could aid in managing scarce resources and provide agencies with the opportunity to effectively implement training and empower employees to improve performance. After a training session was provided, RLs were responsible for ensuring staff were implementing processes consistently, and according to requirements. However, NHVR did not have a strategic training approach to proactively evaluate and identify gaps across the agency. Although management expressed an interest in utilizing reports to target training gaps, management generally relied on staff to seek out guidance individually. We surveyed counselors and found 14 out of 25 respondents (56 percent) reported training sessions sometimes or rarely provided the information needed to appropriately perform job responsibilities. Respondents most frequently cited more training was needed for service provision, IPE development, eligibility determinations, and case closures.

We also found that without a periodic evaluation process, materials provided for training and additional training resources were obsolete or conflicted with NHVR policy, practice, or federal regulations at times. Training modules and other resources were retained on NHVR's internal server to allow personnel to refer to information as needed. However, the contents of the training resources included over 530 files ranging in date from 1987 to 2019 with no indication as to which files were still relevant to national guidance and NHVR policies.

**Recommendations:**

**We recommend NHVR management develop a strategic training program by linking training efforts to agency goals, assessing training and staff needs to allocate resources effectively, and establishing processes to utilize performance and other data to proactively enhance ongoing training and development efforts. As part of a strategic training plan, NHVR should assess whether having one part-time training position is adequate for all staff training needs.**

**We also recommend NHVR management develop training policies and procedures, incorporate federally required training activities into the *State Plan,* and establish periodic evaluation processes to ensure training materials remain relevant and adequate.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *Although the bureau has lost dedicated training positions over the years, the feedback we receive from counselors is that they appreciate centralized training but they value the one-on-one training received in regional offices that allows them to shadow experienced counselors and then be reviewed by those counselors and their supervisor in their own work.*
2. *The bureau currently does frequent trainings on various topics (ethics, disability priority training, New Hampshire Rehabilitation Association trainings, one-stop training, and the new YESLMS learning management system with updated VR trainings).*
3. *The audit report indicates that required federal components on training are not included in the state plan but this is not the case as Rehabilitation Services Administration approved the state plan and made no comment on this not being completed in the plan. The bureau seeks to complete all areas of the state plan completely.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau purchased the "YES LMS" learning management system during the summer of 2019 and worked with the vendor through 2020 to ensure all modules were NH-specific. This new training resource provides new counselors with an updated and complete training system to learn their role as a VRC.*
- *The bureau, as a part of strategic planning, will ensure that training is a part of the plan to ensure staff have quality training and can meet the "qualified professional counselor" criteria.*
- *The bureau will seek legislative approval for a dedicated training/policy position.*
- *The Bureau released a request for proposal seeking assistance to design and implement a comprehensive quality assurance system for the agency. This program once built will monitor compliance independently from local offices. This unit once created will replace the file review form. It is the expectation that this work will be developed and fully implemented by December 2021.*

**Data Reliability And Integrity**

Management must use quality information to monitor, measure, and assist in achieving organizational objectives. Management must identify the relevant information needed to be effective, obtain data from reliable sources, and develop business processes to produce useful and quality information. Management must report quality information both internally and externally to monitor progress towards objectives, ensure compliance, and inform decision making. Quality information depends on accurate records and appropriate documentation. Management is accountable for maintaining and assigning responsibilities over the custody of records and should only provide access to authorized personnel to reduce errors and the misuse of information.

Federal law required each state VR agency to establish data validation procedures to ensure program reports were valid and reliable. Additionally, federal regulations and guidance required VR agencies to establish the policies, procedures, and internal controls necessary to ensure accurate data were being reported timely and agencies achieved compliance with federal laws and regulations. In the *Desk Reference*, NHVR management communicated to staff the importance of maintaining supporting documentation and accurate information to achieve compliance with federal requirements.

We found data contained in NHVR's information systems were at times inconsistent and inaccurate, and case records did not always contain all required documentation. Inconsistent and inaccurate data, and missing documentation affected the quality of information available to make appropriate management decisions, gauge its own performance, as well as the information reported to external stakeholders.

**Observation No. 45**

**Ensure Data Are Accurate And Reliable**

NHVR relied on information systems containing at times inconsistent and inaccurate information to support operations, conduct oversight, and allocate resources. Data entered by NHVR staff in the case management system were at times inaccurate, illogical, and incomplete. Unreliable data impacted the integrity of compliance reporting, hindered or limited the use of quality information to support decision-making, and made evaluating management and staff performance difficult. Without a comprehensive data governance strategy containing fully developed data management processes and a consistent commitment to producing quality information, NHVR management could not ensure data were accurate and reliable.

**Compliance Reported And Monitored With Inaccurate And Unreliable Data**

NHVR monitored compliance with federal laws and regulations by reporting data internally and to federal and State oversight bodies. However, the underpinning data in these reports were compromised due to backdating and contained illogical data. Specifically, we found:

- Backdating Made Some Date Fields Unreliable - NHVR allowed counselors to backdate activities such as determining eligibility, completing eligibility extensions, and developing and amending IPEs by up to 14 days in the case management system. Backdating beyond 14 days could be performed only by staff in the central office. Backdating compromised the date field in NHVR information systems, allowing inaccurate data to be used for determining compliance with federal time limits. For example, an IPE completed in the middle of the month could be backdated in the case management system to the beginning of the same month by the counselor, or to the previous month by central office staff. In some cases the date the activity was actually completed appeared compliant because of backdating. Additionally, we found backdating may have far exceeded controls intended in the case management system. For example, we found one IPE that was recorded as completed in the case management system in December 2017 was not signed until nearly two years later.

- Compliance Monitoring Reports Were Hindered By Illogical Data – NHVR was required to provide routine compliance reports to its federal oversight agency. Additionally, NHVR had internal monitoring reports to manage ongoing compliance efforts. However, these reports lacked comprehensive data integrity processes to proactively identify invalid data or reconcile incorrectly reported data demonstrating compliance. For example, the information system controls allowed eligibility extensions to expire before they started, start before required by regulation, last for zero days, and go beyond the timeframe reportedly allowed in the information system. Additionally, NHVR submitted two different compliance reports tallying the total dollar value of comparable benefits within the same time period, but the two reports had a six-fold difference in total dollars.
- Deleted Records Do Not Reflect A Complete Case File – During our review of NHVR data, we identified one IPE that had been deleted from the case file, affecting the completeness of the case record and the data available to management. The customer had been found eligible for services in mid-April 2018 but did not have an effective IPE by the time NHVR implemented the OOS. Case notes showed the customer requested a waiver from the waitlist due to impending job loss and an IPE was developed in July 2018. The customer reportedly received services necessary to maintain employment and was placed back on the waitlist in November 2018; however, in order to do so, central office staff indicated the original IPE was "removed." As a result, the electronic case file displayed the customer's second IPE, developed in April 2019, as the only IPE developed.

**Planning And Forecasting Used Unreliable Data**

During the audit period, NHVR management made critical decisions pertaining to financial and human resources with substantial impacts on customers, staff, and outside stakeholders. Management's ability to make effective decisions was contingent on the quality of information available. We found unreliable data undermined management decisions involving financial and human resources in the following areas:

- Unreliable Data Negatively Impacted Waitlist Forecasting – According to NHVR managers and staff, prior to implementing an OOS, disability priority assignments were less important, less consistent, and received less emphasis partly because there was no waitlist. As a result, this information was not always accurate. NHVR used this information to forecast how much it would cost to serve customers in each priority category on its waitlist, as well as how long, on average, it would take to serve customers in each priority category and when NHVR could potentially exit OOS. Placing customers in disability priority categories that were not supported by documentation in the case record continued to occur after NHVR implemented an OOS. Continued inconsistent categorizing of disability priority assignments will limit the usefulness of this data in future efforts to forecast or assist with waitlist management activities.
- More Accurate Estimated Case Costs Could Have Improved Management's Financial Forecasting Ability – NHVR made the decision to enter OOS largely based historical expenditure and revenue information. Historical data on non-customer expenses, such as salaries and current expenses, provided management useful insights. However, historical data on customer costs were less reliable for forecasting customers' future funding needs

due to the variability in case costs. Each counselor entered cost estimates onto the IPE and start and end dates for services as part of normal business process. Well-developed IPE cost estimates could provide management with quality information about when customer costs were expected to occur and provide an estimate on future funding needs. However, we found IPE cost estimates were inconsistent and even absent for large purchases, including services for at least one customer exceeding $100,000. Consequently, quality IPE cost information was not available for management to estimate more precisely when customer service expenditures would exceed available funding.

- Unreliable Comparable Benefits Data Made Identifying Cost Saving Strategies Difficult – Upon learning NHVR was in financial distress, management made efforts to pursue costs saving measures including ways to limit spending on customer services. The comparable benefits field in the electronic case management system contained information on whether resources outside of NHVR were available and if they were used to support a customer. However, we found NHVR rarely documented or input comparable benefits data into the electronic case management system. Since NHVR staff inconsistently stored reliable data in this field, NHVR could not accurately depend on this information to explore other resource options to maintain the same level of service for customers without exhausting NHVR's financial resources. For example, some post-secondary institutions provided career counseling services which may have overlapped with services NHVR paid vendors to provide for customers attending college. Without reliable data, NHVR management could not measure the cost saving potential or feasibility of pursing a cost avoidance strategy focusing on college career counseling as a comparable benefit.
- Inflated Caseload Sizes Affected Decisions On Counselor Availability – We found limited controls ensuring timely case closure undermined the accuracy of the number of active cases on counselor caseloads. DOE and NHVR management used potentially unreliable caseload size information in determining staffing needs, determining case assignment, and releasing customers off the waitlist. For instance, one counselor maintained a caseload with more than half of their cases being either inactive or could have potentially be closed out.

**Management Could Not Accurately Assess Staff And Organizational Performance**

NHVR used data to monitor activities and staff compliance with policies and federal regulations but did not have a comprehensive performance measurement system to assess activities relative to outcomes. Nevertheless, any performance measurement system was only as good as the data entered into the case management system. For example, a performance measurement system evaluating how timely customers were served or reached their employment goals relied on accurate dates, case closure data, and employment status information. However, date fields were at times unreliable, rehabilitation status was not always supported by documentation in the case record, and employment outcomes were inconsistently verified.

**No Comprehensive Data Governance Strategy**

After an organization has developed goals and objectives, effective data governance requires it to align its information systems to support those objectives. Any information system designed to add value to the organization and support the achievement of objectives requires quality information.

Management must ensure the information system retains quality data by implementing a data governance strategy that creates a commitment to quality data, outlines roles and responsibilities for data management, and develops procedures and strategies to improve data quality.

