New Hampshire Department of Health and Human Services LTC Financial Eligibility

Application Process Improvement and Efficiency Report

Prepared for New Hampshire Department of Health and Human Services

Public Consulting Group

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EXECUTIVE SUMMARY

The New Hampshire Department of Health and Human Services (DHHS) is experiencing a backlog in Medicaid Long-Term Care (LTC) applications and redeterminations, resulting in extended wait times for New Hampshirites seeking services through nursing facility care or home and community-based services (HCBS). Pursuant to House Bill 2 of the 2025 legislative session, Chapter 141:423 directed DHHS to hire a contractor to assist with the backlog and to develop a plan for the efficient processing of long-term care applications. To address this challenge and state law, DHHS contracted with Public Consulting Group LLC (PCG) in December 2025 to provide staffing support and conduct a comprehensive assessment of the financial eligibility determination processes to identify opportunities to improve efficiency, accuracy, and the overall applicant experience.

PCG employed a mixed-methods approach that included document review, key informant interviews, shadowing sessions, business process mapping, and peer state research. The resulting findings are organized into six key thematic categories: **application processing**, **system functionality and workarounds**, **communication**, **opportunities for automation**, **staffing and training**, and **application usability**. Across these categories, the analysis identified a set of interrelated process, policy, and system challenges that contribute to delays, duplicative work, and inconsistent applicant experiences.

The current task-based processing model, combined with limited staffing resources, manual workflows, and system limitations, has led to fragmented case ownership, multiple handoffs, and increased processing time. DHHS has made tremendous strides to address these limitations through the inter-agency Make Eligibility Easier (MEE) initiative launched in July 2025. While system and process improvements are ongoing, PCG notes that staffing shortages, required manual procedures, limited system-focused training, and inconsistent application completeness continue to impact eligibility at a rate that will not eliminate the backlog.

To address these challenges, PCG developed a set of targeted recommendations focused on simplifying workflows, reducing manual effort, and improving coordination across teams. Key recommendations include:

- **Transition to a hybrid application processing model**, where new applications are managed using a case-based approach to reduce multiple handoffs, improve accountability, and provide applicants with a consistent point of contact.
- **Invest in New HEIGHTS enhancements and automation** to improve **system functionality** including dashboards for case assignment and tracking, automated approval and denial processes, improved document management capabilities, and expanded integration of verification tools such as Asset Verification System (AVS) and Accurint.
- **Improve communication and applicant experience**, including clearer application instructions, better coordination between financial and medical eligibility determinations, and expanded use of online application channels.
- **Eliminate or streamline process steps that create delays**, including removing the Face Sheet requirement and reducing or eliminating mandatory interviews where appropriate.
- **Strengthen staffing and training approaches**, including enhanced system training, development of standardized procedure manuals, and strategies to improve recruitment, retention, and workforce capacity.
- **Increase application usability and improve application completeness** through expanded use of the web portal, alignment between paper and online applications, and improved accessibility for individuals using assistive technologies.

Importantly, not every finding results in a direct recommendation. However, taken together, these recommendations provide a comprehensive roadmap for DHHS to reduce processing times, improve operational efficiency, and deliver a more streamlined and consistent experience for applicants. Implementation of these changes, particularly those related to workflow design, automation, and policy

simplification, has the potential to significantly reduce the LTC application backlog and position DHHS for long-term sustainability and improved service delivery.

ACRONYMS AND DEFINITIONS

Long term care business process and eligibility rules utilize many acronyms. This section provides an alphabetical list of terms used throughout the report followed by brief definitions.

ADRC	Aging and Disability Resource Center; community-based organizations that help individuals access long-term services and supports
AVS	Asset Verification System; an electronic tool used to verify financial accounts and assets
BFA	Bureau of Family Assistance; the DHHS bureau responsible for administering eligibility for public benefit programs
CD	Certificate of Deposit; a financial product with a fixed term and interest rate used to store funds
COC	Cost of Care; calculation used to determine an individual's contribution to their long-term care costs
DHHS	Department of Health and Human Services; the single state agency overseeing health and human service programs
FTE	Full-Time Equivalent; a unit used to measure staffing levels based on full-time workloads
GUARD	Geographic Undisclosed Account Radial Detection; an AVS function that expands the geographic search for financial accounts
HCBS	Home and Community-Based Services; long-term care services provided in home or community settings instead of institutions
HSA	Human Services Associate; staff responsible for intake and initial application processing tasks
HSS	Human Services Specialist; staff responsible for eligibility determination and case processing
LTC	Long-Term Care; services that support individuals with ongoing medical or personal care needs
LTSS	Long-Term Services and Supports; a broader set of services that include medical and non-medical care for individuals with long-term needs
MDS	Minimum Data Set; a standardized assessment used in nursing facilities to evaluate resident needs

