STATE OF NEW HAMPSHIRE
HEALTH AND HUMAN SERVICES
BUREAU OF DEVELOPMENTAL SERVICES
UNSPENT APPROPRIATIONS

PERFORMANCE AUDIT REPORT
FEBRUARY 2016

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To The Fiscal Committee Of The General Court:

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

The purpose of the audit was to determine whether the BDS efficiently and effectively managed Medicaid appropriations to ensure clients timely received needed services during State fiscal years 2014 and 2015.

Office of Legislative Budget Assistant

Office Of Legislative Budget Assistant

February 2016

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ABBREVIATIONS

AA	Area Agency
ABD	Acquired Brain Disorder
BDS (or Bureau)	Bureau Of Developmental Services
DD	Developmental Disability
DHHS	Department Of Health And Human Services
IT	Information Technology
NCI	National Core Indicators
PSNL	Projected Service Needs List
PA	Prior Authorization
SFY	State Fiscal Year

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EXECUTIVE SUMMARY

The Department of Health and Human Services (DHHS) Bureau of Developmental Services (BDS) did not effectively manage Medicaid appropriations to ensure adults with acquired brain disorders (ABD) and developmental disabilities (DD) timely received needed services during State fiscal years (SFY) 2014 and 2015. The ABD and DD Medicaid waiver programs' $498.3 million SFYs 2014-2015 appropriations were a combined $65.0 million (15 percent) increase over SFYs 2012-2013. We found the BDS-operated service delivery system was ill-prepared to take full advantage of the increase in funding. While eight ABD and 101 DD clients, requiring approximately $4.9 million in services, remained on waitlists at the end of SFY 2015, $38.5 million in Medicaid appropriations in the two waiver programs was unspent. However 674 clients were removed from the DD waitlist during SFYs 2014-2015, exceeding the planned number by 20 clients.

Several factors contributed to underutilizing appropriated funds, including DHHS problems with tracking expenditures, constraints imposed by future budgets, delays in hiring people to provide client services, restrictions on reallocating unspent funds, inadequate rules regulating timely service provision, and forces external to the service delivery system. The BDS contracted with ten regional non-profit organizations, known as area agencies (AA), which either provided services directly or subcontracted with service providers. Practices varied statewide and required several coordinating layers for successful service delivery. The BDS typically approved individual client budgets before AAs provided services. AAs charged the Medicaid program directly after providing services. Some families opted to self-manage their own budgets and hire service providers directly. Delays or conflicting decisions in any of these tiers of management could affect timely service provision, leading to unspent funds. Client illnesses, vacations, individual preferences, inclement weather, and difficulty hiring or retaining service staff also contributed to delays or gaps in service delivery, again resulting in unspent funds in client budgets.

We found the DHHS lacked sufficient management controls to separately track spending on waitlist and maintenance clients. Both the ABD and DD programs had separate budget lines for continuing maintenance services for existing clients and new services for waitlisted clients. DHHS practice was to assign most of the expenditures in a biennium's first year to maintenance appropriations and retain waitlist appropriations, which did not lapse within the biennia. This practice disconnected legislatively appropriated funds from their assigned purposes and led to an estimated $6.8 million of maintenance expenditures being misreported as unspent waitlist funds available in SFY 2015. However, the BDS was unware these funds were not allocated to AAs.

Inefficiencies within the service delivery system and BDS-imposed requirements on AAs restricted flexibility in reallocating unspent funds and contributed to the non-delivery of services and underspending. The BDS initially lacked management controls to track and redirect unspent funds efficiently and effectively. Individual waitlist budget allocation methods and availability of unspent waitlist funds from SFY 2014 for use in SFY 2015, totaling approximately $4.4 million, were not clearly communicated to all AAs. This limited reallocating and expending carried

forward funds. In addition, subsequent budgets limited the number of clients that could be removed from the waitlist and remain funded during the next biennium. Budgeting for the DD program was based on DD clients known to the BDS early in the budgeting process. However, individuals added to the waitlist after the start of the budget process and any estimates for other clients who might request services during the next biennium were not projected and were excluded from the budget.

Other inefficiencies can be traced to statutes, rules, and guidelines, which lacked clarity and did not provide overall timeliness requirements for service delivery. ABD client service delivery was incompletely incorporated in statute, and rules were unnecessarily complex. Rules left gaps in the regulatory framework, which were bridged by BDS ad hoc rulemaking. BDS guidelines imposed substantive requirements for waitlist and fund creation and management, contained discretionary decision-making provisions without objective criteria, and comingled maintenance and waitlist funds for certain uses, all without clear basis in statute or rule. The BDS inconsistently enforced compliance with rule timeliness requirements, and the client budget and prior service authorization processes contained inefficiencies. The BDS did not complete redesignation processes for AAs as required by statute and rule, and lacked management controls over information technology systems upon which the service delivery system relied. The BDS was also challenged by a wide span of control for the administrator and several vacant mid-level management positions.

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RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required?	Recommendations	Agency Response
1	13	No	Department of Health and Human Services (DHHS) management accurately report its expenditures to appropriate budget lines.	Concur In Part
2	16	Yes	The Legislature consider changing waitlist budgeting practice to allow for additional, projected but unidentified waitlist clients. DHHS management strengthen controls for carried forward funds and use unspent waitlist funds to start ongoing client services.	Concur
3	19	No	DHHS management incorporate necessary Registry-related guidelines and procedures into rule, ensure clients are added to appropriate lists, and ensure funds are used as appropriated.	Concur In Part
4	23	No	The Bureau of Developmental Services (BDS) implement the revised redesignation process, seek corresponding changes to rule, and ensure compliance with statute and rule.	Concur
5	24	No	DHHS management correct service authorization system inefficiencies to streamline processing, simplify processes for individual budget and service authorization approval, formalize policies and procedures, and collect performance data.	Concur In Part
6	26	No	DHHS management seek to reduce the BDS Administrator's span of control.	Concur
7	29	Yes	The Legislature consider combining the developmentally disabled and brain injuries statutes, establishing overall timeline requirements for service delivery, and requiring the DHHS establish timelines for interim steps in rule.	Concur In Part

Observation Number	Page	Legislative Action Required?	Recommendations	Agency Response
8	31	No	DHHS management revise rules to standardize terms, incorporate rule-like requirements, and ensure funds be expended for appropriated purposes. BDS management systemically collect timeliness data, discontinue ad hoc rulemaking, and formalize procedures for issuing mandates.	Concur
9	35	No	DHHS management consolidate waiver program rules, define and amend time limit and timeliness requirements, define all terms, and simplify or eliminate processes.	Concur In Part
10	39	No	DHHS management incorporate into rule BDS-developed forms for external use, timelines for budget processes, requirements for supplying individual budgets to clients, external documents, standardized definitions, and fiscal controls. BDS management ensure all requirements equating to rule are incorporated into rules.	Concur
11	41	No	BDS management develop written policies and procedures.	Concur
12	42	No	BDS management improve information technology controls and evaluate risks.	Concur

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BACKGROUND

Medicaid Waiver Programs

The Department of Health and Human Services (DHHS) Bureau of Developmental Services (BDS) was responsible for managing programs for different populations of people in need of services, including: developmentally disabled adults and children, adults with an acquired brain disorder (ABD), support services for families with eligible children, early supports for children, forensic services for individuals posing a risk to themselves or the community, and children with chronic health conditions. Some of these services were paid for through federally-approved waivers to the Medicaid program known as Home and Community-Based Services waivers. The waivers allowed states to provide supportive services to eligible individuals in non-institutional, community-based settings. The waivers were last approved in 2011 and contained provisions regulating the service delivery system. The BDS was also responsible for administering the Medicaid to Schools program.

Two Medicaid waiver programs administered by the BDS supported people with an ABD or a developmental disability (DD). State law required the DHHS to establish and manage a system of developmental services, supervised by the Commissioner. The DHHS was authorized to directly operate and administer any program or facility to provide services to developmentally impaired persons, or enter into contracts with service providers. The Commissioner must adopt standards for providing services in rule. RSA 171-A required persons with developmental disabilities and their families be provided services that emphasize community living. Clients had a right to adequate and humane habilitation and treatment, including such psychological, medical, vocational, social, educational or rehabilitative services as their conditions required to bring about an improvement in condition within the limits of modern knowledge.

The BDS oversaw the system providing supportive services to the ABD and DD populations to help individuals live and work in, and contribute to, their communities. Bureau oversight included both programmatic and fiscal monitoring of the system. The Bureau's mission was to promote "opportunities for normal life experience for persons with developmental disabilities or acquired brain disorder in all areas of community life, including: employment, housing, recreation, and community associations. Family Support is a guiding principle for providing valuable assistance and cost effective services." These services could have included:

- instruction;
- service coordination;
- employment and volunteer opportunities, job development, and on-the-job training;
- personal care;
- assistive technologies;
- family support;
- community activities; and

- consultation services to improve or maintain the individual's communication, mobility, and physical and psychological health and well-being.

Services should be relevant to client abilities, goals, and employment based on the client's choices, satisfaction, safety, and positive outcomes. According to the DHHS, without these services the DD population could experience significant crises which could negatively affect hospitals, law enforcement, and adult and child protective services. In addition, family caregivers may lose employment in order to stay home to care for their adult children. State law gave clients and their families increased choices and input into decision-making on how funds would be used. Starting in 1999, clients and families were given the option to have greater control over client budgets, which became a program called Participant Directed and Managed Services.

In 1997, the Legislature stated its intent to provide effective care, rehabilitation, and family support for State citizens with serious brain and spinal cord injuries and who lacked adequate resources to meet their long-term care needs. An advisory council was formed to investigate the needs of citizens with brain and spinal cord injuries, identify gaps in services, annually report its findings, recommend priorities and criteria for disbursing grant moneys, consider establishing a brain and spinal cord injury trust fund, and solicit and receive any gifts, grants, or donations. In 2002, the Legislature established a brain injury program to provide direct services to individuals and their families affected by brain injuries. Beginning in State fiscal year (SFY) 2007, the Legislature directed the DHHS and area agencies to provide services to both eligible ABD and DD persons. The range of services for ABD clients was almost identical to those available for DD clients.

In 2011, the Legislature required the DHHS to submit contracts by March 2012 to the Governor and Executive Council for moving all eligible State Medicaid members to a managed care service provision model. Eligible Medicaid members were required to be enrolled within one year of awarding the managed care contracts. However, this transition had not occurred for the ABD and DD waiver programs by the end of SFY 2015, and the DHHS reported no timeline for transitioning the waivers to a managed care model.

ABD And DD Defined

Statute defined a brain injury as any injury to the brain which causes death or requires medical care and treatment or results in long-term disability. Rule expanded the definition of an ABD to be a disruption in brain functions that:

- is not congenital or caused by birth trauma;
- is a severe and life-long disabling condition which significantly impairs a person's ability to function in society;
- occurs prior to age 60; and
- is attributable to external trauma, inadequate oxygen supply, infectious disease, brain tumor, surgery, cerebrovascular disruption, toxic exposure, or another neurological disorder.

ABD manifests as a significant decline in cognitive functioning and ability or deterioration in personality, impulse control, judgment, modulation of mood, or awareness of deficits.