NHVR did not have a formal strategic plan with clearly defined organizational objectives and goals; therefore, aligning information systems to organizational objectives was difficult. Instead, NHVR managers and staff prioritized entering data into information systems to enable the submission of compliance reports over data accuracy and completeness. However, collecting and maintain unusable data for the primary purpose of completing a required report was inherently inefficient and ineffective. NHVR had other objectives outside of submitting compliance reports, such as managing resources efficiently and ensuring customers were served effectively, but the connection between these other objectives and the implementation of the information system was not communicated in an overarching data governance strategy.

While NHVR management assigned staff specific roles to manage NHVR data and performed some activities to assess data quality, these efforts were not coordinated in a comprehensive strategy adopted by management. NHVR staff responsible for data management were limited in their ability to maintain an information system containing quality information, since data management staff and all users of the information system were not given clear direction, priority, and commitment from management outlining the data quality needs of NHVR. Consequently, we found effective controls to prevent or detect illogical, incomplete, and inaccurate information from being stored in NHVR's information systems were underdeveloped.

**Recommendations:**

**We recommend NHVR develop a comprehensive data governance strategy that includes:**

- **developing organizational objectives, determining the data elements needed to support these objectives, and aligning them to the data collected in the information system;**
- **developing policies, procedures, and training that communicate a commitment to quality information and data needs and priorities of NHVR; and**
- **fully developing procedures to improve data quality for both regulatory compliance and other key organizational objectives.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *This observation repeats all the previous observations related to the area of data governance. This observation could have been deleted as it is covered in every other observation.*
2. *NHVR is very concerned that the audit report asserts that, "Continued inconsistent categorizing of disability priority assignments will limit the usefulness of this data in future efforts to forecast or assist with waitlist management activities." Management staff*

*reviewed the OOS categories and requests from staff to ensure accuracy of disability categories and thus, to the reporting completed.*

3. *Data governance and accuracy is a critical component of the VR program. We collect over 400 data elements that are reported to Rehabilitation Services Administration. The bureau has a comprehensive case management system that captures this data.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

- *The bureau has released a Request for Proposal for the development of an internal quality assurance program where effectiveness and compliance monitoring of all aspects of the vocational rehabilitation program. This work will also include defining specific data management and governance practices. It is the expectation that this work will be developed and implemented by December 2021.*

**LBA Rejoinder:**

**In reference to Remark 3, the federal oversight agency to which NHVR submits reports noted data accuracy and reliability issues with NHVR's case records. In a report encompassing FFYs 2016 through 2018, and released in late 2020, the Rehabilitation Services Administration noted that, for customers achieving an employment outcome in their review, 35 percent of the case records "included some discrepancies or did not have all required documentation."**

**Observation No. 46**

## Improve Records Management

Federal regulations and State law required NHVR to develop an economical records management system to retain records for at least four years, protect the legal and financial rights of the State, safeguard confidential customer information, and allow customers appropriate access to records. NHVR relied on a series of record management review activities and checklists aimed towards achieving federal compliance, which resulted in varying degrees of success. NHVR did not have a comprehensive records management program implemented through policies and procedures, cohesive and complete records, procedures to secure hardcopy files, and methods to allow customer access to files without disclosing protected information. As a result, some of NHVR's records were incomplete or inconsistent.

### Case Records Were Incomplete

NHVR maintained customer records with a mix of hardcopy and electronic files maintained in its case management system. Federal reviewers from the Rehabilitation Services Administration, NHVR's federal oversight agency, verbally commented the mix of records needed improvement, since neither the case management system nor the hardcopy files contained a complete record for each case. Therefore, a review of both simultaneously was the only way to completely review a case. This created an inefficient and sometimes ineffective method for NHVR management to

review complete files, since the absence of a cohesive record allowed for the two records to be in conflict or incomplete. For example, we found:

- Some Signed IPEs Contained In The Hardcopy File Were Different From The IPEs In The Case Management System – Four of 69 IPEs effective in the audit period (six percent) contained a discrepancy between the copy in the electronic file and the hardcopy file which was agreed to and signed by the customer. For example, service dates and selected vendors in the electronic record did not always match those in the hardcopy file which was agreed to and signed by the customer. Therefore, it was not clear whether the customer agreed to the changes in the IPE which was ultimately enacted.
- Medical Documentation Was Often Only Contained In The Hardcopy File – Medical records were not consistently uploaded to the case management system timely or at all. In our review of 39 cases with an eligibility determination made during SFY 2019, 18 cases (46 percent) did not have medical records uploaded electronically. We found an additional six cases (15 percent) where an eligibility recommendation was reviewed by a supervisor prior to medical documents being uploaded to the case management system. This could have created challenges for NHVR upper management and supervisors to effectively review eligibility recommendations timely if hardcopy files were out in the field. Additionally, the medical documentation would not be available if a supervisor outside the regional office where the customer was being served reviewed the eligibility recommendation.
- Documentation Was Added To Some Records After Auditors Requested It For Review – NHVR staff appeared to have added documentation to ten active case files between the time we selected them for review and when review took place. Documents added to the case files included IPEs and annual plan reviews that did not contain the customer's signature, including one case where a customer's signature appeared to have been photocopied onto the IPE. The case had been closed for over a month before our review in September 2019. While the customer's signature had been dated December 2017, the IPE was printed two days before our review in September 2019, making the date of the signature illogical.

NHVR reported the lack of a comprehensive and cohesive records management system was due to technology limitations and the logistical challenge related to the workflow of certain counselors required to frequently travel. NHVR management acknowledged the need to make technology investments to facilitate the transition to a fully electronic records management system and overcome inherent logistical challenges.

**Incomplete Or Missing Files**

NHVR did not have a method to identify or locate missing documentation, resulting in mishandling of some customer files. Federal regulations required NHVR to adopt policies and procedures to safeguard customers' personal information. However, NHVR did not have policies and procedures to ensure hardcopy files were always located in a secure location, tracked when transported outside a State office, and overseen by staff. Consequently, two of the cases we requested for review could not be found, one case where the applicant was a minor when eligibility was determined.

Additionally, one case was missing two of its three hardcopy folders. NHVR eventually located one of the files that was entirely missing 11 months after we requested it for review.

Since hardcopy files usually contained the customer's medical documentation, customer medical documentation was likely contained in all three missing or misplaced files, potentially jeopardizing customer confidentiality, including the privacy of a minor. NHVR staff reported two of the missing cases files were likely misplaced when the counselor assigned to the case left NHVR in mid-2018. According to NHVR central office staff, it was likely the files were not transferred upon the counselor's departure. However, according to the case management system, one of these two case files had never been assigned to this counselor and were instead assigned to active counselors at the time of our file review. NHVR could not determine what happened to the two folders in the last missing file.

**Some Records Contained Other Customers' Information**

The *Code of Professional Ethics for Rehabilitation Counselors* required counselors to make reasonable efforts to correct errors found in case records and not disclose records to customers that may contain information relative to other customers. During our review, we found instances where case files contained information for a different customer. Of the 97 cases we reviewed, we found six instances (six percent) where customer documentation was misfiled, including documentation disclosing the names of customers not associated with the case. Of these six, five cases contained documents intended for another NHVR customer's record and one appeared to disclose the name of a non-customer receiving services from a clinical provider who submitted information to NHVR in error.

Federal regulations required NHVR to allow customers, or their designated representative after obtaining written consent from the customer, to access their file. While it was rare for customers to request their case record for review, misfiled documents could have jeopardized confidentiality by unintentionally allowing access to other customers' information without NHVR knowledge. In one case we reviewed, NHVR allowed a customer's representative access to their case file. NHVR did not appear to have a process to review the file for errors or misfiled documents prior to allowing access to the file. Without a process to routinely review files for misfiled documents prior to allowing access to the file, NHVR may have created additional risks to accidently disclose confidential information.

**External Access To Third-party Records Not Limited**

Federal regulations exempted some information from disclosure to customers, including personal information collected by third-party organizations that was only provided under the conditions established by the third-party. Furthermore, the *Code of Professional Ethics for Rehabilitation Counselors* recommended not directly disclosing personal information collected by third-party organizations, but instead directing the customer to seek information from the original source.

NHVR did not have comprehensive policies and procedures to allow customers access to their files in compliance with these regulations. In one case we reviewed, a customer's representative requested and received access to the customer's file. NHVR staff initially informed the customer's

representative access to third-party assessments in the file may not be allowed. However, after consulting with NHVR management, the customer's representative appeared to have been eventually provided access to the full file including all third-party assessments.

**Recommendations:**

**We recommend NHVR management continue its efforts to transition customer records to a comprehensive electronic records system. Until the transition occurs, NHVR should develop policies and procedures providing guidance on what records are required to be electronically uploaded and set standards defining a complete file.**

**We also recommend NHVR management develop policies and procedures to address:**

- **securing customer files, tracking file movement outside of State offices, and ensuring staff oversight of files;**
- **routinely reviewing files for misfiled documents, remedying issues found, and ensuring confidential information is not disclosed when an external party is seeking to access NHVR files; and**
- **appropriately limiting access to third-party records contained in NHVR files when requested by customers.**

*NHVR Response:*

*We concur, in part with the recommendations. NHVR make the following remarks related to the auditor's observations.*

1. *The bureau has a very complex file system for hard copy files. There has been dedicated staff to manage the hard copy files.*

*The bureau has developed, implemented, or will be implementing the following activities/programs in response to this audit observation:*

*In December 2020, the bureau secured a contract with a vendor to scan all closed cases for the last seven years and all current cases into our case management system. Paper copies of files will no longer exist. A policy and procedure will accompany the new system.*

## CHAPTER 9: OTHER ISSUES AND CONCERNS

In this section, we present issues we considered noteworthy but did not develop into formal observations. The New Hampshire Bureau of Vocational Rehabilitation (NHVR), the Department of Education (DOE), and the Legislature may wish to consider whether these issues deserve further study or action.

### Improve Guidance On Serving Out-Of-State Customers

When determining eligibility, federal regulations prohibited any state vocational rehabilitation (VR) program from establishing "…a duration of residence requirement that excludes from services any applicant who is present in the State." Neither federal regulations nor NHVR rules defined what constitutes an applicant or a customer as being "present" in the State. Besides this requirement pertaining to determining eligibility, no additional law or regulation addressed VR customers relocating between different states or countries while receiving services under an individualized plan for employment (IPE). NHVR policy and training guidance stated the customer had to be able to participate in services to be determined eligible, including attending meetings with the counselor.