MEE	Make Eligibility Easier; a New Hampshire initiative focused on improving eligibility processes and systems
NH EASY	New Hampshire Electronic Application System; the state's online portal for applying for benefits
PNA	Personal Needs Allowance; a portion of income that individuals can retain for personal expenses
PL	Patient Liability; the amount an individual must contribute toward their care costs
SNF	Skilled Nursing Facility; a licensed facility providing medical and rehabilitative care
SSI	Supplemental Security Income; a federal program providing income support to individuals with limited income who are aged, blind, or disabled

INTRODUCTION

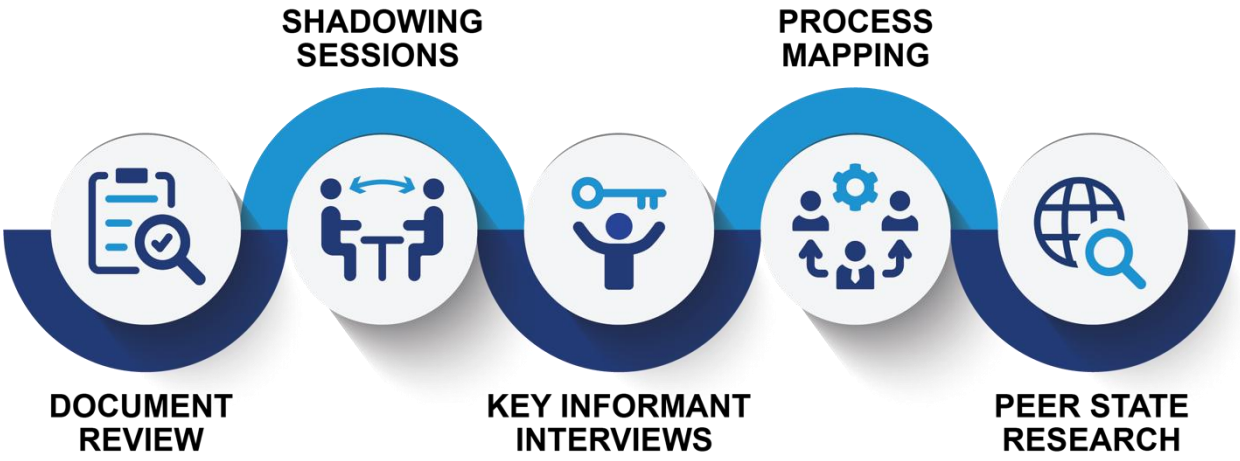
The New Hampshire Department of Health and Human Services (DHHS) promotes the health, safety, and well-being of New Hampshire residents by providing services in areas such as public assistance, housing, health and behavioral health, developmental disabilities, substance use, and public health. Within DHHS, the Division of Economic Stability provides eligibility and access for a number public assistance programs, including Medicaid, which provides access and payment for health care services ranging from routine preventive medical care for children to residential care for the people who are aging and/or have a disability. The Division of Economic Stability includes the Medicaid Long-Term Care (LTC) Financial Unit, which assesses and determines the financial eligibility of applicants seeking Medicaid LTC services.

When fully staffed, the Medicaid LTC Financial Unit is comprised of 43 full-time employees and 3 part-time employees responsible for processing an average of 635 new applications per month. This includes all new LTC applications, and any SNAP, Cash Assistance, and Medicare Savings Program applications for individuals already receiving LTC services. In addition to new applications, this Unit is also responsible for processing annual recertification and regular case changes for individuals receiving LTC.

LTC applications may be submitted on paper or through the NH EASY web portal through New HEIGHTS. New HEIGHTS is an integrated eligibility software system that allows DHHS to review and make determinations on applications for different forms of financial and medical assistance. LTC is one of many programs that use New HEIGHTS. Applications are processed using a task-based system, which allows workers to receive specific assignments each day. New applications go through multiple phases of review, which means that multiple HSS may work on a single application before it is ready to be approved. More details on the LTC workflow can be found in Appendix A.

METHODOLOGY

PCG employed a mixed-methods approach to assess New Hampshire's Medicaid LTC financial eligibility process and develop recommendations to increase efficiency. The methodology combined document review, key informant interviews, shadowing sessions, business process mapping, and peer state research to identify root causes of inefficiencies and develop actionable recommendations.