Individuals with ABD became eligible for waiver services if they met a skilled nursing facility or long-term rehabilitation level of care need, and were eligible for Medicaid. As a result, ABD individuals served by the BDS had, on average, greater needs and more costly services than DD individuals (see Table 1).

State law defined a DD as:

- being attributable to an intellectual disability, cerebral palsy, epilepsy, autism, a specific learning disability, or other conditions closely related to an intellectual disability;
- originating before the age of 22 years old;
- expecting to continue indefinitely; and
- adversely affecting a person's ability to function normally in society.

In SFY 2015, these two programs spent $240.1 million representing 81 percent of all BDS expenditures, which totaled $295.3 million. Approximately one-half of these Medicaid waiver expenditures were funded by the federal government, and the remainder by the State's General Fund.

Table 1

ABD And DD Waivers Services
SFYs 2014-2015

SFY	Waiver	Client Population	Numbers Served[1]	Service Expenditures (in Millions)	Average Per Client Expenditure[2]
2015	ABD	Maintenance	247	$21.7	$85,047
	ABD	Waitlist	31		
2014	ABD	Maintenance	243	20.9	84,942
	ABD	Waitlist	13		
2015	DD	Maintenance	4,648	218.4	45,768
	DD	Waitlist	674		
2014	DD	Maintenance	4,494	198.8	44,736
	DD	Waitlist	462		

Notes: [1]The maintenance population includes clients who also received new services as waitlist clients.
[2]These averages were provided by the BDS and include both maintenance and waitlist clients.
Source: Statements of Appropriations and unaudited DHHS data.

Area Agencies And Service Providers

The DHHS did not directly provide community-based services; instead, it oversaw a system of quasi-governmental entities and their subcontracted service providers. Statute required non-profit corporations called area agencies be established by rules. Each AA was required to plan,

establish, and maintain a comprehensive service delivery system for eligible ABD and DD individuals in one of the ten regions delineated in rule. The terms and conditions of the services provided by AAs were established in law, rules, BDS guidelines, and through sole-source contracts with the DHHS. The DHHS managed AAs through contracts, consultation, monitoring, technical assistance, service reviews, and training. Statute required the DHHS to subject AAs to reapproval every five years, and rules implemented this requirement through a redesignation process.

AAs subcontracted with private non-profit and for-profit service providers to deliver services not directly provided by AA staff. This subcontracting did not absolve the AAs of responsibility for use of the funds, as AAs were still required to fulfill obligations under rule and contract. Contracted services may include day and residential services, rehabilitation, and employment support. AAs reportedly relied on specialized service providers more for ABD consumers than for other groups. Medicaid claims for ABD and DD services were submitted by the AAs, even if services were provided by a subcontractor. AAs must have been certified by the DHHS to be paid by the Medicaid Program. AAs may have received additional funds from other sources to assist in providing services.

Outcome Measurement

The National Core Indicators (NCI) were standardized measures to assess the outcomes of DD services. New Hampshire participated in the NCI surveys of family members or guardians of clients. The participating states mailed surveys to a sample of DD families. For each question, the BDS compared New Hampshire's responses with those from the other states to identify strengths and weaknesses with its program.

According to the NCI 2013 to 2014 *Adult Family Survey*, which surveyed families with a DD service-receiving adult living at home, New Hampshire ranked above average for states with sufficient data in responses to 22 of 69 questions (32 percent) and below average in responses to four of 69 questions (6 percent). Additionally, according to the NCI 2013 to 2014 *Family/Guardian Survey*, which surveyed families with an adult family member who did not live at home and received services, New Hampshire ranked above average in responses to eight of 48 questions (17 percent), and did not rank below average in any responses.

According to the 2014 *StateData: The National Report on Employment Services and Outcomes*, the New Hampshire DD system ranks sixth-highest in the nation with 38 percent of DD clients participating in integrated employment.

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PROGRAM OPERATIONS

The Department of Health and Human Services (DHHS) Bureau of Developmental Services (BDS) distributed funds to ten area agencies (AA) for providing services to clients with acquired brain disorders (ABD) and developmental disabilities (DD). BDS personnel tracked these funds by requiring prior authorization for most budgeted expenditures, exercising oversight through Liaisons assigned to AAs, and requiring certain unspent funds to be returned to the DHHS for reallocating to other clients. The BDS projected agency and service expenditures for each biennial State budget process, and subsequently approved individual client budgets, created by AAs, for the care of specific clients over the course of the biennium. AAs billed for services rendered from the approved budgets, receiving the payment after the Medicaid reimbursement service authorization process. AAs also paid subcontractors directly; three AAs reported using subcontractors to expend less than 25 percent of their service funding, and two reported using more than 70 percent of their service funding through subcontractors.

Budget processes inform decision-makers' choices about service provision and promote stakeholder involvement. Continual evaluation of program and financial performance, including subsequent adjustments based on the evaluation, is a principle of the budget process. Mechanisms such as data collection and reporting systems that control fund disbursement, and contingency plans to address significant deviations from budgets, help promote and ensure compliance.

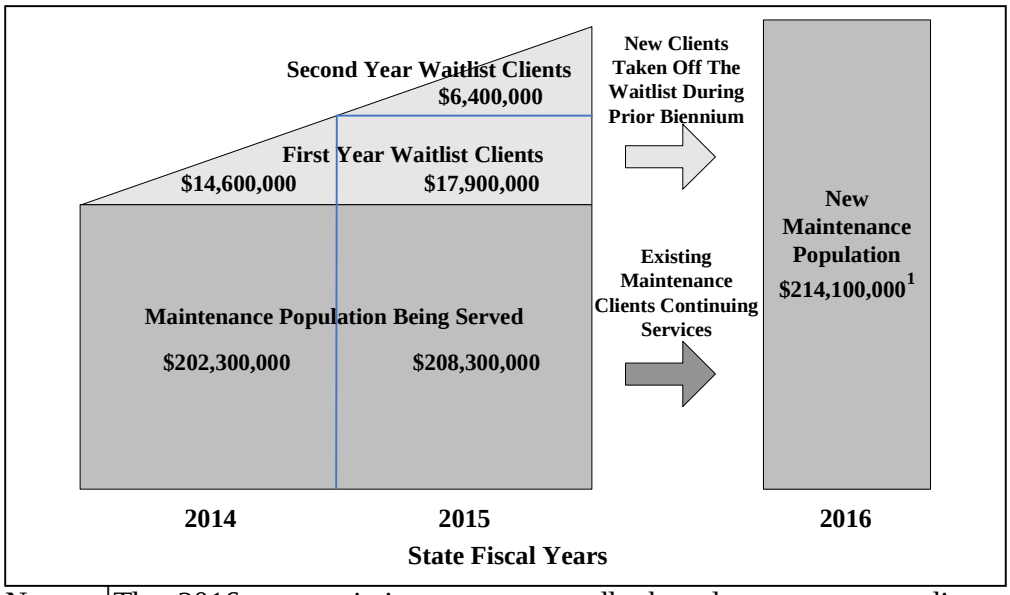
Budgeting For DD Services

The State provided two funding lines for DD services, one for maintaining services to clients to continue receiving services (i.e., the maintenance budget line) and another for new services for existing and new clients, known as the waitlist budget line. The Bureau distributed the maintenance funds through its contracts with AAs. The waitlist funds were distributed based on a formula created by the BDS. Figure 1 provides a graphic representation of the two funding streams with the amounts appropriated and how the Bureau targeted the funding during State fiscal years (SFY) 2014-2016. It also shows all clients (both maintenance and waitlist) receiving services at the end of the one biennium were categorized as the maintenance population for the next biennium.

Waitlist funds to address new needs were lower in the first year of the biennium to account for AAs and clients usually being unable to use the full amount of their "annualized" budget due to staggered service start dates. During the second year, this same group of clients would likely use most or all of their "annualized" budget; hence, the funding allocated for them in the second year was greater than the funding for the first year ($14.6 million in SFY 2014 to $17.9 million in SFY 2015) budgets. Additional funds were appropriated to remove from the waitlist more than the planned number of clients in the second year of the biennium ($6.4 million in SFY 2015).

Figure 1

DD Appropriations By Client Population
SFYs 2014-2016



Notes: [1]The 2016 appropriation was reportedly based on past expenditures rather than prior appropriations.
Source: LBA analysis of Statements of Appropriations, State law, BDS guidance, and interviews with current and former DHHS officials.

Unspent Appropriations And Lapses

While they can be related, unused appropriations and lapses are different financial terms. Based on the SFYs 2014 and 2015 Statements of Appropriations for ABD and DD Medicaid programs, the BDS did not spend $38.5 million (8 percent) of these Medicaid waiver programs' combined $498.3 million appropriations. This caused a total of $20.6 million to lapse back to the General Fund over the biennium from the ABD and DD programs as shown in Table 2. What made this situation troubling was still having eight ABD clients and 101 DD clients on waitlists for services while waitlist funds went unspent.

According to DHHS and AA officials, lapses were normal and relied upon to address required back-of-the-budget cuts. However, over the 2014-2015 biennium, the magnitude of the unspent waiver funds substantially increased. In June 2015, the DHHS reported to the Fiscal Committee that, until recently, it had not tracked waiver funds to meet legislative budget lapse expectations. It was not until the spring of 2015 that the "DHHS began projecting surpluses in certain accounts that normally would have had minimal lapses."

Table 2

ABD And DD Expenditures
SFYs 2014-2015
(In Millions)

	2014	2015	Total	Percent Of Total
Acquired Brain Disorders				
Total Appropriations	$23.2	$25.5	$48.7	--
Total Expenditures	20.9	21.7	42.6	87.5
Unspent Appropriation	2.3	3.8	6.1	12.5
Lapse To General Fund[1]	0.9	2.8	3.7	--
Carry Forward To Next Year	0.9	--	--	--
Developmental Disabilities				
Total Appropriations	$216.9	$232.7	$449.6	--
Total Expenditures	198.8	218.4	417.2	92.8
Unspent Appropriation	18.1	14.3	32.4	7.2
Lapse To General Fund[1]	3.5	13.4	16.9	--
Carry Forward To Next Year	11.2	--	--	--

Note: [1]Based on the 50/50 federal-State match for the Medicaid waivers.
Source: LBA analysis of Statements of Appropriations.

Unspent Appropriation Factors

A wide variety of factors contributed to the $38.5 million in unspent appropriations in the ABD and DD waiver programs during SFYs 2014-2015. Factors included challenges posed by forces external to the service delivery system and limitations associated with internal practices. The BDS and AAs worked together during SFY 2015 to identify reasons why clients' funds went unspent. The following list summarizes a selection of identified factors that created gaps in service provision and expenditures:

- Client Illnesses: If clients were unable to participate in services or required extended hospital stays, services which were allocated funding may not have been used. Residential care services funding practice incorporated 52 days of clients not in beds and away from residences, but absences from other services and extended departures from residential services may have resulted in unspent funds.

- Inclement Weather: Difficult travel days, such as during snowstorms, limited AA abilities to provide certain funded services. During interviews, two AAs reported losing about $20,000 in service expenditures per snow day, and one of those two reported 16 snow days during SFY 2015.