In some cases, we found the customer was not, or was rarely, present in New Hampshire and customers relocating outside of New Hampshire created additional service delivery challenges not addressed in policy or training materials. For example, we found the following areas where policy and training may have been lacking:

- Determining Eligibility For Customers In Distant Locations – In one case we reviewed, the customer had lived, worked, and had family located in New Hampshire, but from the time of application submission to case closure the customer was living and working outside of North America. Although the customer had personal connections and relationships in New Hampshire, the customer's physical presence, if any, in New Hampshire was not documented when determining eligibility.
- Shipping Goods To Distant Locations – Customers who were not present in New Hampshire also created logistical challenges associated with providing goods in a cost-effective manner. For example, NHVR paid over $800 in shipping expenses to deliver a good outside North America. The case notes in the electronic case management system did not document whether the counselor considered coordinating the delivery of the good when the customer was present in New Hampshire to avoid additional costs.
- Effectively Serving Customers Located Outside New Hampshire - While it was common for customers to travel outside New Hampshire for employment and educational opportunities, some customers traveled to distant states or sought to establish a more permanent residency outside New Hampshire. For example, one customer lived in five different states over a seven-year period and continuously lived in two states outside New England for over four years. The counselor advised the customer to seek the VR services from their new state in at least one instance, but the customer continued to move and remain

an NHVR customer. The customer reported a need for the counseling services provided by NHVR, but also reported struggling to navigate the job market, social support system, and services for people with disabilities in their new location. Under certain conditions for customers located outside New Hampshire, NHVR counselors may have been less effective than counselors located in the customer's state. It may be beneficial to develop training materials and guidance to assist counselors in recognizing conditions where advocating for a case transfer to another state best serves the customer.

- Avoiding The Overlapping Of Services With An Outside State VR Program – When a customer left New Hampshire, it was not always known when, or if, the customer was seeking or receiving VR services in the new location. Therefore, providing services while a customer was located outside New Hampshire risked the possibility the customer would receive duplicate services or New Hampshire resources were used when another state could provide support. In at least one case we reviewed, NHVR was notified of the customer's intent to move outside New England in June 2019. In August 2019, NHVR allocated funding to support the customer's ongoing college education during the fall 2019 semester. Around the fall 2019 semester, the customer started receiving VR services in their new state. The case remained open in New Hampshire for six months after the customer informed their NHVR counselor they were receiving services from another state. Although we did not find duplication of services in this case, similar cases risked the potential the same services could be provided by both states. More guidance on transferring a case timely to another state could assist counselors in ensuring NHVR resources were not allocated to serve customers of another state VR program and services were not duplicated.

We suggest NHVR management define, in more detail, what constitutes a "presence" in the State and the circumstances that would warrant a limited presence in New Hampshire. For example, determining when NHVR should reevaluate providing services for a customer who is not present in the State. Additionally, we suggest NHVR management improve policies and procedures to address the different challenges associated with serving customers with a limited presence in New Hampshire and increase training on this subject matter.

## Ensure Timely Follow-up On Unliquidated Obligations

NHVR did not ensure unliquidated obligations (ULOs) were resolved timely. ULOs were open authorizations issued by NHVR for services provided to customers. An authorization was open because either NHVR was waiting for the vendor to provide the service or good, or the authorized service or good was provided by the vendor but NHVR had not yet paid the vendor. Since open authorizations represented a commitment of NHVR funds, it was important authorizations were canceled when no longer needed or paid timely if the activity occurred. To monitor ULOs, the central office sent a routine report to the regional offices of all ULOs still open after the authorized service end date had been expired for 30 days. For ULOs still open 60 days after the authorized service end date, NHVR procedures stated the rehabilitation technician should work with the vendor to resolve the open ULO and the counselor must cancel the authorization if the vendor did not provide the service.

As of October 2019, NHVR had 1,542 outstanding ULOs totaling $887,805, averaging $576. Of these outstanding ULOs 164 totaling $35,659 were at least 60 days past the service end date, including 58 totaling $11,314 at least 90 days past. Of the ULOs 90 days past the authorized service end date, we asked NHVR about the delay in payment for the two highest cost and the two oldest. According to NHVR staff:

- The two highest cost ULOs totaled $3,675 and were delayed because NHVR was still waiting for additional information about the service. These two ULOs remained unpaid until 292 and 405 days after the authorized service end date.
- The two oldest ULOs were both open for over 200 days past the authorized service end date. Both authorizations were canceled after we inquired about them because the service had not occurred as expected.

Management did not ensure all ULOs were addressed timely. One NHVR manager reported a combination of staff turnover and an over-reliance on staff to address ULOs timely without regular oversight likely resulted in outdated ULOs. In the absence of consistent management oversight, different regional offices developed their own informal practices for reviewing and prioritizing follow-up on ULOs with varying degrees of success. Additionally, the ULO report was only sent to rehabilitation technicians in the regional offices and NHVR management in the central office. Finally, the ULO report did not identify individual counselors with old or costly ULOs on their caseload.

We suggest NHVR strengthen management oversight of ULOs by improving follow-up procedures and training management on their role in ensuring ULOs are addressed timely.

## Ensure Internal Controls For Payment Subsystem Are Accurately Reported And Followed

State agencies seeking to operate a payment system external to NHFirst, were required to obtain approval from the Department of Administrative Services (DAS). As part of the approval process, DAS required agencies to describe the internal control system in place to ensure payments were valid and attest to the accuracy of the control system by submitting the *Certification of Payment System Controls* form. If approved, the system would bypass DAS pre-approval processes.

In June 2015, the DOE received approval from DAS to utilize NHVR's electronic case management system for issuing customer service payments outside of NHFirst. However, the internal control system described by DOE was inconsistently documented in policy and inadequately implemented in practice. We found inconsistencies between the control system described in the certification form filed with the DAS and the control system in practice.

- The DOE reported it would verify that vendors completed the work performed prior to paying an invoice. However, our file review found $145,704 of $244,094 in vendor services (60 percent) paid during the audit period did not have an accompanying vendor report describing and documenting the service provided.

- The DOE reported it would follow-up with customers to ensure goods and services were received. However, our file review found $147,045 of $483,926 in vendor services and customer goods (30 percent) paid during the audit period did not contain documentation of follow-up with the customer to ensure the services or goods were received.
- The DOE reported it would conduct internal audits of accounts payable documents in addition to reviewing payments prior to issuance. However, NHVR had no internal audit policy or process to periodically review accounts payable documents for accuracy of payments after issuance.

It is management's responsibility to establish internal control activities. Management's understanding of control activities should be accurate and reflect its actual practices. Furthermore, stakeholders tasked with financial oversight, such as DAS, required accurate information to effectively assess the control design before approving a sub-system outside the State's system. DOE and NHVR should either: 1) implement the internal control system described to DAS; or 2) revise the *Certification of Payment System Control* form submitted to DAS to accurately reflect the internal control system in operation.

## Ensure Employees' Headquarters Are Approved By The Commissioner

One employee was documented as working in the central office in Concord according to the NHVR organizational chart and the State human resource system. However, this employee recorded their headquarters as a regional office. In practice, the employee split time between the regional office and the central office. The *Manual of Procedures*, issued by DAS, required approval from the DOE Commissioner, or designee, for a headquarters designation; however, NHVR did not have documentation the Commissioner approved this deviation from the organizational chart.

NHVR budgeted approximately $11,900 a year in travel expenses to accommodate this headquarters assignment, including $5,300 in hotel accommodations. Additionally, by not requiring the employee to report to the headquarters designated on the NHVR organizational chart, an estimated $12,800 a year in salary and benefit appropriations were allocated towards employee travel time instead of direct program oversight.

NHVR should either: 1) require all employees to report to the headquarters designated on the organizational chart; or 2) obtain required approval from the Commissioner to assign the regional office as employees' headquarters.

## APPENDIX A
## SCOPE, OBJECTIVES, AND METHODOLOGY

### Scope And Objectives

In July 2018, the Fiscal Committee approved a Legislative Performance Audit and Oversight Committee (LPAOC) recommendation to conduct a performance audit of the New Hampshire Bureau of Vocational Rehabilitation (NHVR), which is within the Division of Workforce Innovation under the Department of Education (DOE). We held an entrance conference with the DOE and NHVR at beginning of March 2019. The LPAOC approved our scope statement at its June 2019 meeting. Our audit was designed to answer the following question:

**Did the NHVR operate efficiently and effectively from State fiscal years (SFY) 2017 to 2019?**

Specifically, we evaluated the efficiency and effectiveness of NHVR's processes for:

- tracking and monitoring program costs,
- reviewing program performance and program outcomes, and
- monitoring compliance with program requirements.

### Methodology

To gain an understanding of NHVR's financial operations, monitoring activities, and actions pertaining to NHVR implementing an the order of selection (OOS), we:

- interviewed staff and obtained documentation to understand the events leading up to and occurring after NHVR entered the OOS;
- assessed the reasonableness of NHVR's reported financial status, and financial actions taken both before and after entering the OOS;
- interviewed staff and reviewed data pertaining to the financial reporting and financial monitoring systems implemented by NHVR; and
- assessed primary weaknesses in financial controls which resulted in the need to reduce expenditures and enter the OOS.

To gain an understanding of NHVR's activities and its operating and control environment, we:

- reviewed federal laws and regulations, State laws affecting NHVR responsibilities and activities, administrative rules, the NHVR's budget information and personnel supplemental job descriptions, NHVR policies and procedures, NHVR training materials, New Hampshire reports and studies pertaining to NHVR activities, news articles regarding NHVR activities, and prior LBA audits related to NHVR activities;
- reviewed audits of other states' vocational rehabilitation programs;

- visited all five regional offices and interviewed five central office management staff, 11 regional office staff, the DOE Commissioner, and DOE staff with duties pertaining to NHVR activities;
- observed two State Rehabilitation Council meetings and reviewed minutes from 14 meetings; and
- observed 14 federal Rehabilitation Services Administration monitoring sessions of NHVR and reviewed reports issued by the federal oversight agency.

To determine efficiency and effectiveness of NVHR's activities and relevant internal controls, we:

- conducted reviews of both hardcopy and electronic case files of cases active during the audit period to determine whether decisions made pertaining to eligibility, individualized plan for employment (IPE) development, service provision, and case closure were consistent and compliant with federal, State, and NHVR requirements;
- analyzed unaudited NHVR data related to eligibility, IPEs, case closures, post-employment services, Social Security Administration billing, incentive payments, and unliquidated obligations to determine compliance with requirements or identify trends;
- analyzed training materials, policy documents, administrative rules, service agreements, and NHVR produced reports to determine consistency, comprehensiveness, and completeness;
- conducted a survey of NHVR counselors to solicit their input; and
- conducted a survey of nearby states' vocational rehabilitation agencies to determine vocational rehabilitation processes.

To understand NHVR's implementation of laws, regulations, policies, processes, and service delivery methods, we conducted multiple file reviews of customer case records. NHVR stored case record information both in hardcopy paper files and electronically in its case management system. We conducted one primary file review and requested access to hardcopy records, which were reviewed in conjunction with the information stored in the electronic case management system to examine a complete case record. However, when appropriate and necessary to complete audit objectives, we pulled additional samples and conducted additional reviews using only information stored in the electronic case management system.