DOCUMENT REVIEW

PCG conducted a comprehensive review of policies, procedures, regulations, and operational materials to understand eligibility requirements and constraints. This included:

- State procedure manuals and administrative rules
- Application forms and verification processes
- Internal DHHS improvement initiative materials (e.g. MEE)

This review established a foundation for understanding the policy-driven structure of LTC applications and identifying the opportunities for improvement that were planned by the DHHS team. A full list of documents reviewed can be found below in Table 1.

TABLE 1: DOCUMENTS REVIEWED

Document Name	Category
791A	Application form
791 E	Application form
800MA	Application form
BFA-800	Application form
05.14.2025 Themes	MEE, Strategic Plans, and Roadmap
06.24.2025 Findings and Options	MEE, Strategic Plans, and Roadmap
07.07.2025 Presentation	MEE, Strategic Plans, and Roadmap

07.09.2025 Strategic Plan FINAL	MEE, Strategic Plans, and Roadmap
Charter- Make Eligibility Easier	MEE, Strategic Plans, and Roadmap
DHHS-roadmap-2025-2027	MEE, Strategic Plans, and Roadmap
Governance & Team structure	MEE, Strategic Plans, and Roadmap
ltss-system-of-care-for-healthy-aging-plan-2025-2026	MEE, Strategic Plans, and Roadmap
Making Eligibility Easier Flyer	MEE, Strategic Plans, and Roadmap
MEE change Management Plan	MEE, Strategic Plans, and Roadmap
DHHS Quick guide to LTC	Program Overview
Overview of LTC process	Program Overview
Medical Assistance Manual	Regulations & Process Instructions
NH Medicaid State Plan Amendment	Regulations & Process Instructions
Chapter HE-W 600: Financial Assistance and Eligibility for Medical Care	Regulations & Process Instructions
04.2025 LTC FSS Group Expectations	Regulations & Process Instructions
BFA SR 26-04 Updates to LTC lookback	Regulations & Process Instructions
HSA Procedure Document for Long Term Care Applications	Regulations & Process Instructions
Long Term Care List of Workarounds	Regulations & Process Instructions

Additionally, PCG conducted a comparative analysis of the paper application forms and the web portal application to understand the applicant's experience with each and whether one process results in better information for the HSS than the other.



SHADOWING SESSIONS

PCG conducted first-hand observations of the financial eligibility review process to understand the workflow, pain points, internal workarounds, or other factors that impact the eligibility process and to identify opportunities for improvement. We worked with DHHS to identify appropriate staff at different levels of the eligibility review process (e.g. HSA staff, HSS staff) to virtually shadow their role in the process. Processes included:

- HSA initial case creation and Intake
- Applicant interviews
- Document reviews
- Pending application assignments
- Follow-up activities such as calculating patient liability, lookback reviews, and case updates

The goals of each shadowing session were to observe New HEIGHTS system functionality, interoperability between systems, and overall process review.

PCG staff conducted a total of 13 shadowing sessions between February and March 2026, which varied between two and three hours each. All observations were compiled in an internal document so that our staff had a shared understanding of each other's shadowing experiences and observations.



KEY INFORMANT INTERVIEWS

PCG conducted targeted interviews to provide additional context to the information gathered through the document review and shadowing sessions. In early February, PCG interviewed the

BFA Long Term Care Financial Unit Regional Administrator II and Supervisor III. The topics for these interviews included management's perception of the most significant barriers to application timeliness, the statutory and budgetary constraints the team works within, and the history of efforts to reduce the LTC application backlog. In March, PCG conducted a second round of interviews to gain a more comprehensive understanding of the governance process for technology system maintenance and enhancements. These interviews were with the Bureau Chief of the Bureau of Family Assistance (BFA) and the New HEIGHTS project manager.

Finally, PCG conducted interviews in May with members of the PCG application processing team. The PCG processers were the most recently trained eligibility specialists, so these interviews helped identify opportunities for improvement in staff training and retention.



PROCESS MAPPING

Leveraging data from the document review and shadowing sessions, PCG developed an initial draft of the financial eligibility business process maps using Visio software. In April, we hosted an in-person business process mapping session to refine the draft maps and highlight opportunities for efficiencies. The group involved in this session included members of the BFA's Long Term Care Financial Unit, the DHHS Associate Commissioner, supervisors, and HSS. We were unable to have an HSA in attendance because there were only two in the unit at that time and they did not have the capacity to attend the session. However, one of the HSS in attendance had recently been promoted from HSA.

This session resulted in business process maps that can be used for staff training and support. It also allowed us to collectively identify a short list of items that have the greatest impact on the eligibility timeline. These are discussed further in the recommendations section.