- Client Preferences: Clients may have opted to not consume services, resulting in unspent funds allocated to their budgets; services are not compulsory. These decisions may have been temporary, such as for a vacation or a break from services. Clients may also have decided to permanently refuse services after the budgeting process, which was reportedly more common in the ABD waiver program than in the DD waiver program.

- Late Service Starts: If services started after the projected service start dates, funds allocated to the clients may have gone unused. Clients may not have been ready to receive services based on personal situations or preferences. Service coordination challenges and budget negotiations with service providers, or difficulty finding service provider organizations, might also have delayed starts.

- Difficulty Hiring And Retaining Service Staff: Starts in services were reportedly often delayed by difficulties finding trained service staff. AAs and families reportedly also had difficulty retaining staff. Industry wage levels reportedly contributed to these challenges, which delayed service starts and resulted in unspent funds. Hiring staff for specialized ABD waiver services was reported as particularly difficult.

- Participant Directed And Managed Services: Some participants and families managing their own budgets and directing their own services were reportedly conservative in their use of budgeted funds. This resulted in unspent funds at the end of the budget cycle. Some families also retained portions of their budget allocations which were repeatedly underspent over several consecutive years, reportedly concerned they would not able to return to a higher level of funding if more services were needed later. Underspending due to these family decisions reportedly varied substantially by AA.

- Cost Of Care And Medicaid Reimbursements: Clients with higher incomes receiving Medicaid waiver services were required to pay some of the cost of their services. AAs were reimbursed by Medicaid for a portion of provided services, and reported difficulty collecting the matching payments from some clients. Client Medicaid eligibility status may have changed or may not have been known until after the individual budgeting process and during the Medicaid reimbursement service authorization process. These unforeseen reductions in reimbursement led to reduced overall expenditures for services, relative to the amount originally budgeted for the clients, and contributed to the unspent appropriations.

Additional factors contributed to underspending in the waiver programs through limitations on types of services funded and through allocation mismanagement. These factors included:

- Funding Influx: The increase in appropriation across the ABD and DD waivers was $65.0 million, or 15 percent, from SFYs 2012-2013 to SFYs 2014-2015. Waitlist funding accounted for $18.1 million of that increase, which was an 87 percent increase over the prior biennium's waitlist appropriation levels. DHHS employees and several AA officials suggested these large increases in waiver appropriations may have overwhelmed the system, which had staffing and other constraints, and contributed to the lapse.

- Lack Of AA Flexibility: AAs reported BDS policies limited their ability to allocate funds within their systems and minimize unspent funds, and the overall flexibility to manage their operations was reduced over time. The BDS focused waitlist funds on waitlist clients and, if unused by the originally-assigned client, to covering one-time costs for other waitlisted individuals. AAs reported limited needs for these one-time use funds, permitting some to lapse. BDS officials emphasized that more uses were available and needs may have been unmet. AA officials also stated the reduced opportunities to perform agency-wide reallocations contributed to underspending. (See Observations Nos. 2, 3, and 8 for more information.)

- Individual Budget Management: BDS officials identified challenges managing individual budgets at AAs. Variations in AA performance reportedly indicated AA practices could be improved to increase utilization, including recruiting practices and working with families to permanently reallocate money after consistent underspending.

- Annualizing Waitlist Allocations: Eight of ten AAs reported the BDS approved funding for waitlisted clients based on an annualized cost of services, rather than pro-rating those individual client budgets based on the expected service start date. Funds allocated to waitlist clients but unused were restricted to one-time expenditures and reportedly of limited use to AAs, contributing to unspent waitlist funds. However, the BDS reported including a pro-rating mechanism in their biennial waiver program budgeting process. (See Observation No. 3 for more information.)

- Awareness Of Non-lapsing Waitlist Funding: The BDS permitted AAs to spend unused waitlist funds in SFY 2014 on one-time needs in SFY 2015. All AAs had unspent waitlist funds at the end of SFY 2014, but three did not carry forward these funds to spend in SFY 2015, suggesting they were not aware of the policy or fund availability. Other AAs followed different practices which appeared to deviate from BDS directions, including allocating funds across biennia, to SFY 2016. (See Observation No. 3 for more information.)

- DHHS Waitlist Expenditure Reporting: The DHHS Medicaid payment system did not track which expenditures were for waitlist client services or ongoing, maintenance client services. This practice resulted in additional funds being assigned to a non-lapsing account in SFY 2014. Three AAs reported they were unaware these funds were available in SFY 2015. (See Observations Nos. 1 and 2 for more information.)

Observation No. 1

Accurately Report Waitlist Expenditures

The DHHS inaccurately reported $11.2 million out of $14.6 million of DD waitlist funds were unspent in SFY 2014 and brought forward to SFY 2015. Waitlist funds were non-lapsing during the biennium, whereas at the end of each SFY the State's portion of unspent maintenance funds lapsed back to the General Fund. DHHS officials reported the Medicaid payment system was not programed to differentiate DD expenditures for services to waitlist clients from those for

maintenance clients. Nor did the DHHS reportedly have the systems or resources to subsequently identify DD services used for waitlist clients to accurately record expenditures to the waitlist budget line. Because the DHHS did not track DD waitlist expenditures independently from all other DD services, the Department did not know the actual values of unspent funds from the waitlist and maintenance budget lines.

Due to the inability to otherwise track expenditures, DHHS practice was to record DD service expenditures, including some waitlist expenditures, to the maintenance budget line first. This maximized in the waitlist budget line the amount of funds the system was able to keep for the second year of the biennium. As a result, the expenditures found in the maintenance and waitlist lines of the State's accounting system, as well as the carried forward and lapse reported in the SFY 2014 Statement of Appropriations as shown in Table 3, were inaccurate. In fact, the AAs estimated they had $4.4 million of unused waitlist funds at the end of SFY 2014, not $11.2 million as reported by the DHHS.

Table 3

SFY 2014 DD Appropriations
And Reporting Of Unspent Funds
(In Millions)

Client Population	SFY 2014 Appropriations	Unused Funds At Year End	Reported To The State
Waitlist	$14.6	Not Individually Tracked By DHHS	$11.2 Carry Forward To SFY 2015
Maintenance	$202.3		$6.9[1] Subject To Lapse In SFY 2014
Total	$216.9	$18.1	$18.1

Note: [1] Only the General Fund portion of these Medicaid appropriations ($3.5 million) lapsed back to the State in SFY 2014.

Source: LBA analysis of Statements of Appropriations and interview with a DHHS official.

According to a BDS official, the same situation occurred with ABD waitlist and maintenance funds with the DHHS expending the maintenance line funds first, thereby keeping a larger amount of waitlist funds available for the second year of the biennium.

This practice of combining two budget lines to maximize the amount of non-lapsing funds was not consistent with the State law requiring State officials to expend funds only on purposes for which they were appropriated.

Recommendation:

We recommend DHHS management accurately report its expenditures to the appropriate budget lines consistent with State law.

Agency Response:

We concur in part.

It would be a more efficient use of funding to combine both waitlist and maintenance (waiver) class lines into one budgetary line in order to maximize the use of funding to better meet the needs of individuals with DD. Without a combined expense line, BDS Management has looked for ways to maximize the funding to DD individuals and reduce lapse. If DHHS had not recorded some WL expenses in maintenance (waiver) class line, the result would have been more money lapsing to the GF and less available to DD individuals. (see table below).

SFY 2014
Amount In Millions

	Budget	Expenses	Adjustment	Adjusted Exp	Balance Unspent (Total Funds)	Adjusted Lapse GF Share	Original Lapse GF Share
Waiver	$202.3	$195.3	($7.8)	$187.5	$14.8	$7.4	$3.5
Wait List	$14.6	$3.3	$7.8	$11.1[1]	$3.5		
Note: [1] Amount determined from report run by BDS.							

By allowing more money to be carried forward into the next fiscal year, BDS expected those funds to assist more individuals in need and expected the AAs to commit those funds to new individuals. Unfortunately, the AAs were unable to spend those dollars and subsequently the funds lapsed at the end of SFY15.

The MMIS system is set up to account for claims submitted by procedure/service codes. As such whether an individual is an existing DD individual or a new individual, if both are receiving, for example, Physical Therapy, they will be coded the same in MMIS. It is necessary to be set up this way so that the proper payment for the service is paid to the providers. We recognize that the MMIS therefore cannot be used to identify services by type of individual and therefore does not allocate expenses to the appropriate class line in NH First, as cited by the LBA. BDS has a mechanism to track expenses by individual type by requesting from the Area Agencies a list of WL individual names and BDS can then cross reference the individual names/ID within MMIS to extract expense data.

DHHS will review the factors listed above and will consider including waitlist and maintenance (waiver) DD expenditures to the DHHS Dashboard, which would supplement the current individual caseloads reported.

Observation No. 2

Maximize Funding For DD Waitlist Clients

The Legislature funded the DD waiver program waitlist expecting a defined target number of clients would be served. During the 2014-2015 biennium, the BDS removed a total of 674 DD clients from the waitlist, 20 more than the targeted amount. Yet, at the end of the biennium, 101 clients remained on the waitlist and millions of DD program appropriations were unspent. We identified a number of reasons preventing the BDS and the AAs from maximizing their use of appropriated funds.

Unspent Funds Not Effectively Tracked

The DHHS initially lacked a thorough understanding of the factors contributing to a substantial increase in unspent funds during the 2014-2015 biennium. Prior to this biennium, lapses were smaller and also useful for the DHHS to meet various required budget cuts. As a result, the BDS did not have management controls to effectively track unspent funds and subsequently redirect them to remove additional clients from the waitlist. Additionally, two Bureau officials who handled the financial and budget aspects of the DD program left State employment, which may have also hampered the DHHS response to the growth in unspent funds. One position, the administrator that specifically oversaw finances and utilization, was not filled.

According to the Commissioner, during SFY 2015, the Bureau began analyzing the causes of the large amount of unspent SFY 2014 DD funds (i.e., $18.1 million). As requested, the AAs reported to the Bureau which services were not being fully utilized and identified reasons why clients' funds were not being spent. During this process, the BDS identified several reasons, including:

- insufficient numbers of adequately trained workers to provide services,
- AAs not providing agreed upon services,
- AAs not timely requesting prior authorizations,
- AAs not timely billing for provided services,
- complex service needs of some individuals, and
- inadequate client budget management.

By July 2015, with a better understanding of where and why DD funds were not being spent, the BDS established a schedule of meetings with each AA to identify and track unspent funds on regular basis during the 2016-2017 biennium.

Redistribution Procedures Limited Use Of Unspent DD Funds

Bureau guidelines for redistributing unspent DD funds limited AA abilities to take clients off of the waitlist. The funding guidelines developed before the 2014-2015 biennium were designed for a budget-constrained environment and sought, in part, to prevent AAs from obligating the DD program to continue providing services to clients in subsequent years without accounting for those expenditures in future DD program budgets. Appropriated waitlist funds were distributed to AAs, and subsequently most were allocated to DD clients' budgets.