***Review Of Hardcopy And Electronic Customer Records***

We received a list of 11,816 customers with an case active during the audit period, of which 2,032 customers were considered potentially eligible customers and 9,784 were determined eligible customers. Our customer file review sample included a mix of random cases, subjectively selected cases, and subjective sub-samples to ensure a diversity of regional offices were represented in our review. We further stratified the sample by regional office and chose a sample based on each regional office's percentage of the entire caseload. Therefore, we sampled fewer cases from regional offices with smaller volume of the total cases, and more cases from regional offices with higher volume.

Our original sample included 150 cases; however, due to time constraints we collected information for 97 cases, 57 cases with application dates prior to the OOS and 40 cases during the OOS. Our sample was designed to test the control environment in place prior to and during the OOS, consistency among regional offices, controls over different types of services, and additional controls in place pertaining to high-risk cases. Our sample was not designed to be statistically representative and we did not intend to project the results to the general population of customers receiving NHVR.

Our sampling methodology identified subsets for review. Since subsets could overlapped (e.g., high-cost cases and cases with vehicle medications), we used procedures to try to prevent duplicate cases from being selected in our final sample. Our sample was selected using the following procedures:

- Random Selection Of Cases Before And After OOS – Based on 9,784 customers who had been determined eligible for services, we used a 90 percent confidence level and a ten percent margin of error. We calculated a sample size of 80 case files. However, the random sample was not designed to be statistically significant. To compare controls before OOS and after OOS, 40 cases were randomly selected with an application date before May 1, 2018, and 40 cases were randomly selected with an application date on or after May 1, 2018. Due to time constraints, our final review included 39 post-OOS cases and 28 pre-OOS cases.
- Subjective Selection Of Cases With Vehicle Modifications – The NHVR identified a universe of 59 cases open during the audit period which had vehicle modifications. We subjectively selected ten of the costliest vehicle modification cases including at least one case from each regional office. After selecting our sample, we eliminated one case because the customer eventually did not complete a vehicle modification. Our final review included four vehicle modification cases. During our review of cases in our other subsets, we found some contained vehicle modifications. We collected vehicle modification information from these cases and added them to our analysis. In total, we analyzed eleven vehicle modifications, four from our original sample, and seven identified through the other samples.
- Subjective Selection Of High-cost Cases – We subjectively selected the ten costliest cases from the dataset, specifically excluding cases identified by NHVR as having vehicle modifications. We collected information for all ten cases.
- Subjective Selection Of Cases Open For A Long Time– We subjectively selected ten cases open for longer than ten years and stratified the sample to ensure the longest case, or cases, within each regional office were selected. Due to time constraints, we collected information for four cases.
- Subjective Selection Of Ineligible Applicants And Customers – NHVR's data contained a universe of 249 applicants and customers whose cases were closed for ineligible reasons. We subjectively selected a stratified sample of 20 files ensuring a case from each regional office was included. Due to time constraints, we collected information for eight cases.
- Random Selection Of Cases With Pre-employment Transition Services (Pre-ETS) – We randomly selected 20 Pre-ETS cases, ten cases were determined potentially eligible and

ten were already determined eligible. Three cases selected as part of our sample were for students who only participated in Pre-ETS workshops provided by NHVR. These cases did not have a corresponding hardcopy file and contained little information in the electronic case record. We eliminated these files from our review. Due to time constraints we collected information for four Pre-ETS cases.

***Review Of Unaudited Data From The Electronic Case Management System***

We conducted multiple reviews of only electronic records in the electronic case management system. These reviews did not include documents that may have been contained in the hardcopy file. Our samples were not intended to be statistically representative of the entire population, nor do project these results to the entire population of cases. In addition to electronic case reviews, we conducted analyses of electronic case management system data from July 2015 and June 2019 to determine compliance with the 60-day time limit to determine eligibility or file an extension. Additionally, we assessed the same dataset for compliance with NHVR's 120-day standard, the federal 90-day time limit, and NHVR's 90-day standard, as applicable, to assess timeliness of IPE development. Our samples were not designed to be statistically representative and we did not project the findings to the general population.

- Sample Of Eligibility Determinations Made Within 60 Days With Extensions – Our review focused eligibility determination and eligibility extension requirements. We identified 30 cases with eligibility determinations made within 60 days, but also had extensions. We subjectively selected eight of the 30 cases for additional review including at least one from each regional office and one case from the Services for the Blind and Visually Impaired (SBVI) unit.
- Sample Of Eligibility Determinations Made After 60 Days Under Expired Extensions – We identified 146 cases with eligibility determinations made after 60 days, under expired extensions. Our review focused on information relevant to eligibility determination requirements and eligibility extension requirements. We subjectively selected ten of the 146 cases for additional review: five cases where the extension was expired for 60 to 99 days, and five cases where the extension was expired for 100 or more days.
- Sample Of Eligibility Determinations Made Within Five Days Of The Time Limit – We identified 398 cases without extensions had eligibility determinations made 56 to 60 days after customer application, between June 2018 and June 2019. Our review focused on information relevant to eligibility determination requirements and timeliness of decision-making. We subjectively selected 12 cases for additional review: two cases from five regional offices, where each office had an average eligibility time greater than 50 days; and one case from one regional office and from the SBVI unit, where each office or unit had an average eligibility time of less than 50 days.

***Review Of Counselor Caseloads***

NHVR provided information on all counselors' caseloads as of October 2019. Our review focused on information relevant to case progress, customer contact, case closure, and post-employment services. We subjectively selected two caseloads for analysis: one caseload with a relatively high

number of cases (164 cases), and one caseload with a relatively low number of cases (69 cases). We identified 36 cases active prior to July 2015, 208 cases active at some point between July 2015 and June 2019, and all 233 cases active in October 2019. Our sample was not designed to be statistically representative and we did not project the findings to the general population.

***Review Of Incentive Payments Paid To Vendors***

We conducted an analysis of all incentive payments in the case management system from SFYs 2016 through 2018. From this universe, we subjectively selected five customers whose cases contained multiple incentive payments which were paid to a vendor within 90 days. We reviewed these payments to determine if they were correctly calculated and if the additional payment was a duplicate. Our sample was not designed to be statistically representative and we did not intend to project the results to the general population of vendors receiving incentive payments.

***Review Of Weekly Case Monitoring Reports***

We reviewed weekly case monitoring reports issued by NHVR from September 27, 2017, through October 25, 2019. Weekly case monitoring reports contained cases: 1) in which eligibility determinations were not completed within 60 days of the application date, 2) in which IPEs were not completed within 90 days of the eligibility date, 3) currently in eligibility extension status, 4) active under an expired initial eligibility extension, 5) currently in IPE extension status, 6) active under an expired initial IPE extension, 7) active under an expired IPE, 8) identified as having a customer in stable employment for more than 120 days, and 9) over 90 days without a case note entered into the case management system. We did not review the weekly case monitoring reports to determine how many reports were issued, or were missing, for each of these categories during the time period specified. However, to determine certain compliance rates and effectiveness of the reports, we conducted analysis as needed under each category.

*Reports Showing 90-Day Without A Case Note*

From September 2017 through October 25, 2019, NHVR issued 97 weekly case reports showing gaps in case notes being entered into the electronic case management system. Prior to June 22, 2018, NHVR issued summary information but not the actual cases overdue for a case note. Therefore, reports issued from September 2017 until June 22, 2018, were excluded from our review to determine cases repeatedly appearing on the case reports. We found 66 applicable weekly case monitoring reports of the 97 total reports. Beginning with the report issued on October 25, 2019, we identified and documented how many times each case was consistently reported on previously issued weekly case reports without being addressed. Once cases were removed or addressed, we did not determine how many of those cases returned to the reports or for what length of time the cases remained on reports. In our review of all 97 reports, we calculated the number of counselors noted on more than 50 percent of the reports as well as the average of 30 or more cases on each prior to the OOS from September 2017 through April 2018 and during the OOS from June 2018 through October 2019.

*Reports Showing 60 Days Due For An Eligibility Determination And Eligibility Extension Status*

We subjectively selected cases appearing on the weekly case monitoring reports pertaining to eligibility determinations and extensions to further review these cases in the electronic case management system. Our subjective sample was not designed to be statistically representative and we did not project the findings to the general population. Our samples included:

- Eligibility Determination Time Limits – We subjectively selected 12 cases that appeared on multiple monitoring reports between September 2017 and June 2019, focusing our review on information relevant to eligibility determination time limit requirements and supervisory review.
- Eligibility Extension Status – We subjectively selected 13 cases that appeared on multiple monitoring reports between September 2017 and October 2019, focusing our review on information relevant to eligibility extension requirements.

***Survey Of Vocational Rehabilitation Counselors***

We surveyed 31 Vocational Rehabilitation Counselors (VRC) to understand NHVR processes and practices. NHVR provided email addresses for 30 VRCs employed as of June 2019. We initially sent the survey to all 30 VRCs. However, when launching the survey in October 2019, a recently hired VRC not included in the June 2019 list contacted us and was added to the survey population. Therefore, our survey population was 31 VRCs.

***Survey Of Other State Vocational Rehabilitation Programs***

We surveyed 17 other state vocational rehabilitation programs, representing 10 different states. The ten states selected included 17 different vocational programs, since seven states selected had separate programs for providing general vocational rehabilitation services and services focused towards blind or visually impaired individuals. The ten states were subjectively selected based on similarities to New Hampshire and NHVR including: statewide population, federal grant award, and when they entered an order of selection. When finalizing the sample, preference was given to states in close geographic proximity to New Hampshire.