PEER STATE RESEARCH

After reviewing the New Hampshire Medicaid LTC financial eligibility processes and identifying key challenges, PCG identified states of a similar size, or states with similar integrated eligibility systems to learn how they have implemented processes to address common challenges with financial eligibility. The criteria used to identify states for research included:

- Administration and operation of 1915(c) waivers
- Use of a Deloitte-built integrated eligibility system
- Regional and demographic similarities
- Administration and operation of 1115 waivers (when a 1915(c) was not used)

The table below includes the criteria and the selected states with the criteria they met.

TABLE 2: RESEARCH CRITERIA AND SELECTED STATES

	Colorado	Georgia	Maine	Pennsylvania	Rhode Island
1915(c) waivers	✓	✓			
Deloitte-built integrated system	✓	✓		✓	✓
Regional and demographic similarities			✓		
1115 waivers				✓	✓

To begin our research, PCG conducted a review of publicly available information about each state's Medicaid LTC financial eligibility process. We also conducted interviews with state administrators and subject matter experts to gain a better understanding of the processes and workflows and to learn from

the experience of those with direct knowledge of policy and operations. PCG, in collaboration with DHHS, drafted questions and developed topics for discussion ahead of the interviews to ensure standardization across conversations,

PCG scheduled one-hour interviews with representatives from each state virtually using Microsoft Teams. Interviews were transcribed for accurate reporting and were facilitated by two PCG staff members, one who led the conversation and one who took notes. PCG obtained consent from participants before transcribing each conversation and shared questions verbally. Everyone was encouraged to provide additional comments via email at the conclusion of each interview. PCG informed participants that the findings from the interviews would be compiled and shared with everyone as a summary once all interviews were completed. PCG has included the summary of the interview findings in a table in Appendix C.

KEY FINDINGS

The following key findings reflect insights gathered through document review, key informant interviews, shadowing sessions, business process mapping, and peer state research. Collectively, these findings highlight the primary drivers of delay and inefficiency within New Hampshire's Medicaid LTC financial eligibility processes, as well as opportunities to improve timeliness, consistency, and the overall applicant experience. While each finding is presented as a distinct issue, many are interconnected and should be considered holistically when evaluating process improvements

The findings are organized into thematic categories, identified as priorities by DHHS. These include application processing, system functionality and workarounds, communication, opportunities for automation, staffing and training, and application usability. Within each category, specific observations and examples are presented to illustrate key challenges and their impact on the eligibility determination process.

APPLICATION PROCESSING

Fragmented case ownership: Multiple staff (HSS) handle the same case at different points

Limited communication for applicants: Applicants must rely on a central line, making it difficult to get updates or ask questions during a complex process.

Process inefficiencies and delays: Redundant steps (e.g., Face Sheet, required interviews, repeated case reviews) and scheduling delays significantly slow eligibility determinations.

Task-based vs. Case-based

PCG recognizes the rationale for moving from a case-based system to a task-based system for processing Medicaid LTC applications. However, our observations found several areas in which the current approach has created some inefficiencies. These are detailed below.

1A. Multiple HSS Are Involved in A Single Application
The task-based system results in numerous staff working on the case at different intervals, each with their own case notes, methods, etc. It can create confusion and a disconnect between the HSS. For example, one case had 8 different HSS work on it at various points.

1B. Task-Based System Limits Applicant Access to Updates or Questions Related to Their Application
During the interview process, applicants often ask who they can contact about questions, but the formal option is a central telephone number. The HSS explain that the case is entered into the system and there is not a primary contact. This impacts consistency for the applicants who are often trying to navigate a confusing process during a challenging personal time.

1C. HSS Review of Each Case Upon Assignment of Task(s) Adds Additional Time to Case Processing
As HSS receive their assigned tasks, it takes them time to review the applicant's case via the various windows in New HEIGHTS to familiarize them with the specifics of the applicant and application. In addition, there is sometimes confusion about certain aspects of the application / case notes, due to the

number of HSAs and HSS involved in the case. This adds additional time to the eligibility determination process.

It should be noted that the task-based system does seem to work efficiently for case changes and for redeterminations.

Case Process Flow

1D. Face Sheet
The HSA has been required to complete a Face Sheet for each applicant during the scheduling call, which is a high-level summary of the facts of the application. Developing this sheet can be time-consuming, difficult to complete (e.g., the scheduling call is unannounced, and the applicant may not have all the requested information readily available), and it is generally redundant to what the HSS would ask during the interview. The HSS reported not using the Face Sheet at all for their initial case review.