When clients did not use their budgeted funds, Bureau guidelines directed AAs on how those unspent funds could be redistributed to other clients. The guidelines did not allow AAs to simply reassign unspent funds to take other clients off the waitlists. The guidance was complex but ultimately restricted most redistributions to only funding one-time expenses and addressing time-limited crises, instead of for necessary services of a continuing nature. Additionally, carried forward waitlist funds from the first to the second year of the biennium were also limited to meeting crisis and one-time funding needs, according to BDS instructions emailed to the AAs.

Future Budgets Constrained Use Of Unspent DD Funds

Future budget constraints limited the DD service delivery system from using unspent funds to permanently remove additional clients from the waitlist during SFYs 2014-2015. In SFY 2014, when $18.1 million of DD waiver program funding went unspent, 79 clients were on the waitlist at year end. Similarly, at the end of SFY 2015, with $14.3 million of unspent funds, 101 clients remained on the waitlist. According to 2015 waitlist data, these 101 clients required about $4.5 million to be taken off the waitlist. However, the budgeting process for SFYs 2016-2017 DD clients did not take into account any clients not known at the time the budget was set in the fall of 2014. While the system had sufficient funds in the aggregate to serve the 101 waitlist clients during SFY 2015, the costs of continuing to cover their services were not included in the next biennium's budget request, which would have been needed to continue funding the services and to avoid a potential budget shortfall, having to stop providing services, or finding supplemental funds. As a result, the DD service delivery system allowed demand for unplanned services from new and existing clients, whose needs were not factored into future budgets, to build up over the State fiscal year.

Certain restrictions on the use of waitlist funds unspent in the first year of the biennium were self-imposed. Those unspent, carried forward funds could have been used to begin services for waitlist clients in the second year of the biennium, prior to developing the subsequent biennium's budget, thereby allowing additional clients and their ongoing services to be factored into the next budget. However, the BDS did not have a process in place to efficiently use these carried forward funds to reduce the number of waitlisted clients.

Recommendations:

We recommend the DHHS strengthen management controls over the carry forward of waitlist funds and develop a process to use unspent waitlist funds to start clients' ongoing services, and remove them from the waitlist, prior to developing the subsequent biennium's budget. This may necessitate statutory or budget process changes.

The Legislature may wish to consider changing waitlist budgeting practice to allow for including additional, projected unknown waitlist clients based on historical DHHS data, in addition to budgeting for known waitlist clients, as has been practice in past budgets.

Agency Response:

We concur.

BDS agrees that it did not have adequate mechanisms in place in the past for tracking funds that were unspent or underspent at the area agency level. This was self-identified prior to the audit and analysis of same began at the start of SFY15. The Area Agencies have begun reporting to BDS the services not being fully utilized and identifying reasons why funds are not being spent for individuals. BDS is now meeting monthly with Area Agencies to continue to identify and track unspent funds.

Reallocating funds that are underutilized by one individual to another individual is a complex process. Each individual goes through a person centered planning process to identify their needs and a service agreement is developed which indicates which supports they will receive. An individualized budget for these services is also developed. BDS approves the budget for each individual, and when the agency provides the services for the individual, they can bill for those services. Once this process has been completed, reallocating underspent funds to other individuals could result in a loss of available funding for future service for the individual. This is an area that is currently receiving significant attention and Area Agencies and BDS are working together to address this challenge. The meetings with Agencies to identify and track unspent and underspent funds are critical to this evaluation and BDS will continue to do work with the Area Agencies on this issue.

An additional consideration in reallocating allocated but underutilized funds is that the expenditure of allocated funds must comply with RSA 9:19, as well as meet the needs of individuals in accordance with RSA 171-A. The service delivery system's ability to be flexible and allow reallocation of funds from one individual to another while also expending funds for their appropriated purposes may require changes to the budgetary process, statute, and subsequently rules. For example, BDS' flexibility to reallocate unspent maintenance appropriations for use by other individuals from one year in the biennium to the next is currently limited by budget language and law. This limits BDS' ability to meet individuals' needs and increases the potential for lapse.

It is important to note that the waitlist is a dynamic list. Individuals are added at various times throughout the year for a number of reasons. RSA 171-A:1-a describes the processes by which funding allocations are made to individuals so as to not have them on a waiting list for more than 90 days, as opposed to complete elimination of the wait list.

Waitlists

The ABD and DD waitlists were designed to contain the names of individuals who needed and were ready to receive waiver services, but whose individual service plans were yet not fully funded or service providers were not yet available. An individual may have been receiving services and been on the waitlist if the individual required additional services, the individual's status had changed, or the services were temporary and addressed short-term needs. AAs prioritized an individual's standing on the list by determining the urgency of need based on rules.

Table 4 presents the average annual and actual end of year total of individuals on the ABD and DD waitlists between SFYs 2011-2015. The end of year total was typically the higher number,

and many waitlisted clients received services at the beginning of the subsequent fiscal year, when new waitlist funds became available.

Table 4

ABD And DD Waitlists
SFYs 2011-2015

Yearly Average[1]		
SFY	**ABD Waitlist**	**DD Waitlist**
2011	0	20
2012	8	46
2013	0	148
2014	10	177
2015	2	114
End Of Year Total		
SFY	**ABD Waitlist**	**DD Waitlist**
2011	0	24
2012	0	94
2013	8	288
2014	19	79
2015	8[2]	101

Notes: [1]The yearly averages in recent DHHS dashboard reports were inaccurate and the formulas have been corrected by the DHHS for this table.
[2]Only includes clients waiting over 90 days.
Source: Unaudited DHHS data.

In addition to the waitlists for waiver services, there was the Projected Service Needs List (PSNL) which contained names of individuals who were, within the current or a future SFY, either: 1) not receiving required services but who would need them and were eligible, or 2) receiving services but who would likely have an increased need for services.

Observation No. 3

Improve Management Of The Waitlist And The PSNL

Management practices for eligible persons either needing services, or needing additional services, should be improved. Related BDS guidelines were not adopted in rule or contract, conflicted with rules at times, permitted misallocation of appropriated funds, inconsistently supported statutory requirements to reduce waitlist backlogs, and lacked clarity on waitlist fund uses. Unused waitlist funds constituted a portion of funds lapsed by the BDS during the SFYs 2014-2015.

State law required the DHHS and AAs provide services to eligible persons in a timely manner. Undue delays were contrary to the welfare of such individuals, their families, and the State. Existing waitlist backlogs of undue delays were to be eliminated and new backlogs prevented using specifically appropriated funds. Funds were to be used only for the purposes for which they were appropriated. The DHHS was required to promulgate rules to implement its statutory obligations. Agencies must adopt rules of practice and procedure binding on non-agency personnel for them to have effect.

Establishing Waitlists

Services provided to ABD and DD clients were essentially the same kinds of services but the DHHS maintained separate parts of rule to define relevant terms, determine eligibility, regulate entry into the service delivery system, control service provision and agreements, and allocate funds. Rules included regulation of each category's waitlist, encompassing individuals in need and ready to receive services, and the PSNL, encompassing eligible persons in need of services at a future date and not presently ready to receive them. However, only DD rules defined the waitlist and the PSNL, and, while neither part of rule defined the Registry, an online software application used by AAs to manage their waitlists, DD rules referred to it and described its content. Contracts did not expand upon the requirements in rules, except to require AAs obtain and enter data into the Registry.

Funding Guidelines

To implement law, rule, and contract, the BDS issued funding guidelines that, in part, addressed the waitlist, the PSNL, and the Registry, treating them as though the two parts of rule were homogeneous. Various provisions of the guidelines:

- focused on the Registry, which was otherwise inapplicable to ABD clients;
- expanded upon requirements in rules by imposing additional requirements or imposing new requirements on AAs, requirements directly and indirectly affecting clients and services;
- restricted partial waitlist allocations to keep an individual's name listed as needing services;
- provided AAs a mechanism for not waitlisting clients in need of "temporary" services for one or more six-month periods, provisions that seemed to undermine the statutory intent of timely providing services, eliminating waitlist backlogs, and dedicated funding to waitlist management;
- provided a means of prioritizing ABD waitlistees for funding that differed substantively from ABD rules;
- incorporated elements of AA contracts, but did not clearly integrate regulatory and contractual requirements or align requirements from each in an orderly manner;
- did not define terms used or encompass applicable conditions for several provisions, indicating AAs required clarification beyond what rule, contract, and guidelines provided to understand the full extent of their obligations; and
- allowed using funds for purposes other than for which they were appropriated.

Lack Of Written Policies

Written policies and procedures are a necessary part of an effective management control system. However, the BDS lacked an effective process to control policy promulgation. The BDS allocated appropriated waitlist funds and the minimum number of eligible persons to be served using waitlist funds via a spreadsheet and email, not by a contract as was used for other appropriated funds and service minimums. Each AA reported inconsistency in BDS guidance and BDS reliance on ad hoc instruction or practice. Nine of ten AAs reported this inclination confused implementation, including implementation of waitlist-related procedures such as whether to remove partially-funded registrants from the Registry. One reported maintaining its own internal waitlist as a result of BDS management practices. Other inconsistencies in adding eligible persons to the Registry and potentially inflating the waitlist were reported by BDS staff.

Inconsistent Fund Allocations

BDS controls were unclear, leading to confusion and misunderstandings regarding allocation and use of funds. Eight of ten AAs reported annualized allocation of waitlist funds to individual clients to provide a full year of services, rather than pro-rating allocations based on projected start dates of waitlistees, contributed to the lapse. Funding allocated to waitlistees before services started resulted in unused funds which the BDS required be used only for one-time needs and not for incorporation into permanent budgets. AAs reportedly did not find uses for all of these funds, and two AAs reported over $4 million lapsed statewide during SFYs 2014-2015 due to lack of available uses for annualized waitlist funds. BDS officials reported having a pro-rating mechanism in their budgeting processes, and also expressed skepticism that all one-time needs were identified and met by AAs.

Inconsistent Use Of Carried Forward Funds

AAs also reported inconsistent understanding of BDS guidance on moving waitlist funds across fiscal years within a biennium. An emailed BDS guide instructed AAs to retain unspent waitlist funds allocated in the first fiscal year of a biennium and spend them only on one-time needs in the second year. However, three of ten AAs reported following this guidance during SFYs 2014-2015, and all ten AAs reported having unspent waitlist funds at the end of SFY 2014 totaling $4.4 million. Three other AAs did not carry forward SFY 2014 waitlist funds to SFY 2015, and the four remaining AAs moved SFY 2014 funds to take clients off of the waitlist, for one-time needs or other needs. Five AAs also reported moving unspent waitlist fund allocations across biennia and into SFY 2016.

Recommendations:

We recommend DHHS management:

- **incorporate all Registry-related guidelines, instruction, terms, and procedures affecting anyone external to the DHHS into either a single rule (for standardized or recurring requirements) or contract (for negotiated requirements) regulating the operation of the waitlist and budgeting, the PSNL, and the Registry regardless of the waiver under which they may be or are being served;**

- **ensure eligible persons meeting waitlist or PSNL criteria are consistently added to the applicable list; and**
- **ensure funds are used for their appropriated purpose.**

Agency Response:

We concur in part.

BDS concurs that it will use rules as required by RSA 541-A or contract as appropriate for the regulation and operation of the waitlist and budgeting.