## APPENDIX B
## SURVEY OF NH VOCATIONAL REHABILITATION COUNSELORS

We sent surveys to all 31 vocational rehabilitation counselors (VRC Is, VRC IIs, and VRC IIIs) employed by the New Hampshire Bureau of Vocational Rehabilitation (NHVR) as of October 2019. We received 25 complete responses for an 81 percent response rate. We combined and simplified similar answers to open-ended questions and presented them in topical categories; multipart responses were counted in multiple categories where applicable. Some totals in the following tables may not add up to 100 percent due to rounding or where respondents could respond multiple times to the same question.

| **Question 1. What is your current position title?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Vocational Rehabilitation Counselor (RC) I | 12 | 48.0 |
| Vocational Rehabilitation Counselor (RC) II | 9 | 36.0 |
| Vocational Rehabilitation Counselor (RC) III | 4 | 16.0 |
| I am not a RC | 0 | 0.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 2. How clear and understandable are NHVR administrative rules (Ed 1000)?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very clear and understandable | 13 | 52.0 |
| Somewhat clear and understandable | 11 | 44.0 |
| Neither clear nor understandable | 0 | 0.0 |
| I am not familiar with NHVR rules | 1 | 4.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 3. In which areas are NHVR administrative rules (Ed 1000) not clear and understandable? (Please select all that apply.)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Eligibility determinations | 3 | 27.3 |
| Eligibility extensions | 1 | 9.1 |
| Disability priority assignment | 5 | 45.5 |
| IPE development | 2 | 18.2 |
| IPE amendments | 1 | 9.1 |
| IPE extensions | 2 | 18.2 |
| Service provision | 4 | 36.4 |
| Case closure | 2 | 18.2 |
| Other (please specify) | 3 | 27.3 |
| ***respondent answered question*** | **11** | |
| ***respondent skipped question*** | **14** | |

| **Question 3. Text Responses, Other:** | **Count** |
|---|---|
| Waivers. | 1 |
| Measurable skills gained, annual reviews, and financial needs assessments. | 1 |
| Trial work. | 1 |
| ***provided comment*** | **3** |

| **Question 4. Please provide a comment to clarify your response.** | |
|---|---|
| **Comments** | **Count** |
| Difficult to understand the waiver process, what type of justification is needed, who has final approval. | 1 |
| The data entry requirements, with associated justifications regarding processes is cumbersome. As an RCI adding the layer of approval requirements increases the amount of data entry needed. | 1 |
| Not always sure if someone is Most Significant Disability. | 1 |
| ***provided comment*** | **3** |

| **Question 5. How clear and understandable are NHVR policies and procedures?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very clear and understandable | 13 | 52.0 |
| Somewhat clear and understandable | 9 | 36.0 |
| Neither clear nor understandable | 2 | 8.0 |
| I am not familiar with NHVR policies and procedures | 1 | 4.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| Question 6. In which areas are policies and procedures not clear and understandable? (Please select all that apply.) | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Eligibility determinations | 3 | 27.3 |
| Eligibility extensions | 0 | 0.0 |
| Disability priority assignment | 3 | 27.3 |
| IPE development | 1 | 9.1 |
| IPE amendments | 0 | 0.0 |
| IPE extensions | 1 | 9.1 |
| Service provision | 2 | 18.2 |
| Signature authority/supervisory review | 3 | 27.3 |
| Case closure | 2 | 18.2 |
| Other (please specify) | 5 | 45.5 |
| ***respondent answered question*** | **11** | |
| ***respondent skipped question*** | **14** | |

| Question 6. Text Responses, Other: | Count |
|---|---|
| Waivers. | 1 |
| Too many gray areas. | 1 |
| Driving education. | 1 |
| Use of technology. | 1 |
| None. | 1 |
| ***provided comment*** | **5** |

| Question 7. Please provide a comment to clarify your response. | |
|---|---|
| **Comments** | **Count** |
| What justification is needed. | 1 |
| Helping students obtain assistance with driving is sometimes confusing. | 1 |
| Not consistent. | 1 |
| Case management is now complicated due to the addition of waitlist. | 1 |
| Use of technology in rehab services, like using phone to text, etc. | 1 |
| Too many changes too frequently of the "right" way to do something. | 1 |
| ***provided comment*** | **6** |

| Question 8. In your experience, how frequently does management ensure policies and procedures are consistently applied? | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Always | 10 | 40.0 |
| Often | 11 | 44.0 |
| Sometimes | 2 | 8.0 |
| Rarely | 2 | 8.0 |
| Never | 0 | 0.0 |
| I don't know | 0 | 0.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 9. In your experience, in which areas did management not always ensure policies and procedures were consistently applied? (Please select all that apply.)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Eligibility determinations | 3 | 20.0 |
| Eligibility extensions | 3 | 20.0 |
| Disability priority assignment | 4 | 26.7 |
| IPE development | 2 | 13.3 |
| IPE amendments | 3 | 20.0 |
| IPE extensions | 3 | 20.0 |
| Service provision | 6 | 40.0 |
| Signature authority/supervisory review | 3 | 20.0 |
| Case closure | 7 | 46.7 |
| Other (please specify) | 5 | 33.3 |
| ***respondent answered question*** | **15** | |
| ***respondent skipped question*** | **10** | |

| **Question 9. Text Responses, Other:** | **Count** |
|---|---|
| Waivers. | 1 |
| Not applicable. | 2 |
| Use of technology in VR process. | 1 |
| VRC training. | 1 |
| ***provided comment*** | **5** |

| **Question 10. Please provide a comment to clarify your response.** | |
|---|---|
| **Comments** | **Count** |
| Not consistent application of the process. | 1 |
| Not applicable. | 2 |
| Changing, unclear, or limited guidance. | 3 |
| In the past, our agency allowed purchases/services that were not necessary; driven by policy, and as a result, the participants have false expectations about what our agency can provide. | 1 |
| Management paid little to no attention to work in these areas. | 1 |
| Due to short staff, limited time for training. | 1 |
| ***provided comment*** | **9** |

| **Question 11. Overall, what is your level of satisfaction with internal training sessions?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very satisfied | 2 | 8.0 |
| Satisfied | 9 | 36.0 |
| Neither satisfied nor dissatisfied | 6 | 24.0 |
| Dissatisfied | 6 | 24.0 |
| Very dissatisfied | 2 | 8.0 |
| I have never attended an internal training session | 0 | 0.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 12. How frequently have internal training sessions provided information needed to appropriately perform your job responsibilities?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Always | 4 | 16.0 |
| Often | 7 | 28.0 |
| Sometimes | 10 | 40.0 |
| Rarely | 4 | 16.0 |
| Never | 0 | 0.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 13. In which areas have training sessions not always provided needed information? (Please select all that apply.)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Eligibility determinations | 6 | 28.6 |
| Eligibility extensions | 4 | 19.0 |
| Disability priority assignment | 5 | 23.8 |
| IPE development | 7 | 33.3 |
| IPE amendments | 3 | 14.3 |
| IPE extensions | 3 | 14.3 |
| Service provision | 10 | 47.6 |
| Signature authority/supervisory review | 1 | 4.8 |
| Case closure | 6 | 28.6 |
| Other (please specify) | 6 | 28.6 |
| ***respondent answered question*** | **21** | |
| ***respondent skipped question*** | **4** | |

| **Question 13. Text Responses, Other:** | **Count** |
|---|---|
| Measurable skill gains. | 2 |
| None. | 1 |
| Question and answer. | 1 |
| Internal process and AWARE changes. | 1 |
| ***provided comment*** | **6** |

| **Question 14. Please provide a comment to clarify your response.** | |
|---|---|
| **Comments** | **Count** |
| Still unclear as to how to document goals, and what qualifies as a credential. | 1 |
| None. | 1 |
| Given the individual nature of the work involved to serve each participant, it may be necessary to discuss individual needs related to particular services or procedures. | 1 |
| This is a broad area that includes a lot of things. | 1 |
| We tend to learn from each other in our offices rather than having agency trainings, which sometimes suffices, but then offices don't always do things the same. Some supervisors interpret the regulations and guidance differently and thus, the message isn't always consistent. | 1 |
| Applying policy to practice. | 1 |
| Being totally clear on Significant Disability and Most Significant Disability. | 1 |
| As of this past year, we have had to have training on the new procedures, in a very rapid manner. This has caused discrepancies with established metrics to be sidelined with no provision for rectifying. | 1 |
| Not all questions are answered. | 1 |
| Internal process and AWARE changes. | 1 |
| ***provided comment*** | **10** |

| **Question 15. To what extent have training materials been useful in performing your job responsibilities?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very useful | 4 | 19.0 |
| Moderately useful | 10 | 47.6 |
| Slightly useful | 5 | 23.8 |
| Not useful | 2 | 9.5 |
| ***respondent answered question*** | **21** | |
| ***respondent skipped question*** | **4** | |

| **Question 16. How frequently are physical or mental health records provided with sufficient information for you to determine an applicant has an impairment constituting or resulting in a substantial impediment to employment?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Always | 1 | 4.8 |
| Often | 14 | 66.7 |
| Sometimes | 5 | 23.8 |
| Rarely | 1 | 4.8 |
| Never | 0 | 0.0 |
| I don't know | 0 | 0.0 |
| ***respondent answered question*** | **21** | |
| ***respondent skipped question*** | **4** | |

| **Question 17. When physical or mental health records provided do not include sufficient information for you to determine an applicant has an impairment constituting or resulting in a substantial impediment to employment, how do you typically respond?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Request additional physical or mental health records | 12 | 60.0 |
| Make a determination that the impairment constitutes or results in a substantial impediment to employment by other means (e.g., interview client or family members) | 4 | 20.0 |
| Other (please specify) | 4 | 20.0 |
| ***respondent answered question*** | **20** | |
| ***respondent skipped question*** | **5** | |

| **Question 17. Text Responses, Other:** | **Count** |
|---|---|
| Multiple methods depending on situation, more records, interviews/questions to participant or important partners, testing. | 1 |
| Request additional testing. | 2 |
| If the response time is within the first 4 weeks of eligibility, I will request additional documentation. If it is later in the eligibility process, I will make a determination based upon my observations during the initial interview client and/or family members. | 1 |
| ***provided comment*** | **4** |

| **Question 18. Please provide a comment to clarify your response.** | |
|---|---|
| **Comments** | **Count** |
| Work with clinical providers to get clarification. | 2 |
| We may have to provide the testing to get a clear picture of a person's abilities. | 1 |
| Work with the information received and the client to reach a determination. | 2 |
| Because I have a diagnosis, I have to find them eligible, but do not have enough for functional limitations, putting them in a lower priority than they actually are. | 1 |
| We have been told varying things on how to deal with this. If within the 60 days, I request additional information in the form of records. We have been told not to make the determination based on other means. We have been told the records need to spell out the functional limitations, which is extremely rare, difficult and time consuming for the counselor to chase records. | 1 |
| ***provided comment*** | **7** |

| **Question 19. Which of the following factors do you primarily consider when determining whether to provide a service yourself or contract it out, such as through a Community Rehabilitation Program (CRP)? (Please select all that apply.)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Caseload size | 9 | 42.9 |
| Cost of services | 5 | 23.8 |
| Client disability and functional limitations | 15 | 71.4 |
| My own skills and abilities | 7 | 33.3 |
| Other (please specify) | 4 | 19.0 |
| ***respondent answered question*** | **21** | |
| ***respondent skipped question*** | **4** | |

| **Question 19. Text Responses, Other:** | **Count** |
|---|---|
| Specifically, to Community Rehabilitation Programs – level of supportive services needed, level of community job development and related assistance. | 1 |
| My time availability. | 1 |
| Our territory is very large and not conducive to our doing it ourself. | 1 |
| Filing the need to spend Pre-Employment Transition Services funds. | 1 |
| ***provided comment*** | **4** |