1E. The Interview Requirement
Current policy requires an interview as a first step in the review process for most Medicaid LTC applications. HSAs schedule the interviews for at least 15 days from the date they review and register the application so that there is enough time for the AVS results to be returned. However, due to the HSA's current delay in reviewing new applications, and the limited number of HSS, these interviews are currently scheduled 30-40 days after the application is submitted. This requirement adds another delay in the eligibility process, between attempts to make contact with the applicant, conducting the actual interview (no-shows are fairly common and must be rescheduled at least once), confirming the information with the applicant/representative, and trying to answer various questions the applicant may have, some of which are not related to the eligibility determination process.

SYSTEM WORKAROUNDS

In addition to the system work arounds identified by DHHS, New HEIGHTS issues were identified, including:

Note-taking inefficiencies

Errors on the Living Situation and lookback screens

Transitions from Medicaid to LTC

As an integrated eligibility system, New HEIGHTS was designed to support eligibility determinations for a wide range of public benefit programs. However, the Medicaid LTC financial eligibility process has its own unique complexities that have resulted in the use of various workarounds by staff as they work on an application. The DHHS team provided the following list of workarounds:

- Resource assessments don't properly transfer to the budget in some cases. In these instances, they mark the resources as inaccessible in order to get the case to open.
- For applicants with nursing facility stays, the HSS has to manually zero out the patient liability on the Patient Liability screen in order for the information to be entered on the SNF side. Then the HSS has to enter an expected change to remove the manual override on the Patient Liability screen once the SNF stay is complete.

- For nursing facility stays, in order to get the applicant's Medicaid ID number to display on the facility notice, the HSS has to enter the SNF stay, move to any other screen in New HEIGHTS, then go back to the SNF screen and click on the print button.

- When an applicant has a patient liability, if there are medical expenses entered on the Medical Expense screen, the HSS has to manually zero out each individual medical expense entered so the data doesn't get automatically pulled into the patient liability budget calculation.

- If a HSS is recalculating the spousal allocation and needs to make an adjustment for a previous year, the HSS doesn't have the ability to update the personal needs allowance (PNA) on the spousal allocation screen, so the spousal allocation has to be manually calculated to override the amount calculated by New HEIGHTS.

- If the applicant incurs a penalty time period due to inappropriate asset transfers and are thus ineligible for Medicaid, the HSS has to manually calculate the time periods and enter into New HEIGHTS.

PCG also identified additional workarounds as observed in our staff shadowing.

2A. Notetaking on required verifications
Many HSS keep a document outside of New HEIGHTS (e.g., electronic sticky notes) with template communication language to copy/paste into the system to save time. PCG understands that a standardized approach to this workaround is being implemented as part of New Hampshire's MEE system enhancements.

2B. Limited text box fields
The text box fields do not expand to show all text entered in an applicant's case, which often entails a cut/paste workaround to ensure accuracy of the case notes entered.

2C. Lookback Screen Errors
The lookback screen used to review an applicant's financial history for asset transfers does not often work correctly. A HSS needs to go through batch tracking to find the documents, for example, searching by received dates to find bank documents and re-index them.

2D. Living Situation for Individuals Who Are Incarcerated
Currently the system will not be able to pend a new LTC applicant if they are incarcerated. The workaround is to document the individual as 'living in an apartment' in the New HEIGHTS system

2E. Medicaid Recertifications Can Create Complications for LTC Applications
In some instances, an individual receiving NH Medicaid applies for LTC. If their Medicaid recertification is due while their LTC application is still under review, processing the recertification will close the LTC application task. A workaround is required to remedy this issue. Whenever there is a task for an individual who has a LTC application under review, workers need to delete the LTC application, process the recertification task, and then re-add the LTC request. The medical unit needs to be notified via email whenever this happens as well.

This list is based on what was observed directly through shadowing sessions and is not necessarily inclusive of all workarounds currently employed by LTC team.

COMMUNICATION

Lack of clarity in application instructions

No formal communication between Financial LTC eligibility team and Medical eligibility teams.

There are opportunities for DHHS to enhance its internal and external communications tools and processes to improve the timeliness of the application process. Challenges in communication that the PCG team identified are detailed below.

3A. Application Process Instructions Are Not Clear

Public-facing instructions about the application process are not as detailed or clear as they can be. Some applications submitted to DHHS are more complete than others, especially when the applicant uses community agencies that are familiar with the process. The more complete the application is, the less likely it is that additional information requests and lengthy follow-up will be required. PCG understands that the MEE team is actively working on clarifying the application instructions.

3B. Applicant Has Limited Consistent Access to DHHS HSS

Applicants frequently ask for a specific point of contact to direct questions and request status updates throughout the application process. This is not feasible under the task-based system since individual HSS workers are not fully responsible for the case. Some HSS include their email in communications with the applicant after the initial intake interview as a courtesy in case they need to follow-up.