BDS agrees that funding guidelines should be reflected in rule and has already taken action in this regard. For example, He-M 503 was revised and approved by JLCAR and became effective on July 25, 2015. The waitlist registry procedure was incorporated into the rule. BDS intends to amend He-M 522, which provides for services for individuals receiving services due to an acquired brain disorder, to include the same information.

With respect to the recommendation that there should only be one set of rules to include both DD and ABD populations, BDS neither agrees nor disagrees. BDS will conduct a review to determine whether it is appropriate to continue to maintain two sets of rules for the two different populations served.

RSA 171-A:1-a provides for limits on waiting lists. This statute became effective on July 1, 2007. He-M 503 had been amended in January 2007 and was not amended again until July 2015. BDS concurs that during the audit period of SFY 14 and 15, the rule was not in compliance with the statute in this regard. However, the July 2015 rule incorporates the language of this statutory provision, which ensures that individuals meeting waitlist criteria are consistently added to the applicable list. BDS intends to amend He-M 522 to include this language as well.

While BDS does not agree that guidance to the Area Agencies regarding the use of waitlist funds was unclear, BDS understands the importance of ensuring that individuals receive services in accordance with proper program standards. Rules, contracts, and policies all have a role in the service delivery system. BDS will work to ensure that rules are properly adopted pursuant to RSA 541-A and that contracts and policies are used appropriately and are applied consistently internally and across all Area Agencies.

With respect to the recommendation that BDS ensure that funds are used for their appropriated purpose, the response to Observation No. 2 is incorporated herein by reference. The service delivery system's ability to be flexible and allow reallocation of funds from one individual to another while also expending funds for their appropriated purposes may require changes to the budgetary process, statute, and subsequently rules. For example, BDS' flexibility to reallocate unspent maintenance appropriations for use by other individuals from one year in the biennium to the next is currently limited by budget language and law. This limits BDS' ability to meet individuals' needs and increases the potential for lapse.

Observation No. 4

Improve Compliance With Redesignation Statute And Rule

Statute required the DHHS to subject AAs to reapproval every five years, and rules implemented this reapproval through a redesignation process. Reviewing AA compliance with statute and rule was an important management control element and helped the BDS ensure programs meet their objectives. Suspending redesignation reduced BDS oversight of AA operations and fiscal management.

The redesignation process evaluated AAs based on eight indicators:

- mission;
- client rights, health, and safety;
- client choice, control, and satisfaction;
- individual and family or guardian involvement;
- system of quality improvement;
- governance and administration;
- budget development and fiscal health; and
- compliance.

Redesignation was a labor-intensive and lengthy process, involving BDS interviews with AA personnel and interest groups, surveys of staff and stakeholders, and reviewing meeting minutes, AA policies and procedures, and other documents. BDS staff also reviewed AA budgeting practices, funds management, financial audits, service start delays, and compliance with timelines in rule.

Following the Legislature's 2011 decision to adopt a managed care model for all Medicaid programs, the BDS sought and received permission from DHHS management to suspend redesignation due to reported staffing shortages and in anticipation of managed care implementation. Redesignation processes were not completed after early 2011, and the BDS mailed letters to agencies extending the designation of AAs during SFYs 2014-2015. In response to a federal quality review, the BDS conducted a series of file audits focused on the ABD and DD waiver programs at each AA in the fall of 2014. Also in the fall of 2014, the BDS began developing a new, streamlined redesignation process focused on ongoing monitoring, which it implemented beginning in June 2015. However, prior to this new process, suspended redesignations created a gap in quality assurance in the ABD and DD service delivery system.

Additionally, rules did not describe redesignation application, form, or information submission requirements imposed on AAs. Such requirements should be established in rule or contract.

Recommendations:

We recommend BDS management:

- **fully implement the revised redesignation process,**

- **establish in contract or seek changes to rule to incorporate forms and other required information submissions, and**
- **ensure the new process complies with statute and rule.**

Agency Response:

We concur.

BDS has reinstated the redesignation process and will have completed two area agency redesignation reviews before the end of SFY 16. BDS intends to fully implement the revised redesignation process and ensure that the process complies with statute and rules.

BDS will review the redesignation rule to determine whether changes are necessary to either the rule or contracts regarding the application, forms, and information submission requirements. Any changes identified will be made in contract or rule as appropriate.

Observation No. 5

Improve Timeliness Of Medicaid Waiver Services Authorization Approval Processes

The BDS was responsible for operation, performance, and oversight of the service delivery system. Services were to be provided timely. BDS Liaisons were required to approve individual client budgets and utilization control rules required an initial BDS determination of eligibility, an annual redetermination, and a service authorization approval before AAs could submit bills through the State's Medicaid Management Information System for Medicaid-covered home and community-based case services. AA service authorization, also referred to as prior authorization (PA), requests were due to the BDS at least 30 days prior to initiation of the services or at least 30 days prior to expiration of a current authorization, and in practice no more than 45 days beforehand. Rule also required any changes be authorized. PA was intended to ensure payments were made for approved timeframes and amounts. AAs were contractually required to obtain PA before providing services or submitting claims for payments. However, BDS practice permitted PA submission up to 120 days after service initiation.

Without PA approval, services may be provided without reimbursement or denied. PA process delays could delay service delivery. Three AAs indicated PA approvals remained pending across fiscal years. Two AAs reported ad hoc tracking of PA processing times, but none consistently maintained data to describe average approval times or other metrics. Two AAs asserted they experienced over $1 million in pending PAs at a point-in-time while another reported PAs pending from one fiscal year to another. None consistently tracked values systematically, however. Three indicated the BDS was insufficiently staffed to timely process the PAs.

Five of ten AAs identified the PA process as labor intensive for them to manage, requiring multiple steps, which included hard copy documentation and physical mailing. One AA reported experiencing a 30 percent loss of hardcopy PA submissions by the contractor managing the Medicaid billing system. While routine or renewal PAs could be processed smoothly, change PAs stalled processes, and iterations of changes could layer on each other, which was reportedly

labor intensive to reconcile. One AA also reported hiring staff specifically to manage the PA process.

Nine of ten area agencies reported services may begin before a PA was approved. While posing financial risk to the AA, the urgency of service need overrode the financial risk. Seven of those nine agencies indicated they wanted to avoid the risk of this practice and used it sparingly or they were phasing out this practice altogether. Each AA reported pending PAs could produce lapses under certain conditions, but could not quantify amounts or values. The BDS maintained the PA processing delays were due to incomplete or inaccurate PA claims submitted by the AAs.

One former BDS official indicated PA regulations created a barrier, delaying processes, inefficiently allocating resources, and contributing to relatively minor lapses. BDS staff recognized PA processing was at times a bottleneck, asserting inadequate staffing and down-time for State information technology (IT) systems integral to the process contributed to processing delays. Additionally, inflexibility in underlying IT systems limited the ability of BDS staff to make minor corrections, compelling either the generation of a new PA or approval of the erroneous PA, at times with the wrong service. Other BDS practices, such as reallocating unused funds to other clients, could require processing thousands of additional PAs. To manage the high volume of pending applications, BDS field staff were at times taken from their usual responsibilities to process PAs.

There was no manual or other formal written policies and procedures addressing PA processes, and rules did not address the entirety of the PA process. For example, rules did not include processing time limits. Pieces of the process were reflected in emails and other documents. AAs were observed to delay PA submission, at times by months, and request approval across fiscal years. AAs reportedly paid for some services without reimbursement due to delays. The BDS used to complete quarterly reconciliations and meet with AAs on the PA process, but those reconciliations and meetings were reportedly discontinued in the last quarter of SFY 2015 due to lack of available staff time. Also, while redesignation examined aspects of timeliness, completeness, and other measures, it too was earlier discontinued. The BDS had no system to track PA processing times or other measures to assess system operation, but reported undertaking an analysis to improve PA processes in the first quarter of SFY 2016.

Recommendations:

We recommend DHHS management:

- **correct PA system faults and inefficiencies of underlying IT systems to streamline the mechanics of PA processing;**
- **consolidate and simplify administrative processes for approving individual service budgets and PAs;**
- **formalize the simplified policy and procedure in rules and procedure manuals; and**
- **collect performance data to assess timeliness of PA processing to identify sources of delays, underpin staffing requirements, and measure performance over time.**

Agency Response:

We concur in part.

Delays in the PA approval process have not led to delays in service starts, or contributed in any way to funds lapsing. Information provided to the auditors by BDS, which came directly from the Area Agencies, confirmed that in the years audited, delays in budget approvals and PA request approvals did not delay services or impact the amount of reimbursement. Accordingly waitlist funds did not lapse due to delays in the approval of budget or PA requests. However, BDS agrees that the PA process can be improved to provide greater efficiencies, and has already begun to do so by amending He-M 503 in July 2015 to include timelines for the approval of PA requests.

BDS will consider whether any other changes are appropriate to consolidate or simplify administrative processes for approving individual budgets and PA requests. Any changes will be formalized into procedure manuals and/or rules as appropriate. As noted in the response to Observation No. 2, there are several factors in addition to the PA process which have contributed to lapsing funds, and those factors are incorporated herein by reference.

BDS will review whether any PA system faults and inefficiencies of underlying IT systems exist, and will work to address any identified. It is important to note that any improvements to IT systems will require appropriations.

BDS has developed processes for collecting data to assess the timeliness of PA processing. In assessing the data collected to date for SFY 16, it has become clear that Area Agencies are still not submitting waiting list PA requests timely. Additionally, when PAs are being requested and approved by BDS, the Agencies are not beginning to bill for the waiting list services provided.

Observation No. 6

Reduce Administrator's Span Of Control

The BDS Administrator's span of control was too wide, which created management challenges. Span of control measures the number of subordinates reporting directly to a single supervisor. Spans of control are considered narrow if supervisory personnel oversee few subordinates and wide if the supervisory personnel have many direct subordinates.

No universally recommended span of control exists for all organizations setting an optimal number of subordinates per supervisor in all circumstances. Instead, optimal spans of control are influenced by the difficultly of the work and should be narrowed with increasing task complexity, public scrutiny, and risk to the organization. Spans of control also should be narrowed when rule and policy lack clarity and management has limited support staff.

Workers with discretion in public human services organizations, such as those evaluating eligibility and service types for clients, may benefit more than other organizations from narrower spans of control due to accountability requirements and the complexity of the work. When a span

of control is too wide, supervisory personnel have less ability to monitor employees or anticipate performance and cost challenges. Supervisors may also have excessive workloads.

In late 2015, the BDS Administrator reported serving as the direct supervisory position for 14 subordinates, including all six AA Liaisons, five administrative positions (including one shared with a Liaison position), and four federal grant program employees. BDS Liaisons oversee AA operations, review and approve individual client budgets, provide technical assistance, and have other associated duties, some of which are autonomous and complex. Three Liaisons noted a lack of access to the heavily-scheduled BDS Administrator, and two of those three indicated existing management was overtasked. Seven of the ten AAs identified a lack of staff at the BDS as a weakness.