| **Question 20. In which of the following areas do you currently have signature authority/AWARE rights? (Please select all that apply.)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Eligibility determinations | 5 | 20.0 |
| IPE development | 11 | 44.0 |
| Authorizations | 13 | 52.0 |
| I do not have any signature authority | 12 | 48.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 21. What threshold do you currently have for IPE signature authority/AWARE rights?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| I have no signature authority and require supervisory approval | 14 | 56.0 |
| I can approve IPEs and amendments up to $5,000 | 1 | 4.0 |
| I can approve IPEs and amendments up to $10,000 | 9 | 36.0 |
| I can approve IPEs and amendments up to $20,000 | 0 | 0.0 |
| I am unsure of the threshold | 1 | 4.0 |
| Other (please specify) | 0 | 0.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 22. Which costs are used to calculate and apply the IPE signature authority/AWARE rights threshold?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Total cost, regardless of payer | 8 | 72.7 |
| NHVR costs only | 2 | 18.2 |
| I am not sure | 1 | 9.1 |
| Other (please specify) | 0 | 0.0 |
| ***respondent answered question*** | **11** | |
| ***respondent skipped question*** | **14** | |

| **Question 23. When you apply the IPE signature authority/AWARE rights threshold, is it for the cost of each individual IPE and its amendments, or the cost for all IPEs and amendments across the case?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Individual IPEs and amendments | 6 | 54.6 |
| Aggregated case (all IPEs and amendments) | 4 | 36.4 |
| I am not sure | 1 | 9.1 |
| Other (please specify) | 0 | 0.0 |
| ***respondent answered question*** | **11** | |
| ***respondent skipped question*** | **14** | |

| **Question 24. Under what circumstances do you meet clients in a location other than the regional office?** | |
|---|---|
| **Comments** | **Count** |
| I frequently travel. | 6 |
| Convenience for client. | 2 |
| School setting. | 11 |
| Library setting. | 4 |
| Employment security setting. | 7 |
| Transportation barrier exists. | 8 |
| Client's disability impacts transportation. | 4 |
| Local non-profit. | 1 |
| Meeting referral provider. | 1 |
| All circumstances. | 1 |
| None. | 1 |
| ***provided comment*** | **25** |

| **Question 25. How do you document that a client has obtained competitive employment?** | |
|---|---|
| **Comments** | **Count** |
| Pay stub. | 17 |
| Employment verification. | 3 |
| Case note. | 8 |
| Community rehabilitation program report. | 5 |
| Communication with client. | 5 |
| Employment page in AWARE. | 3 |
| Placement notification form. | 5 |
| Pay stub with start date. | 1 |
| Information from Employment Security. | 1 |
| Tax return. | 1 |
| Profit or loss statement. | 1 |
| I don't. | 1 |
| ***provided comment*** | **24** |

| **Question 26. How frequently do you review your entire caseload to identify cases for potential closure?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Every month or less | 16 | 64.0 |
| Every two to three months | 5 | 20.0 |
| Every four to eleven months | 1 | 4.0 |
| Every year | 1 | 4.0 |
| Never | 0 | 0.0 |
| Other (please specify) | 2 | 8.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 26. Text Responses, Other:** | **Count** |
|---|---|
| Weekly reviewing activity dues. | 1 |
| ***provided comment*** | **1** |

| **Question 27. How clear were expectations of your job performance, including the outcomes you were expected to achieve?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very clear | 9 | 36.0 |
| Moderately clear | 10 | 40.0 |
| Slightly clear | 2 | 8.0 |
| Not clear | 4 | 16.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 28. For what reason were expectations of your job performance not very clear?** | |
|---|---|
| **Comments** | **Count** |
| Operations change frequently. | 4 |
| No clear numbers on amount of referrals a month or other measurable activities. | 1 |
| New federal regulations are unclear. | 2 |
| Not applicable. | 3 |
| Expectations are clear. | 1 |
| Thought there would be more counseling. | 1 |
| The longer you stay in this position the more you question your abilities and communication is not clear. | 1 |
| Unsure how to access clarification regarding case status, case movement, amount of intakes, etc. | 1 |
| NHVR often jumps from one priority (crisis) to another. | 1 |
| Caseload sizes have changed dramatically. | 1 |
| Training opportunities have been eliminated. | 1 |
| I don't know exactly what is expected of me. | 1 |
| ***provided comment*** | **15** |

**Question 29. To what degree does your current caseload allow you adequate time to contact your clients at least every two months and update case notes at least every three months?**

| **Answer Options** | **Count** | **Percent** |
|---|---|---|
| Always | 5 | 20.0 |
| Often | 6 | 24.0 |
| Sometimes | 9 | 36.0 |
| Rarely | 4 | 16.0 |
| Never | 1 | 4.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 30. How effectively does your regional leader communicate to ensure your regional office achieves its overall responsibilities?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very effectively | 13 | 52.0 |
| Effectively | 7 | 28.0 |
| Neither effectively nor ineffectively | 2 | 8.0 |
| Ineffectively | 0 | 0.0 |
| Very ineffectively | 1 | 4.0 |
| I don't know | 2 | 8.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 31. How effectively does the Central Office communicate to ensure your regional office achieves its overall responsibilities?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very effectively | 2 | 8.0 |
| Effectively | 11 | 44.0 |
| Neither effectively nor ineffectively | 6 | 24.0 |
| Ineffectively | 3 | 12.0 |
| Very ineffectively | 2 | 8.0 |
| I don't know | 1 | 4.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 32. How effectively is NHVR managed?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Very effectively | 2 | 8.0 |
| Effectively | 9 | 36.0 |
| Neither effectively nor ineffectively | 10 | 40.0 |
| Ineffectively | 4 | 16.0 |
| Very ineffectively | 0 | 0.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 33. Please provide a comment to clarify your response:** | |
|---|---|
| **Comments** | **Count** |
| Director, regional leader, and other administrative staff always available to answer questions and offer guidance. | 1 |
| I feel our management doesn't provide us with adequate information about changes to how we operate. I think we need to have quarterly whole staff meetings to allow us to be more cohesive within our agency. There feels like a disconnect between management, counselors/rehab techs, and other support staff. I'd like to hear from management as things ebb and flow. For example, as this audit has been taking place, my work is being scrutinized (not a bad thing), but as the agency is learning they should be telling us as a whole what to do correctly/differently not one person at a time. There is a lot of reactive vs. proactive communication, which makes us less effective as a team. | 1 |
| As I mentioned in previous comments, sometimes there are unclear or mixed messages from administration. | 1 |
| The director lacks some leadership skills at times of crisis (going into order of selection and being on vacation). | 1 |
| The current DOE Chairman indicated that as an organization the agency was "immature" in its oversite. This leads me to believe that the agency was not managed very well. | 1 |
| For those of us who have been here several years, we have seen a lot that could have been prevented if management had a better understanding of the work the counselors do, and, in turn, figured out processes that worked for all. Currently central office makes policies based on their knowledge of the VR system and rules and regulations, but not because they have an accurate understanding of the work we do and the problems we face when doing it. | 1 |
| Since we have much more oversite of funding being spent and programs running, it seems smoother. | 1 |
| ***provided comment*** | **7** |

| **Question 34. Do any gaps exist in management oversight and policies which could allow an unethical RC or rehabilitation technician to commit fraud or to waste NHVR resources without detection by management (e.g., stealing goods, purchasing unnecessary services, etc.)?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No – I have no knowledge of any gaps that could allow for fraud or waste of NHVR resources | 15 | 60.0 |
| I am not sure | 9 | 36.0 |
| Yes – (Please describe a gap which could allow for undetected fraud or waste) | 1 | 4.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 34. Yes – (Please describe a gap which could allow for undetected fraud or waste):** | **Count** |
|---|---|
| As an RCI, every decision is reviewed and scrutinized. It seems that RCII has discretion up to $10,000 on an IPE or authorizations. | 1 |
| ***provided comment*** | **1** |

| **Question 35. Are there any ways in which NHVR operations could be made more efficient or effective?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No | 9 | 36.0 |
| Yes (please specify) | 16 | 64.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| **Question 35. Text Responses, Other:** | **Count** |
|---|---|
| Streamline the purchase order process, reduce data collection, and paperwork. | 1 |
| If working remotely, counselors require up to date technology such as scanning, signature pads, etc. | 1 |
| Addressing staffing needs relative to counselors and large caseload sizes. | 5 |
| More effective training. | 2 |
| A lack of effective communication exists. | 2 |
| More training opportunities for all VRCs. In addition, I feel that the training new counselors receive is not adequate. We used to have a New Counselor Training that was held in Concord. It was in a classroom format with a face-to-face trainer. There were opportunities for questions, discussion, clarification, etc. That's how I was trained many years ago and it was very helpful as a new VRC. Currently, there are video modules for new VRCs. They usually sit in a room alone watching the modules and ask their supervisor if they have any questions. I don't think this is an appropriate or adequate to train our new VRCs. | 1 |
| Become more client centered vs. data centered. | 1 |
| Mileage could be submitted electronically instead of snail mail. In one previous place of employment, mileage was attached to the same system as timecards and done bi-weekly. The travel policy for out of state now requires permission request from supervisor and director of VR, but a simpler policy would allow easier access to customers attending out-of-state programs. | 1 |
| Less micromanaging/allow counselors to have more autonomy in decision making. | 1 |
| There are a number of redundancies in documentation and justifications; (e.g.) restating the functional limitations with each and every justification for every service, approval, in an on-going case. | 1 |
| Be mindful of employees, be consistent across the agency. | 1 |
| Appoint those with more recent counseling experience to these upper level positions. Those who are managing have little to no relevant experience in the field. | 1 |
| ***provided comment*** | **18** |

**Question 36. Would you like us to contact you to further discuss issues or concerns you may have? In lieu of providing work-related contact information, you may provide us with personal contact information (cell phone or personal email address), if you prefer. (Please note, personal contact information will not be shared, reported, or used for any reason other than for the LBA-Audit Division staff to follow up with you about this questionnaire.)**

| Answer Options | Count | Percent |
|---|---|---|
| No | 23 | 92.0 |
| Yes (please provide name and contact information) | 2 | 8.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

| Question 36. Yes – (Please provide name and contact information): | Count |
|---|---|
| Contact information provided. | 2 |
| ***provided comment*** | **2** |

**Question 37. Would you like to receive email notification when we release our final report on NHVR? (Please note, this information will not be shared, reported, or used for any other reason than to transmit a copy of the final audit report to you.)**

| Answer Options | Count | Percent |
|---|---|---|
| No. | 11 | 44.0 |
| Yes (please provide email address). | 14 | 56.0 |
| ***respondent answered question*** | **25** | |
| ***respondent skipped question*** | **0** | |

## APPENDIX C
## SURVEY OF OTHER STATE VOCATIONAL REHABILITATION AGENCIES

We sent surveys to 17 other state vocational rehabilitation agencies. We received ten complete responses for a 59 percent response rate. We combined and simplified similar answers to open-ended questions and presented them in topical categories; multipart responses were counted in multiple categories where applicable. Some totals in the following tables may not add up to 100 percent due to rounding or where respondents could respond multiple times to the same question.