3C. No Formal Mechanism to Ensure Consistent Communication Between the Financial and Medical Eligibility Programs

If medical eligibility is determined first, and is approved, a notice is sometimes sent to the applicant before the financial eligibility is determined, which creates confusion for the applicant. New HEIGHTS lacks a seamless way for the two programs to communicate and ensure the process is completed and an approval notice is sent to the applicant in an orderly way.

OPPORTUNITIES FOR AUTOMATION

Verification and data gaps slow processing: High rate of AVS “no findings” and manual Accurint requests

Manual, duplicative workflows: Case assignments, document tracking, eligibility coordination, and case closures require significant manual effort, increasing workload and risk of errors.

System limitations create confusion and inefficiencies: Uncoordinated eligibility notices, missing data (e.g., expense end dates), and duplicate documentation complicate processing and can mislead applicants.

PCG observed several opportunities for DHHS to further automate New HEIGHTS functions and processes to streamline workflows and gain efficiencies. We have prioritized and summarized our findings below.

4A. High Rate of AVS "No Findings"

Electronic AVS is a federal requirement for determining LTC eligibility. In NH, HSAs submit an electronic AVS request for each new application. Responses are returned within 15 days. Once the HSS determines the lookback period for a case as determined by statute (e.g., individuals who have not been receiving DHHS assistance for 3+ years, receiving SSI for 2 years, or receiving SSI and SSDI for 2+ years), the HSS views the AVS results in New Heights to determine if all requested bank records are present. However, AVS frequently returns "no findings" after 15 days, a result of DHHS' "tiered" pricing contract with Accuity (for use of the AVS), which limits the catchment area to 5 miles. In addition, AVS frequently fails to return information from credit unions and local banks. If no AVS records are returned, HSS may submit a second AVS request with updated information, such as an updated address or a specific bank, if identified. During the business processing review session, LTC staff cited the current AVS as one of the biggest contributing factors to interview and case processing delays.

4B. Manual Process for Accurint Check

During intake, the HSA manually triggers a request in New HEIGHTS for all electronic verifications. The exception is the Accurint system—a LexisNexis tool used by authorized agencies to verify real property ownership, assess property, and investigate assets—that DHHS uses to identify real property owned or jointly owned by the applicant. When real property appears on an applicant's application, the HSA must manually generate and send an e-mail request to DHHS' Trust Unit, which has the Accurint log in license. Typically, Accurint returns a report prior to the HSS' interview with the applicant, and the HSS must manually enter the results into New HEIGHTS. When the results are returned, the Trust Unit emails the results. However, the Trust Unit is only one individual. While this individual is generally responsive, the timeframe for completion can vary based on complexity and workload.

Note: As of April 2026, DHHS is implementing a system improvement to trigger Accurint requests and receive results within New HEIGHTS, so the manual process will be eliminated.

4C. Applicant Eligibility Letters

Financial and Medical eligibility decisions are entered into New HEIGHTS by two separate teams. Currently, this requires communication between DHHS bureaus outside of the New HEIGHTS system in order to coordinate entering eligibility decisions into the system at the same time. If the entry of eligibility decisions is not coordinated, applicants may receive a notification of medical eligibility letter if a medical determination occurs prior to determining financial eligibility. This is confusing to applicants because they may get the impression that this letter means they are fully LTC-eligible.

4D. Manually Run Case when Documents not Returned

HSS must manually check the New HEIGHTS system to determine whether or not applicants have returned all requested documents. If the applicant has not returned all required documents, the worker must then manually close the case after 10 days. This takes additional time and effort to monitor, reassign and manually close the case. While this is not time-consuming for an individual case, the process can occur on hundreds of applications per month and the HSS time could be better spent reviewing and processing new applications.

4E. Case Assignments

At the start of each day each LTC supervisor must review their New HEIGHTS cases to manually identify and build a daily list to assign and distribute cases to each of their staff members. The distribution of work is accomplished by taking a screenshot of the New Heights list and emailing it to each staff member. Then the staff member tracks their assignment updates each day through a shared excel spreadsheet. This daily manual process is time-consuming for supervisors and staff, resulting in duplicative work and, in some cases, a failure to prioritize high-risk cases.

4F. Medical Expense End Dates

When the HSS calculates the cost of care and/or patient liability, some medical expenses are populated without end dates. As a result, HSS must make manual updates. Due to the manual nature of this step, it is easy to miss adding end dates for individual expenses and can result in inaccurate cost of care calculations. HSS reported that the Patient Liability screen, which is used for applicants living in nursing facilities, functions more smoothly than the Cost of Care (COC) screen which is used for applicants residing in community settings.