An assistant administrator position, left vacant since before SFY 2014, reportedly served as a manager for the Liaisons. A financial manager position vacancy also hindered operations, according to four Liaisons and four AAs. Eleven employees directly reported to these two mid-level management positions in July 2013, which at the time gave the BDS Administrator a narrower span of control. DHHS management reported hiring front-line staff was the priority, which may have resulted in leaving mid-level management positions vacant to meet budgetary targets. Overall reductions in staffing levels at the DHHS have reportedly also challenged financial operations.

Recommendation:

We recommend DHHS management seek to reduce the BDS Administrator's span of control.

Agency Response:

We concur.

The BDS administrator's number of direct reports should be reduced. BDS is in the process of revising the BDS organizational chart to determine where changes can be made to reduce the number of direct reports to the administrator. We will also explore with senior management in the Department the hiring of additional personnel.

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MANAGEMENT CONTROL

The management control system underpinning the State's acquired brain disorders (ABD) and developmental disabilities (DD) service delivery system included several State laws; rules; contracts; Bureau of Developmental Services (BDS) guidelines, practices, and procedures; and the control systems at each of the area agencies (AA) and their subcontractors. Effective management control systems facilitate agency mission accomplishment and statutory compliance. State law established objectives for the service delivery system and provided the Department of Health and Human Services (DHHS) authority to promulgate rules to achieve those objectives.

Rules have the force and effect of law when properly adopted, and are the statutorily-sanctioned mechanism agencies have to 1) implement, interpret, and make specific statutes they enforce, and 2) prescribe or interpret agency policy, procedure, and practice binding outside the agency. Additionally, the BDS issued guidelines and other instructions, and entered into contracts with each AA. All contained additional requirements intended to control the service delivery system. However, the BDS-developed framework was ineffective, being incomplete; lacked focus on timely service delivery and statutory compliance; and was inefficient, at times working at cross-purposes.

Observation No. 7

Improve Statutory Framework

State laws regulating the service delivery system incompletely incorporated ABD clients and did not facilitate timely service delivery.

Original Intent

Brain and Spinal Cord Injuries (RSA 137-K) was based on chapter law which intended to prevent significant brain and spinal cord injuries from various causes and to provide effective care, rehabilitation, and family support to seriously injured New Hampshire citizens through establishing an advisory council and using grants. Subsequent changes to statute added elements to the ABD law but did not change the fundamental regulatory structure.

This differed from the DD statutory framework contained in *Services for the Developmentally Disabled* (RSA 171-A), which provided for a service delivery system for DD clients. There was no similar element in ABD statute providing a purpose for establishing, maintaining, implementing, and coordinating a comprehensive service delivery system for individuals with ABD and their families. Further, the DD statute required services be based on individual and family participation; be comprehensive, responsive, and flexible; evolve over time; be community-based; be age, ability, and goal specific; include employment focused on self-sufficiency and independence; include individual choice, satisfaction, safety, and positive

outcomes; and be provided by competent, appropriately trained and compensated staff. The ABD statute lacked these requirements.

The ABD statute did provide rulemaking authority which enabled the DHHS to establish eligibility and service requirements for ABD clients to access the service delivery system. While clients' needs differed, ABD and DD services were similar enough to have "bolted" the ABD program onto the existing DD service delivery system. The State's ABD Medicaid waiver program, which funds ABD services, did not cover spinal injuries.

Additionally, service guarantees for DD clients and certain rights of DD persons were established in statute, but not addressed in the ABD statute. Rules were again substituted. AA human rights councils were by statute required to have a majority of DD representatives and the client and legal services section within the DHHS was formed by the DD statute, and was expressly missioned to serve DD clients.

Timeliness

Brain and Spinal Cord Injuries lacked any provision related to timeliness of service delivery. *Services for the Developmentally Disabled* provided several time limits for certain steps in the process of applying for and receiving services, time limits that were inconsistently applied to ABD services. The DD statute required the DHHS and AAs provide services to eligible individuals in a timely manner without providing an overall time limit to receive services or providing clear connections between the time limits it did contain. The DD statute specified:

- preliminary evaluations must be completed and preliminary recommendations for services made within 21 days after application for service;
- preliminary written individual service agreements must be completed within 14 days of the initial service planning meeting;
- funds for eligible individuals in school must be allocated 90 or more days before graduation or exiting the school system;
- funds for newly eligible adults must be allocated no more than 90 days after completion of their individual service agreement; and
- new services for clients experiencing significant life changes must start no more than 90 days after amendment of their individual service agreement, unless an extension was mutually agreed to.

The 90-day time limits explicitly included ABD clients, but the 21- and 14-day time limits were inconsistently explicit in their applicability to ABD clients. Additionally, statute inconsistently defined the events starting and ending time limits, and consequently the steps and their associated time limits were not explicitly contiguous. For example, the 90-day time limit for delivering services to a client experiencing a significant life change lacked a time limit on amending an individual service agreement after the significant life change occurred. This left a void for the BDS to fill via rulemaking and AAs to fill with practice and procedure, but without a statutory limit on their duration.

Further, statute did not provide for an overall timeline on service delivery, with the 90-day time limit for service delivery to clients experiencing significant life changes being the *only* provision setting a time limit on *service delivery*. The other 90-day time limits imposed only a time limit upon making funds available, not actually delivering services, and the 21- and 14-day time limits addressed other sub-processes. Statute did not mandate tracking or reporting of timeliness in service provision, or compliance with other statutory time limits. Neither the BDS nor AAs consistently tracked timeliness in service delivery.

An outgrowth of the separate statutes was two distinct sets of rules which inconsistently reflected common requirements, and created the potential for discrepant results for clients of the service delivery system.

Recommendations:

The Legislature may wish to consider consolidating *Services for the Developmentally Disabled* and *Brain and Spinal Injuries* into a single, comprehensive statute that standardizes rights, service guarantees, and other features of both statutes.

The Legislature may also wish to consider amending statute to establish an overall time limit between receipt of a complete application for services and delivery of services, and obligating the DHHS to develop time limits for interim steps within the process via its existing rule making authority.

Agency Response:

We concur in part.

In considering whether to consolidate services for the DD and ABD populations into one statute, the legislature will need to consider the different and frequently complex service needs of individuals with ABD and the different levels of funding legislatively appropriated for the respective populations.

BDS concurs that it would be appropriate to add the rights and protections features of RSA 171-A into RSA 137-K.

Observation No. 8

Improve Regulatory Framework

Rules regulating the developmental services system inconsistently ensured statutory compliance and timely service delivery, were unnecessarily complex, lacked clarity and required ad hoc supplementation, and may have contributed to, or exacerbated, lapses. The *Developmental Services* (He-M 500) chapter of rule contained separate parts regulating service provision to ABD and DD, but was supplemented by provisions of waiver applications, AA contracts, BDS-issued funding guidelines, and an indeterminate number of BDS-issued emails, memoranda, and

other informal communications. The rules were approved by the Joint Legislative Committee on Administrative Rules.

Complexity

While the care rendered may differ, the types and controls over services provided to ABD and DD clients were essentially the same, but the DHHS maintained two separate parts of rule to regulate application, eligibility, service provision, funding, and other processes. During State fiscal years (SFY) 2014-2015, ABD and DD rules differed substantially. DD rules issued after SFY 2015 were designed to reduce differences, but differences remained. There was no objective reason for maintaining distinct parts of rule.

Common to both parts of rule was a reliance on business days, not days, in describing time limits, and a process to waive time limits. This contrasted with underpinning statutory requirements which relied upon days and did not provide for waiving time limits. These discrepancies resulted in rules not complying with statutory time limits, as rules allowed more days to transpire than did statute for the same activity. These discrepancies remained in post-SFY 2015 DD rules. Also, waitlist management, service eligibility determination processes, and eligibility criteria for certain crisis funds differed between ABD and DD rules, for no apparent reason.

In addition to complexity with rules, the BDS issued funding guidelines and other directions which expanded upon or added to statutory or rule-based requirements. Guidelines contained substitute processes for individuals in need of services, diverting them from the formal waitlist for an unlimited number of six-month periods. Guidelines also identified an advisory committee to review advance authorization requests, which lacked statutory and regulatory underpinnings or authority, but was instrumental in allocating funds to clients and itself created additional binding guidelines separate from and in addition to rules.

Informal Policy Making

AAs noted issues with statutory and regulatory language, and reported the BDS routinely provided substantive instructions informally. BDS staff reported no formal system existed to distribute policy, procedure, and interpretations, and they relied on past practice to control AA activities and on informal methods to change procedures. Guidance was also subject to informal or ad hoc changes.

More generally, rules established multiple definitions of the same term in multiple parts of the chapter. These definitions were at times inconsistent with statute or other rules within the same chapter. Guidelines introduced more terms, infrequently defining them. In practice, additional terms were used to reflect processes contained in rule or guidelines. This led to inconsistent understanding across the BDS service delivery system.

Rules should singularly define terms and definitions should be consistent with statute. Rules must be clear and coherent, understandable by the average person, and should avoid language open to interpretation. Rules requiring additional interpretation are subject to ad hoc rulemaking, a prohibited practice.

Notwithstanding a prohibition against ad hoc rule-making, BDS-issued guidelines affecting AA operation and service delivery:

- contained numerous substantive requirements related to waitlist and Projected Service Needs List management, creation and control of funds, data entry, processes for advance authorization of unfunded services, and reallocation of funds which had no basis in rule or differed substantially from rule requirements and reported practice;
- filled the role of a contract in allocating waitlist funds and setting minimum waitlist service requirements;
- claimed discretionary decision-making without providing the criteria to be used and contained a discretionary decision-making formula for allocating waitlist funds to AAs for client services, a formula which was subsequently changed informally, deleting the number of waitlistees from the calculation and reportedly creating inequitable regional outcomes and potentially undermining the statutory intent of waitlist funds;
- created an individual budget requirement to obtain service authorization which lacked a basis in rule or law, a specified format, criteria the BDS would use to approve or deny a budget, and a timeline for approval;
- created processes to collect unused allocations of waitlist and regular funds, commingle them, and reallocate them to other uses, including uses other than for which they were originally appropriated, contrary to rule and statute;
- provided some procedural requirements without defining the conditions under which those procedures should be followed or to which they applied;
- allowed deficit spending;
- permitted waitlist funds be used within six months of a future requested date of service, potentially permitting use of funds across biennia;
- stipulated partial waitlist allocations should not be assigned, resulting in an individual's name being kept on the waitlist for specific service category in spite of being allocated funds for that type of service, potentially 1) undermining statutory intent of timely providing services and 2) contributing to lapse; and
- allowed AAs to request financial assistance from the BDS to make up revenue shortfalls due to residential vacancies for up to 60 days, essentially paying for services not rendered.

Additionally, we found ABD rules were the only set of rules to define and require service planning using the *Supports Intensity Scale* evaluations. Neither ABD nor DD rules required the use of the *Health Risk Screening Tool* evaluations. AA contracts addressed both evaluations, but did not clearly connect their use to the rule-based process of intake, eligibility determination, and service planning. Guidelines reflected contracts and expected AAs would project annualized waitlist cost estimates based, in part, on the results of these evaluations, but did not require their use or clarify their connection to the rule-based process of intake, eligibility determination, and service planning. The BDS reportedly instituted the requirement AAs use both evaluations for every client.