**Question 1. Please indicate for which type of vocational rehabilitation agency you are completing this survey:**

| Answer Options | Count | Percent |
|---|---|---|
| Combined – I am completing the survey to reflect all vocational rehabilitation services | 2 | 20.0 |
| Separate – I am completing the survey to reflect general vocational rehabilitation services | 5 | 50.0 |
| Separate – I am completing the survey to reflect vocational rehabilitation services for people who are blind of visually impaired | 3 | 30.0 |
| Other (please specify) | 0 | 0.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

**Question 2. When determining eligibility, which of the following does your agency categorize as "qualified personnel" who can make a determination that the applicant's physical or mental impairment constitutes or results in a substantial impediment to employment, as required by federal regulations [34 CFR §361.42(a)(1)(ii)]? (Select all that apply)**

| Answer Options | Count | Percent |
|---|---|---|
| Licensed medical professionals | 1 | 10.0 |
| Licensed mental health professionals | 1 | 10.0 |
| Secondary education professionals (non-licensed) | 1 | 10.0 |
| Vocational rehabilitation counselors employed by your agency | 10 | 100.0 |
| Professionals in federal agencies, such as the Social Security Administration, or other state agencies, such as Health and Human Services or equivalent | 1 | 10.0 |
| Other (please specify) | 1 | 10.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| Question 2. Text Responses, Other: | Count |
|---|---|
| Social Security Administration presumed eligible. | 1 |
| ***provided comment*** | **1** |

| **Question 3. If information from a medical, mental health, education, or other professional does not indicate the applicant's impairment constitutes or results in a substantial impediment to employment, does your agency allow vocational rehabilitation counselors to make this determination without obtaining additional assessments?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Yes | 6 | 60.0 |
| No | 4 | 40.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 4. Under what circumstances does your agency allow a rehabilitation counselor to make a determination of eligibility when information from medical, mental health, education, or other professionals is lacking?** | |
|---|---|
| **Comments** | **Count** |
| Employee observation | 4 |
| Disability benefits recipient | 1 |
| Functional limitations due to disability are observed and documented | 1 |
| Falls within employee's skill set | 1 |
| Previous history with the agency | 1 |
| Has been found eligible for another state agency service based on disability | 1 |
| ***provided comment*** | **6** |

| **Question 5. Is your agency currently under an order of selection, or has it been under an order of selection within the past two years?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Yes | 6 | 60.0 |
| No | 4 | 40.0 |
| I don't know | 0 | 0.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 6. What information do, or did, counselors primarily rely on to determine the appropriate priority for services?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Counselor observation and information self-reported by the applicant | 0 | 0.0 |
| Medical, psychological, or other similar documentation | 1 | 16.7 |
| A combination of observation, self-reported information, and medical documentation | 5 | 83.3 |
| My agency does not determine priority for services | 0 | 0.0 |
| Other (please describe) | 0 | 0.0 |
| ***respondent answered question*** | **6** | |
| ***respondent skipped question*** | **4** | |

| **Question 7. Does your agency assign the task of assessing/determining eligibility to generally all vocational rehabilitation counselors?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Yes – counselors are responsible for either assessing or determining eligibility. | 10 | 100.0 |
| No – only certain counselors are responsible for assessing or determining eligibility while other counselors have no role or a very limited role in the eligibility process. | 0 | 0.0 |
| I don't know. | 0 | 0.0 |
| Other (please describe) | 0 | 0.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 8. How does your agency perform supervisory review of eligibility determinations and priority assignments for service?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Supervisors or senior staff review all determinations/ priority for services made by all staff | 2 | 20.0 |
| Supervisors or senior staff review all determinations/ priority for services made by certain staff (such as less experienced counselors) | 4 | 40.0 |
| Supervisors or senior staff review a random selection of determinations/ priority for services | 4 | 40.0 |
| Supervisors or senior staff do not perform supervisory review of determinations/ priority for services | 0 | 0.0 |
| Other (please describe) | 0 | 0.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 9. What action does your agency take relative to the individualized plans for employment (IPE) under the following circumstances?** | | | | | | |
|---|---|---|---|---|---|---|
| **Answer Options** | **Amend IPE** | **Create A New IPE** | **Create A New IPE Or Amend IPE** | **No Change To IPE** | **Unsure** | **Response Count** |
| Adding new services | 7 (70.0%) | 0 (0.0%) | 2 (20.0%) | 1 (10.0%) | 0 (0.0%) | 10 |
| Deleting unneeded services | 5 (50.0%) | 1 (10.0%) | 0 (0.0%) | 3 (30.0%) | 1 (10.0%) | 10 |
| Changing vendors | 5 (50.0%) | 0 (0.0%) | 0 (0.0%) | 5 (50.0%) | 0 (0.0%) | 10 |
| Updating cost estimates | 4 (40.0%) | 0 (0.0%) | 0 (0.0%) | 5 (50.0%) | 1 (10.0%) | 10 |
| Changing a job goal | 6 (60.0%) | 2 (20.0%) | 2 (20.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| | | | | ***respondent answered question*** | | **10** |
| | | | | ***respondent skipped question*** | | **0** |

| **Question 10. Please select how your agency provides the following services.** | | | | | | |
|---|---|---|---|---|---|---|
| **Answer Options** | **Mainly Provided By Staff In-House** | **Mainly Provided By Vendors** | **Service Provision Is Somewhat Evenly Split Between Vendors And In-House Staff** | **Service Is Not Provided** | **I Don't Know** | **Response Count** |
| Resume Development | 3 (30.0%) | 4 (40.0%) | 3 (30.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Interviewing | 2 (20.0%) | 3 (30.0%) | 5 (50.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Job Search | 3 (30.0%) | 3 (30.0%) | 4 (40.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Guidance and Counseling | 9 (90.0%) | 0 (0.0%) | 1 (10.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Discrepancy Analysis | 3 (30.0%) | 1 (10.0%) | 2 (20.0%) | 0 (0.0%) | 4 (40.0%) | 10 |
| Barrier Intervention | 6 (60.0%) | 1 (10.0%) | 3 (30.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Benefits Counseling | 3 (30.0%) | 6 (60.0%) | 1 (10.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Situational Assessment | 2 (20.0%) | 6 (60.0%) | 1 (10.0%) | 0 (0.0%) | 1 (10.0%) | 10 |
| Pre-Employment Activities | 2 (20.0%) | 2 (20.0%) | 5 (50.0%) | 0 (0.0%) | 1 (10.0%) | 10 |
| | | | | ***respondent answered question*** | | **10** |
| | | | | ***respondent skipped question*** | | **0** |

**Question 11. For all services you selected above as "Mainly provided by staff in-house," please select whether the service is provided by specialized staff or whether most staff are trained to provide the service.**

| Answer Options | Provided By Specialized Staff In-House | Most Staff Are Trained To Provide This Service | Not Applicable (This Service Is Not Mainly Provided By In-House Staff) | I Don't Know | Response Count |
|---|---|---|---|---|---|
| Resume Development | 2 (20.0%) | 4 (40.0%) | 4 (40.0%) | 0 (0.0%) | 10 |
| Interviewing | 1 (10.0%) | 5 (50.0%) | 4 (40.0%) | 0 (0.0%) | 10 |
| Job Search | 1 (10.0%) | 5 (50.0%) | 4 (40.0%) | 0 (0.0%) | 10 |
| Guidance and Counseling | 4 (40.0%) | 6 (60.0%) | 0 (0.0%) | 0 (0.0%) | 10 |
| Discrepancy Analysis | 2 (20.0%) | 3 (30.0%) | 3 (30.0%) | 2 (20.0%) | 10 |
| Barrier Intervention | 3 (30.0%) | 5 (50.0%) | 2 (20.0%) | 0 (0.0%) | 10 |
| Benefits Counseling | 3 (30.0%) | 1 (10.0%) | 6 (60.0%) | 0 (0.0%) | 10 |
| Situational Assessment | 1 (10.0%) | 2 (20.0%) | 7 (70.0%) | 0 (0.0%) | 10 |
| Pre-Employment Activities | 3 (30.0%) | 2 (20.0%) | 5 (50.0%) | 0 (0.0%) | 10 |
| | | | | ***respondent answered question*** | **10** |
| | | | | ***respondent skipped question*** | **0** |

| **Question 12. Besides requiring customers to apply for financial aid prior to attending a post-secondary institution and collecting information on a customer's medical insurance prior to providing medical services, what other common scenarios require a comparable benefit? (Please describe)** | |
|---|---|
| **Comments** | **Count** |
| Housing | 1 |
| Daycare for children | 1 |
| Reader services | 1 |
| All services | 1 |
| Contracted job placement | 1 |
| None | 1 |
| Vehicle purchases or modifications | 1 |
| Small business expenses | 1 |
| Whenever another possible source exists for the service | 1 |
| Eyeglasses | 1 |
| Training | 1 |
| Medicaid | 2 |
| The respondent posted a hyperlink to their program website. | 1 |
| ***provided comment*** | **10** |

| **Question 13. How does your agency verify a client has obtained employment? (Select all that apply)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| A recent paystub | 5 | 50.0 |
| Written or verbal confirmation from the employer | 5 | 50.0 |
| Written or verbal confirmation from the client | 4 | 40.0 |
| Written or verbal confirmation from the job placement vendor | 6 | 60.0 |
| We do not verify employment | 0 | 0.0 |
| Other (please specify) | 1 | 10.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 13. Text Responses, Other:** | **Count** |
|---|---|
| We are transitioning to a stronger mode for verification of employment, and will be requiring more than verbal confirmation of the client. | 1 |
| ***provided comment*** | **1** |

| **Question 14. If your agency is unable to confirm employment, does your agency close the case as a successful rehabilitation?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Yes | 4 | 40.0 |
| No | 5 | 50.0 |
| Other (please specify) | 1 | 10.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 14. Text Responses, Other:** | **Count** |
|---|---|
| Depends on the circumstances. | 1 |
| ***provided comment*** | **1** |

| **Question 15. Does your agency verify clients have obtained a competitive employment outcome? For example, do you perform an analysis of the job market to determine whether the wages and benefits are similar to that paid to a non-disabled individual performing similar work?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No – we do not analyze whether the position is competitive. | 2 | 20.0 |
| Yes (please describe how competitive employment is verified). | 8 | 80.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 15. Text Responses, Yes:** | **Count** |
|---|---|
| Labor market information. | 2 |
| Counselor's determination. | 2 |
| We double-check the client is being paid, as the job posting has described. We don't pay clients under minimum wage. | 1 |
| Online data. | 1 |
| Wages, Substantial Gainful Activity, type of employer and job classification. | 1 |
| When job placement is made, staff make sure that the client is being placed in a competitive integrated setting, or we will not consider the client employed for purposes of successful closure. | 1 |
| ***provided comment*** | **8** |