4G. Duplicate Documentation

New applications often require significant documentation to verify eligibility. This may include verifications of citizenship and documentation of assets such as burial agreements, trusts, life insurance policies, and bank statements. In PCG's shadowing sessions, we witnessed cases with over 85 documents and another with over 100. In these cases, each document needed to be reviewed and indexed, and we observed that many were duplicated. This may be due to a scanning error, a system issue, or the applicant submitting the same documentation numerous times.

OPPORTUNITIES TO IMPROVE STAFF HIRING AND TRAINING

Staffing has not kept pace with the growth of applications;

New hire training could be strengthened to include more focus on New HEIGHTS

Call Center would benefit from additional training

Many states face issues with staff retention, and all states interviewed during the course of this project reported high turnover as a major challenge. Staff hiring and training can have a direct impact on staff retention, and PCG observed the following challenges in the New Hampshire hiring and training processes.

5A. Persistent Staff Vacancies

In 2023, DHHS funded 33 full time employee positions in the LTC financial eligibility unit to process an average of 400 applications per month. Today, the LTC financial eligibility unit has 39 fully funded positions and is responsible for processing an average of 635 new applications each month. These applications include eligibility determinations for programs such as SNAP, Cash Assistance, and the

Medicare Savings Program. A four-month average indicates that 491 of these applications are exclusively for LTC programs, including Nursing Facility, Choices for Independence, and Developmental Services. In other words, while the workforce has increased by 21%, the average monthly applications the unit is responsible for has increased by 58%. To add to this challenge, the unit experiences difficulty with recruitment and retention for the 39 funded positions. At the date of publication, the LTC financial unit had a 21.7% vacancy rate and were actively recruiting for 1 funded HSAs and 2 funded HSSs. In addition to these positions, the LTC unit is tracking 5 unfunded positions.

5B. Limited System and Process Training
Training currently focuses on high level program overviews and policy reviews. This information is important and should remain part of the training, however there are opportunities to expand training to set new employees up for success and encourage retention. In some of PCG's interviews it was noted that the Medical Assistance Manual is an important document that new and current staff should be comfortable navigating and referencing, but that many staff may not be familiar enough with the manual to fully utilize it in their work due to a lack of training.

5C. Call Center Lacks Detailed LTC Training
The external call center was reported to often give out incorrect information, leading to confusion and delays during the application process.

APPLICATION USABILITY

There are several differences between the web-based application and the paper application that may contribute to less complete paper applications.

When applying for Medicaid LTC services in New Hampshire an individual may submit a paper application using the BFA Form 800 where they can select that they are applying for LTC, or they may submit an application online through the NH Electronic Application System (EASY) portal. PCG conducted an analysis of both versions of the application to understand how they compare from the applicant's experience and whether one process results in better information for the HSS than the other. The following list outlines the differences between the paper and online Medicaid LTC applications by section:

6A. Information Requested in the NH EASY portal compared to the Paper Application:

TABLE 3: COMPARISON OF QUESTIONS IN EACH APPLICATION METHOD

Information Only Requested in the NH EASY Portal	Information Only Requested on the Paper Application
Contact information for the person who will do the LTC interview	Information about why the applicant needs help
Information identifying whether an individual is applying on behalf of someone else.	Information about the applicant's household members
Contact information for individual assisting the applicant	Information about TANF

Information identifying whether the applicant has applied for New Hampshire benefits in the past	Information about the applicant's migrant or seasonal worker status
Applicant's education history	Information about SNAP assistance
Applicant military status	Information about whether the applicant is living in a shelter for battered individuals
Applicant medically fragile status	
Tax filer information	
Information identifying what the applicant is requesting services for	
Information identifying the applicant's preferred area agency (drop down menu provided)	
Information about whether anyone in the applicant's household has a burial contract, plot, or fund	
Additional information about the application	
Information about whether anyone in the applicant's household is a member of a federally recognized tribe	

6B. Web Portal Accessibility

Additionally, the online application requires the creation of an online account on the NH EASY portal. This process is not accessible to individuals who use accessible technology like screen readers. Once the account is established, navigating through the account creation screens, including the security check and the requirement to select an image for additional security protections, is difficult and may take a significant amount of time for an applicant to complete if using accessible technology.