We also found during the audit period rules exceeded their statutory underpinnings by providing temporary service arrangements to individuals in crisis throughout the continuum of service, where statute only permitted emergency, temporary service arrangements be made before

screening evaluations were completed. Post-audit period DD rules were modified to better conform to statute, but ABD rules were unchanged.

Recommendations:

We recommend DHHS management revise rules to:

- **ensure rules require funds be expended for their appropriated purpose;**
- **standardize the terms used throughout the developmental services system;**
- **incorporate all rule-like requirements established in guidelines or other media into duly promulgated rules; and**
- **provide statutorily-compliant provisions for temporary service arrangements for ABD clients.**

We also recommend BDS management:

- **develop a system to collect, validate, and analyze timeliness data to ensure statutory and regulatory compliance; and**
- **discontinue ad hoc rulemaking and formalize procedures to issue mandates either by rule (for standardized or recurring requirements) or contract (for negotiated requirements).**

Agency Response:

We concur.

BDS intends to amend He-M 522 to include the same language as He-M 503 with respect to the provisions for temporary service arrangements.

BDS is in the process of developing, and has begun to utilize, a system to collect, validate, and analyze timeliness data to ensure statutory and regulatory compliance.

BDS will conduct a review to determine whether it is appropriate to continue to maintain two sets of rules for the two different populations served.

With respect to the recommendation that BDS ensure that rules require funds to be expended for their appropriated purpose, the response to Observation No. 2 regarding reallocation of underutilized funds is incorporated herein by reference. The service delivery system's ability to be flexible and allow reallocation of funds from one individual to another while also expending funds for their appropriated purposes may require changes to the budgetary process, statute, and subsequently rules. For example, BDS' flexibility to reallocate unspent maintenance appropriations for use by other individuals from one year in the biennium to the next is currently limited by budget language and law. This limits BDS' ability to meet individuals' needs and increases the potential for lapse.

Rules, contracts, and policies all have a role in the service delivery system. BDS will work to ensure that rules are properly adopted pursuant to RSA 541-A and that contracts and policies are used appropriately and are applied consistently internally and across all Area Agencies.

BDS will review whether terms in rules need further standardization, and will make any appropriate changes through the rule making process.

Observation No. 9

Improve ABD And DD Rules

ABD and DD rules regulating the service delivery system did not facilitate statutory compliance or timely service delivery. State law intended services be provided timely, specified time limits for certain steps in the process of applying for and receiving services, and required the DHHS Commissioner adopt implementing rules.

While the rules were intended to establish standards and procedures for eligibility determination, developing service agreements, and providing and monitoring services, the rules carried forward statutory shortcomings by not establishing clear overall time limits for service provision after application. Further, aggregating rule-based timelines arrived at potentially very different permissible overall limits between ABD and DD rules. Statute provided for no such differentiation. Rules also:

- did not define or use certain statutory terms essential to timely service delivery, such as "timely manner," "comprehensive screening evaluation," and "initial evaluation;"
- relied on business days, not days, when establishing time limits, extending the permissible duration of processes essential in delivering services timely beyond corresponding statutory limits;
- did not provide time limits for some required processes;
- provided for a time limit extension not envisioned by statute and which alone could add as many as 21 days to the duration of a statutory 21-day time limit; and
- often concluded with BDS funding approval, not service provision, which can be problematic as service provision and funding approvals do not necessarily occur at the same time, with service provision occurring after, and at times well after, funding approval, and contributing to a funding lapse.

ABD Rules

ABD rules were never expressly designed to implement statutory time limits applicable to service delivery. No statutory time limit was accurately incorporated into ABD rules. Rule language differed from the associated statutory language, changing meaning and disconnecting the rule-based time limits from corresponding statutory time limits.

- Rule limited the application of a 90-day statutory time limit to individuals already receiving Medicaid services, unlike statute that provided for the time limit's application to an individual receiving any type of services. Either might require additional services.

- Rule expanded the application of a 90-day statutory time limit to an individual needing additional services, whereas statute provided for its application only to individuals experiencing significant life changes.

- Rules alternatively started the same 90-day time limit with a "preliminary service recommendation" or "completion of preliminary planning," creating an internal inconsistency, and instead of starting the time limit with completing an individual service agreement as statute provided.

While ABD rules created several time limits, the rules:

- did not define or use additional statutory terms, such as "preliminary evaluation;"
- created a two-staged eligibility determination process which did not clearly allocate funds for service provision after initial eligibility was determined, or demonstrate both stages were to run concurrently;
- lacked a 21-day time limit provided in statute, but provided as many as 54 or 80 days for the equivalent process to occur, including an extension;
- lacked a 14-day statutory time limit, and provided as many as 59 days for the equivalent process to occur;
- provided as many as 170 days for the BDS to make funding available from the date of application, while three disconnected statutory time limits for subprocesses aggregated to 125 days;[1]
- provided as many as 233 days, including an extension, between receipt of an application for services and completing the rule-based process to allow services to be delivered; and
- incompletely described the start of a time limit.

DD Rules

During SFYs 2014-2015, DD rules were outdated. Regular and interim DD rules in effect during this period were updated in July 2015, eight years after significant statutory changes in 2007 that, in part, required the DHHS and AAs provide services to eligible persons in a timely manner, and inserted 90-day time limits to either make funds available or deliver services under differing circumstances. Among other limitations, DD rules in effect during SFYs 2014-2015 lacked any of the statutory time limits and provided as many as 135 days, including an extension, between receipt of an application for services and completing the rule-based process to allow services to be delivered, which may be problematic as service provision may not occur at the same time.

The DHHS issued new DD rules after SFY 2015 to address deficiencies. While the new DD rules introduced the statutory time limits and made other improvements, such as imposing day-based time limits on some processes, instead of business day time limits, reducing the permissible duration of those processes, inadequacies remained. The new DD rules:

[1] As we discuss in Observation No. 7, statute provided 14-, 21-, and 90-day time limits for key steps in the process of applying for and receiving services. Statute did not provide an overall timeline on service delivery. We provided the aggregated time limit for context as it contrasted with the potential timelines contained in rules.

- still did not define key statutory terms including "timely manner" and "initial evaluation;"
- commingled business days and days in time limits, at times within the same paragraph of rule;
- added a two-step eligibility determination process with steps intended to run concurrently with one another, but without clearly structuring the rules to do so and without clarifying the new processes' relationship to existing prior service authorization and eligibility determination processes and time limits in separate rules;
- including a waiver, provided as many as 47 days, or 71 days when the full duration of the new, two-step eligibility determination process was included, to accomplish essential tasks, while statute provided 21 days;
- including a waiver, provided for as many as 72 days, or 96 days including the full duration of the new, two-step eligibility determination process, to hold an initial service planning meeting and develop a timeline for initiating services;
- including a waiver, provided either 86 or 110 days to complete a basic service agreement covering a client's basic services or 130 days to complete an expanded service agreement covering all the services a client would receive;
- used different phrases to describe the same event;
- used language deviating from underpinning statutory language;
- provided ambiguous starting points for other time limits;
- provided two definitions for an individual service agreement, each with their own effect on timely service delivery and both of which concluded one statutory time limit while starting another;
- provided as many as 153 days, including an extension, between receiving an application for services and completing the rule-based process to allow services to be delivered; and
- provided as many as 176 days, including an extension, between receiving an application for services and the BDS making funds available for basic services, or 243 days to fund complex services, while three disconnected statutory time limits for subprocesses aggregated to 125 days.[2]

The rules inserted additional steps between and among the statutory framework, creating unnecessary complexity and adding time to the processes of applying for and receiving services. Neither rules nor BDS-issued guidelines clearly connected rule-based and statutory time limits, eliminating the opportunity to assess statutory compliance by following the rules. DHHS staff and AAs reported compliance with the statutory and regulatory time limits was not routinely examined either by BDS or AA management. Consequently, no responsible party within the service delivery system had any accurate measures of how long clients had to wait from applying to receiving services.

Rules should singularly define terms and rule definitions should be consistent with statute. Rules must be clear and coherent, understandable by the average person, and should avoid language open to interpretation. Rules requiring additional interpretation are subject to ad hoc rulemaking, which is prohibited. DHHS staff reported in the first quarter of SFY 2016 that ABD rules were scheduled for revision to correct certain deficiencies.

[2] See footnote 1 on previous page.

Recommendations:

We recommend DHHS management revise the rules to:

- **consolidate ABD and DD rules and standardize requirements;**
- **establish standard overall time limits for service delivery, not just making funds available;**
- **incorporate all statutory time limits;**
- **standardize the use of days, instead of business days;**
- **eliminate the option to waive statutory time limits;**
- **standardize the language used to start and end timed steps within processes;**
- **ensure rule language conforms to statute and is internally consistent and clear;**
- **simplify or eliminate processes;**
- **establish time limits for all steps necessary to receive services; and**
- **define all relevant terms.**

Agency Response:

We concur in part.

BDS will consider whether an overall timeline for the provision of services should be placed in rule. Factors that will be considered include the availability of appropriately qualified staff to deliver services identified in the individual service agreement and amount of specialty assessments and evaluations needed to determine the appropriate level of service.

He-M 503 was amended and approved by JLCAR in July 2015. Prior to entering rule making, BDS engaged stakeholders, including all Area Agencies, CSNI, and the Quality Council. Many of their recommendations were incorporated into the final rule. RSA 541-A:22, II, provides that rules "shall be prima facie evidence of the proper interpretation of the matter that they refer to." BDS properly adopted rules pursuant to RSA 541-A and during the rule making process no concerns about the rule issues identified in this Observation were raised. However, BDS will review the following areas, identified in this Observation, and consider whether any further changes to rule are necessary:

- *Standardizing the use of days instead of business days;*
- *Standardizing language use to start and end timed steps within processes;*
- *Ensure rule language conforms to statute and is internally consistent and clear; and*
- *Defining all relevant terms.*

RSA 171-A:6, III, provides for preliminary evaluations to be completed and preliminary recommendations for services to be made within 21 days after an individual applies for services. He-M 503 now provides that the initial service planning meeting is to be held within 30 days of the eligibility determination. RSA 171-A:12 provides that a written individual service agreement be completed within 14 days after the initial service planning meeting. RSA 171-A:1-a is the only other statutory time frame, and subsection (b) provides that after the completion of a service agreement pursuant to RSA 171-A:12, funds must be allocated within 90 days. Notably, neither

the statute, nor the rules in effect during the audit period provided a time frame in which the initial service planning meeting must be held, and thus, at the point of the preliminary recommendation, there was a gap in the timeframe structure for the entire process. While adding the three statutory time limits together results in 125 days, the subprocesses were disconnected, as the timeframe for the initial service planning meeting is not included in statute.

Likewise, as indicated above, during the audit period, the same gap existed in rule and the rule based timelines did not run consecutively. Therefore, there was no way to quantify the timelines in the statute or rules during the audit period. BDS therefore does not concur with the timeframes in this Observation that were purported to exist during the audit period. The statute has not been amended, and therefore the statutory time limits still cannot be aggregated. However, He-M 503 has now filled in the gap that existed in the timeline from application to the allocation of funding during the audit period by requiring the initial service planning meeting to occur within 30 days of the preliminary recommendation for services. The current rule based timeline from when an application is received until funds are allocated is 155 days, which does not conflict with any statutory time frames.