| **Question 16. Please describe briefly how your agency monitors counselor performance. For example, are there key performance targets counselors are evaluated against?** | |
|---|---|
| **Comments** | **Count** |
| Case review. | 2 |
| Timeliness requirements (e.g., eligibility determinations, IPE). | 4 |
| Management reviews employees individually. | 3 |
| Job placements. | 2 |
| Business engagement milestones. | 1 |
| Counselor targets are linked to agency performance outcomes. | 1 |
| Job application submissions. | 1 |
| Job interviews obtained. | 1 |
| We have performance metrics. | 1 |
| Caseload statistics. | 1 |
| Case closures. | 1 |
| Timely communication with customers. | 1 |
| ***provided comment*** | **10** |

| **Question 17. Are there any rehabilitation counselors in your agency with specialized caseloads (such as working only or primarily with customers who are blind and visually impaired, deaf and hard of hearing, secondary students, post-secondary students, etc.)?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No | 3 | 30.0 |
| Yes (please list the types of specialized caseloads) | 7 | 70.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 17. Text Responses, Yes:** | **Count** |
|---|---|
| Blind or visually impaired. | 4 |
| Pre-employment transition. | 5 |
| Deaf and blind. | 2 |
| Deaf or hard-of-hearing. | 3 |
| Spanish-speaking. | 1 |
| Blind with developmental delay. | 1 |
| Workers' Compensation. | 1 |
| Mental health. | 1 |
| ***provided comment*** | **7** |

| **Question 18. What is the average caseload size for rehabilitation counselors with general caseloads, and, if applicable, each type of specialized caseload at your agency?** | |
|---|---|
| **Comments** | **Count** |
| 56. | 1 |
| Typically 75, but with OOS the past year was around 50. | 1 |
| 40. | 1 |
| General caseload, deaf specialists, and Spanish-speaking specialists average 80-100. Pre-ETS counselors average 175. | 1 |
| Counselors with consumers who are blind only is about 60; Pre-ETS Counselors is about 50; Deaf and blind is about 15. | 1 |
| 80-100. | 1 |
| 95. | 1 |
| 80 open cases. | 1 |
| Same. | 1 |
| General: 75; Deaf/Blind: 35; Transition and Deaf or Hard-of-hearing: 75. | 1 |
| ***provided comment*** | **10** |

| **Question 19. How does your agency review rehabilitation counselor caseloads to identify inactive cases or cases that could potentially be closed out? (Select all that apply)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Counselors are responsible for reviewing their own caseloads for timely case closure | 9 | 90.0 |
| Supervisors periodically review their counselors' caseloads for timely case closure | 10 | 100.0 |
| Internal performance reports use certain metrics to identify potentially inactive cases agency-wide | 8 | 80.0 |
| Other (please specify) | 1 | 10.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 19. Text Responses, Other:** | **Count** |
|---|---|
| I checked the counselors option not that they are a key part of the internal controls, but it is an expectation of their job to review for cases that are inactive or needing to move to exit services. | 1 |
| ***provided comment*** | **1** |

| **Question 20. Does your agency have a policy on if or when a counselor should meet a client out in the field or in their home?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No - we do not have a policy. | 5 | 50.0 |
| Yes - but the policy is informal and not written down. | 5 | 50.0 |
| Yes - we have a formal policy (please describe). | 0 | 0.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| Question 21. Does your agency have a policy on paying vendors an incentive payment for achieving a successful employment outcome (e.g., the client is placed in a job quickly, the job pays above a specific wage, the job provides medical insurance, etc.)? | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No – we do not pay incentive payments to vendors. | 5 | 50.0 |
| I don't know | 0 | 0.0 |
| Yes – we have an incentive payment policy (please describe your incentive payment policy). | 5 | 50.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| Question 21. Text Responses, Yes: | Count |
|---|---|
| Collective Bargaining Agreement - Bonuses for permanent employment and for healthcare benefits through job. | 1 |
| Additional payment for maintaining the job 90 days. | 1 |
| We have had, but are changing. | 1 |
| There are a few different incentives available. | 1 |
| Require 10 hours minimum. | 1 |
| ***provided comment*** | **5** |

| Question 22. Does your agency have predetermined fiscal or personnel levels which determines when to enter an order of selection (OOS)? | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| Yes – my agency has predetermined fiscal or personnel levels in policy which automatically trigger entering into an OOS. | 0 | 0.0 |
| Somewhat – my agency has predetermined metrics in policy which are considered in the discussion of entering OOS, but do not automatically trigger the OOS. | 0 | 0.0 |
| No – management monitors resources needed to serve clients and would enter into OOS based on management's judgment. | 10 | 100.0 |
| I don’t know. | 0 | 0.0 |
| Other (please explain) | 0 | 0.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| Question 23. Please provide information to explain your response, if necessary. | |
|---|---|
| **Comments** | **Count** |
| No comments were provided. | |
| ***provided comment*** | **0** |

| **Question 24. Does your agency have a set benchmark or expectation on how much carryover a VR grant should bring into the second year of grant?** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No | 4 | 40.0 |
| I don't know | 0 | 0.0 |
| Yes – (please describe the approximate percentage of the grant you expect to carry over into the next federal fiscal year). | 6 | 60.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

| **Question 24. Text Responses, Yes:** | **Count** |
|---|---|
| 30 percent of federal grant. | 1 |
| 25 percent of federal grant. | 1 |
| 2-3 months of program funding. | 1 |
| At least 3 months of program funding. | 1 |
| 2 months of program funding. | 1 |
| Based on a four-year budget projection to determine fiscal solvency. | 1 |
| ***provided comment*** | **6** |

| **Question 25. Would you like to receive email notification when we release our final performance audit report on New Hampshire Vocational Rehabilitation? (Please note, this information will not be shared, reported, or used for any other reason than to transmit a notice of our report's release to you.)** | | |
|---|---|---|
| **Answer Options** | **Count** | **Percent** |
| No | 2 | 20.0 |
| Yes (please provide email address) | 8 | 80.0 |
| ***respondent answered question*** | **10** | |
| ***respondent skipped question*** | **0** | |

## APPENDIX D
## STATUS OF PRIOR AUDIT FINDINGS

We previously reviewed the New Hampshire Bureau of Vocational Rehabilitation (NHVR)'s processes and management controls relevant to the current audit in the:

- *State Of New Hampshire Bureau Of Vocational Rehabilitation And Service Delivery Performance Audit*, and
- *Department of Education Financial and Compliance Audit Report For the Year Ended June 30, 2000*.

We evaluated NHVR's status towards resolving the recommendations from all relevant observations, shown in Table 13.

**Table 13**

**Status Of Prior Audit Observations And Status Key**

| Status | Key | Total |
|---|---|---|
| Resolved | ● ● | 0 |
| Resolution in process (action beyond meetings and discussion) | ● ○ | 3 |
| Unresolved | ○ ○ | 9 |
| | **Total** | **11** |

Source: LBA analysis of demonstrated prior audit statuses.

A copy of all prior audits can be accessed at our website, http://www.gencourt.state.nh.us/LBA/.

**Department of Education Financial and Compliance Audit Report For the Year Ended June 30, 2000.**

The following is the status of five applicable observations contained in our *Department of Education Financial and Compliance Audit Report For the Year Ended June 30, 2000.*

| No. | Title | Status |
|---|---|---|
| 5. | Controls Over Authorization Levels Within The Vocational Rehabilitation Case Management System Should Be Strengthened<br>*Supervisory controls over service costs can be circumvented by creating cost amendments below the threshold that required supervisory approval. (See current Observation No. 16)* | ○ ○ |

| | | | |
|---|---|---|---|
| 6. | Financial Approval Controls Within The Vocational Rehabilitation Case Management System Should Be Tightened<br>*Controls in the case management system designed to alert users if costs exceeded an established threshold could be overridden. (See current Observations No. 14, No. 15, No. 16, No. 23, and No. 28)* | ○ | ○ |
| 7. | Authorization For Vocational Rehabilitation Services And Approval For Payment Should Be Segregated<br>*The person creating the service authorization also approved the invoice for payment. (See current Observations No. 31 and No. 42)* | ○ | ○ |
| 28. | Vocational Rehabilitation Should Ensure Compliance With Federal Eligibility Regulations<br>*Some eligibility determinations were not made within the timeframe required by federal regulations. (See current Observations No. 5, No. 6, and No. 7)* | ○ | ○ |
| 29. | Vocational Rehabilitation Should Enhance Compliance With And Controls Over Customer Employment Plans<br>*Individual plans for employment were missing documentation of plan approvals, signatures, annual reviews, approvals for certain expenses, and timelines for providing services. (See current Observations No. 14, No. 19, No. 18, No. 24, No. 25, No. 26, No. 27, and No. 33)* | ○ | ○ |

**Bureau Of Vocational Rehabilitation And Service Delivery Performance Audit**

The following is the status of seven applicable observations contained in our 2001 *Bureau Of Vocational Rehabilitation And Service Delivery Performance Audit*.

| **No.** | **Title** | **Status** | |
|---|---|---|---|
| 1. | Develop And Adopt Administrative Rules For The Program<br>*The Bureau did not have administrative rules for important aspects of the vocational rehabilitation program. (See current Observations No. 7, No. 8, No. 10, No. 13, No. 18, No. 24, No. 29, No. 31, No. 32, No. 36, No. 37, No. 38, No. 39, and No. 41)* | ● | ○ |
| 2. | Develop An Agreement With The Bureau Of Special Education<br>*The Bureau did not have a written agreement with the agency responsible for educating students with disabilities, as required by federal law.* | ● | ○ |
| 3. | The Bureau Should Develop Performance Information On Providers<br>*The Bureau did not track performance of community rehabilitation programs, despite federal regulations requiring it provide customers with information necessary to make informed choices in developing and implementing their individual plans for employment. (See current Observation No. 31)* | ○ | ○ |

4. The Bureau Should Ensure Accuracy Of Caseload Data
*Caseload data reported to the federal government were inconsistent and appeared to be overstated. (See current Observations No. 34, No. 43, and No. 45)* ○ ○

5. The Bureau Should Ensure Accuracy Of Program Data
*Federally required reports documenting cost and customers served contained unexplained data errors. (See current Observations No. 4, No. 6, No. 7, No. 9, No. 17, No. 19, No. 23, No. 34, No. 35, No. 36, No. 37, No. 38, No. 45)* ○ ○

6. The Bureau Should Improve Oversight of Case Files
*Case files lacked required documentation such as secondary approvals, annual reviews, and financial needs assessments. (See current Observations No. 7, No. 8, No. 9, No. 11, No. 12, No. 13, No. 14, No. 17, No. 18, No. 19, No. 21, No. 23, No. 24, No. 25, No. 26, No. 27, No. 29, No. 30, No. 31, No. 33, and No. 46)* ○ ○

7. The Bureau Should Improve the Timeliness Of Social Security Reimbursement Claims
*Reimbursement claims for almost $85,000 were denied because they were not filed timely.* ● ○

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