He-M 503 includes a provision whereby individuals or their guardians can waive certain statutory time frames to ensure effective service provision. While this may extend the overall 155 day time frame noted above, there is no prohibition against doing so. In fact, allowing the waiver is in the individual's best interest to ensure the most appropriate services will be provided, and is not in conflict with the statute.

He-M 503 now connects the processes of allocating the funds for service provision and the prior authorization process to ensure that the funding for services is approved and authorized prior to service initiation. He-M 517 requires that prior authorization requests be submitted at least 30 days prior to the start of services. BDS has implemented processes to monitor the PA submission requirements and ensure they are being followed.

He-M 503 has also now included a concurrent step during the eligibility determination phase that includes seeking a determination on an individual's waiver eligibility within three days of the area agency eligibility determination. BDS will evaluate this provision of the rule to determine whether it needs to be amended to make it clear that these two processes are occurring simultaneously.

BDS will conduct a review to determine whether it is appropriate to continue to maintain two sets of rules for the two different populations served, as noted in BDS' response to Observation No. 3.

Observation No. 10

Improve Compliance With *Administrative Procedure Act*

DHHS rules regulating the BDS service delivery system imprecisely conformed to statutory and procedural requirements for State rules. Rules must either 1) fully describe definitions and

requirements or 2) incorporate by reference external standards and definitions, citing specific editions by date or version.

The gaps we found in rules included:

- a person seeking service was statutorily required to apply in accordance with rules and while rules reflected such a requirement, they did not establish a standard application form, leaving the BDS service delivery system without a standard application form;
- requirements the DHHS and AAs provide individualized budgets to service recipients, and while BDS-issued guidelines required AAs develop budgets, this was for internal BDS approval and was without underpinning authority, defined format, and timelines for BDS approval, or a requirement to provide them to clients;
- guidelines required AAs submit Advanced Authorization Request Forms and budgets to the BDS to demonstrate the need for advanced crisis funding, but did not establish a format for either, nor were forms or formats adopted in rule or incorporated by reference;
- an undated federal form no longer in use;
- three BDS forms either improperly described or not incorporated by reference, including the "amendments to service agreement" form;
- four undated external references or definitions;
- two BDS forms that were not generally available;
- three distinct definitions of an individual service agreement, two of which deviated from the statutory definition; and
- substantial fiscal control requirements imposed on AAs via guidelines and other informal instructions, supplementing rules.

BDS management reported ABD rules were to be revised and an effort to provide standardized service agreement and budget formats was underway during the first quarter of SFY 2016.

Recommendations:

We recommend DHHS management:

- **ensure all BDS-developed forms and formats for external use, such as applications, individual service agreements, individual budgets, and advanced authorization requests, are standardized and either fully described in rule text or properly incorporated by reference;**
- **develop timelines for budget development and approval;**
- **include a requirement AAs provide individual budgets to clients;**
- **ensure all external references, including those to federal forms and definitions, are properly incorporated;**
- **make all rules, including forms, readily available to the public;**
- **standardize definitions, such as individual service agreement, within the *Developmental Services* chapter and ensure they conform to statute; and**
- **formalize fiscal controls and guidelines via rulemaking.**

We recommend BDS management ensure all requirements equating to rule are incorporated into DHHS rules.

Agency Response:

We concur.

While there are several references in current rules to budgets needing to be submitted to BDS and BDS making the final determination on cost effectiveness of services, BDS will review the rules to determine whether any changes are necessary in this regard. BDS is already in the process of developing standardized service agreements and standardized budget templates. BDS will further explore whether standardization of any other documents is appropriate and will incorporate any forms developed in rule. BDS will also further explore whether any definitions in rule should be standardized and will incorporate any changes through the rule making process.

Rules, contracts, and policies all have a role in the service delivery system. BDS will work to ensure that rules are properly adopted pursuant to RSA 541-A and that contracts and policies are used appropriately and are applied consistently internally and across all Area Agencies.

Observation No. 11

Improve Internal Policies And Procedures

The BDS did not have sufficient written policies and procedures or an effective policy promulgation process. Documented policies are a necessary part of an effective management control system, communicating management directives to BDS staff to fulfill the organization's mission and achieve its objectives. With the exception of two BDS documents providing funding and participant-directed services guidelines, the BDS informally recorded and transmitted internal policies and procedures via email or adopted them as practice without documentation during SFYs 2014-2015. The BDS lacked formal policies and procedures for key functions and internal processes, including:

- individual client budget approval processes, such as supervisory review, tiered high-cost budget approvals, and targeted timelines;
- prior service authorization approval processes, such as supervisory review and targeted timelines;
- criteria for evaluating, and the approval of, service agreements;
- Liaison training and methods standardization;
- frequency, substance, and documenting Liaison site visits;
- ongoing tracking and enforcement of AA timeliness and compliance with rules;
- timing and data source management of the "snapshot" measurement of wait list needs for BDS budgeting forecasts;
- allocation of wait list funds to clients captured in the "snapshot;" and

- management and use of information technology (IT) systems, including those used to track and approve client budgets, manage the waitlist, and share files.

The absence of written policies reportedly created inconsistencies in individual client budget approval processes, including their duration and methods of approval and BDS acceptance of individual client service agreements. The BDS reportedly planned to standardize individual service agreement and budget templates to alleviate some of these inconsistencies.

Additionally, the BDS changed the substance of written guidelines informally, affecting the method by which certain funds were allocated to the ten AAs and otherwise expanding upon or altering the meaning of existing rules to manage wait list, advanced authorization, and reallocation decisions and funds as described in Observation No. 8.

Recommendations:

We recommend BDS management develop written policies and procedures, and formalize processes for developing and distributing them and measuring their effectiveness.

Agency Response:

We concur.

Observation No. 12

Improve IT Management Controls

The BDS lacked management controls over the IT systems it owned, interacted with, or relied upon to operate the ABD and DD waiver programs. The BDS did not have policies and procedures detailing or assuring the proper use of these systems, their security and integrity, or update frequency. IT systems were based on dated technology and were not supported by the New Hampshire Department of Information Technology.

The BDS identified four IT systems used for interactions with AAs, including systems for document sharing and event reporting, waitlist information and AA data management, budget review and approval, and waiver requests. The BDS and AAs also relied on the State Medicaid payment system, and AAs may have interfaced with two systems for performing needs assessments on individuals. Among these seven systems, two were owned by the BDS and two were controlled by other subdivisions within the DHHS. Several of these systems reportedly did not interact efficiently, creating administrative burdens such as re-keying or submitting hardcopy information.

System users expressed concerns about the age of, and lack of updates to, the IT system used to manage AA information, including waitlist entries and files associated with client budgets. Some updates to this system reportedly were delayed in anticipation of Medicaid managed care implementation. This IT system, and another for tracking and managing individual budgets, also lacked external reviews or audits.

Management controls help ensure IT systems collect, process, and communicate information completely, accurately, and securely. Management must document control activities in policies and procedures. Outsourced IT systems create risks for dependent organizations which should be evaluated, and controls should be reviewed for effectiveness. External reviews and audits of IT systems, including externally-administered systems, provide assurances to clients, regulators, and other stakeholders that management controls function as intended and data are reliable and secure.

Recommendations:

We recommend BDS management improve IT controls and evaluate risks associated with the IT systems used to oversee and operate the BDS service delivery system.

Agency Response:

We concur.

BDS will review IT systems and evaluate any risks associated with said systems, and make changes as appropriate. It is important to note that any improvements to IT systems will require appropriations.

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APPENDIX A
OBJECTIVE, SCOPE, AND METHODOLOGY

Objective And Scope

In April 2015, the Fiscal Committee approved a joint Legislative Performance Audit and Oversight Committee request for a performance audit of the Bureau of Developmental Services (BDS). We held our entrance conference with the Department of Health and Human Services (DHHS) officials during the same month. Our audit sought to answer the following question about Medicaid waiver services for clients with an acquired brain disorder (ABD) or a development disability (DD):

Did the BDS efficiently and effectively manage Medicaid appropriations to ensure ABD and DD clients timely received needed services during State fiscal years 2014 and 2015?

The audit focused on why millions of dollars appropriated for services went unspent while clients remained on the waitlist.

Methodology

To gain an understanding of the BDS service delivery system for the ABD and DD waiver programs we:

- reviewed and analyzed relevant State laws, rules, and BDS guidance and policy documentation;
- reviewed BDS organization charts, data, information technology (IT) systems documentation, and the DHHS website;
- reviewed minutes and documents from Governor and Council and legislative committee meetings;
- reviewed audits from other states, prior LBA audits, relevant articles, research, and reports from national surveys of state developmental disability programs;
- reviewed federal Center for Medicare and Medicaid Services quality evaluations of the BDS and the BDS response;
- reviewed redesignation reports, area agency (AA) contracts, BDS audits of AA activities, and AA corrective action plans;
- reviewed Statements of Appropriations, BDS and AA assessments of unused funds, and BDS budget requests;
- interviewed DHHS, BDS, and other State personnel, as well as AA officials, private service providers, and other stakeholders;
- reviewed policies, data, and other documentation provided by AA officials;
- reviewed literature and criteria related to span of control and IT controls; and
- assessed ABD and DD rule and BDS guideline compliance with statute, the prior authorization process, waitlist management, old and new redesignation processes, the

BDS administrator's span of control, the IT control environment, and BDS policies and procedures.

Data Reliability

While data reliability was not an objective of this audit, because of the methods the DHHS used to record Medicaid waiver service expenditures, information provided to the State resulted in inaccurate Statements of Appropriation for ABD and DD expenditures. BDS and AA personnel believed other data used by the BDS and AAs to manage clients and their budgets were generally accurate; however, we did not evaluate these systems, including a key system operated by a third party. We did note a lack of management controls for the IT systems used by the BDS service delivery system, which put program data at greater risk for being unreliable.

APPENDIX B
AGENCY RESPONSE TO AUDIT

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 1-800-852-3345 Ext. 9200
Fax: 603-271-4912 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Jeffrey A. Meyers
Commissioner

February 3, 2016

Stephen C. Smith, MS, CPA
Director of Audits
Office of Legislative Budget Assistant
Audit Division
107 North Main Street
State House
Room 102
Concord, NH 03301-4906

RE: Bureau of Developmental Services Performance Audit Report – February 2016

Dear Mr. Smith:

The Department is in receipt of the audit report entitled, "Bureau of Developmental Services Performance Audit Report - February 2016," regarding the Bureau's management of budget appropriations for the Developmental Disabilities waiver and the Acquired Brain Disorders waiver programs. The Department values the observations and recommendations made as a result of the LBA audit process.

We are committed to working with the State's developmental services delivery network, the area agency system, to improve the services provided to disabled patients and families, and we are committed to ensuring that money appropriated by the legislature for services for the developmentally disabled community is disbursed as intended.

Sincerely,

Jeffrey A. Meyers
Commissioner

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

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