RECOMMENDATIONS

Recommendations are organized into the following themes: **policy changes to reduce eligibility processing time, system and process improvements, improving application completeness and staffing and training opportunities**. Importantly, not every finding results in a direct recommendation. However, taken together, these recommendations provide a comprehensive roadmap for DHHS to reduce processing times, improve operational efficiency, and deliver a more streamlined and consistent experience for applicants. Implementation of these changes, particularly those related to workflow design, automation, and policy simplification—has the potential to significantly reduce the LTC application backlog and position DHHS for long-term sustainability and improved service delivery. A number of these recommendations were identified by DHHS leadership prior to the PCG business process review and are already prioritized for implementation through the MEE workgroup. These recommendations are clearly marked as “in progress.”

POLICY CHANGES TO REDUCE ELIGIBILITY PROCESSING TIME

- Eliminate the Requirement for Face Sheets and Update the General Check List (in process)
- Reduce the Interview Requirement

SYSTEM AND PROCESS IMPROVEMENTS

- Case-Based Processing for New Applications (in process)
- Worker and Manager Dashboard
- Auto Approval/Auto Denial
- AVS GUARD Radius & Local Bank Expansion
- Cost of Care/ Patient Liability Screen Update
- Provider Portal

IMPROVE APPLICATION COMPLETENESS

- Enhance Web Portal for accessibility compliance
- Recommend Online Applications
- LTC Application Manual for Providers and Applicants (in process)
- Community Partner Training (in process)
- Align Paper and Online-Based Applications

STAFF HIRING AND TRAINING

- Fully Staff LTC and Expand the Trust Unit
- Improve Training and Familiarity with the Medical Assistance Manual
- Create a LTC Staff Procedure Manual
- Expand and Enhance New Hire Training (in process)
- Conduct a comparative pay analysis
- Develop Career Pathway programs

POLICY CHANGES TO REDUCE ELIGIBILITY PROCESSING TIME



1. Eliminate the Requirement for Face Sheets and Update the General Checklist
Addresses findings: 1D

PCG understands that the Face Sheets were implemented to allow the applicants to receive a tailored check list of documents needed for verification early in the process. Theoretically, this should allow more documents to be available for the HSS at the time of the interview. However, creating this Face Sheet has also been very time consuming for HSAs, and directly leads to a backlog of new applications. At the time of the Business Process Mapping meeting in April, the HSAs were reviewing applications that had been submitted three weeks prior. There is a scheduled system enhancement for July that will automate the Face Sheet for applications submitted online; however, manual work will still be required for paper applications, which is at least 50% of applications. **PCG recommends eliminating the Face Sheets and instead improving the general check list** so that it is easier for individuals to identify which documents they will personally be required to submit.

2. Reduce the Interview Requirement:
Addresses findings: 1E

The NH LTC Medicaid financial eligibility process includes a requirement that all applicants, or their authorized representative, be interviewed to review the application and supporting materials. This interview requirement adds another step in the process that contributes to delays in the application approval timeline. There is no federal requirement that Medicaid LTC applications must include an interview. The NH regulations governing Eligibility for Medical Assistance (Chapter He-W 800) do reference an interview requirement, however, these regulations warrant a review given the goal of expediting the eligibility determination process. The two sections are included in Appendix B for reference. Moreover, NH's Medicaid State Plan makes no reference to interview requirements, so no State Plan Amendment will be required. The only other reference to an interview requirement is in the Medical Assistance Manual. Federal authorities, such as the Medicaid State Plan and Waivers supersede state regulations. Since the state plan does not require interviews for eligibility, NH will be able to implement changes relatively quickly.

PCG recommends reviewing and, if necessary, amending the regulations and the Medical Assistance Manual to reduce the interview requirements. For example, if a facility or trained community partner submits the application on behalf of the individual seeking services, the interview could be waived entirely. In other instances, the LTC Procedure Manual should be updated to include HSS outreach for individuals applying on their own or with the support of a family member, or if there are questions that come up during the review process. This outreach does not need to be pre-scheduled – it can happen as an HSS is processing the case. If recommendation #1 is accepted, HSAs will return to processing cases within 2-3 business days of an application date and HSS can review an application once the AVS is returned. This will put the HSS initial review date at 12 – 18 days from the application submission date, rather than the current 30 – 40 days.

SYSTEM AND PROCESS IMPROVEMENTS



3. Case-Based Processing for New Applications
Addresses findings: 1A, 1B, 1C, 1D and 3B

Based on staff interviews, observations from shadowing, and peer state research, PCG recommends a hybrid approach to workflow management. Task-based assignments work well for case changes and recertifications. However, new applications should be assigned to one HSS

and stay with that HSS until eligibility is determined. This will reduce the multiple HSS involved with a single application, reduce the time between a case update and the application being worked on, and will provide the applicant with a single point of contact if questions come up throughout the process. PCG has recently learned that this approach is currently in the process of implementation by DHHS.

4. Worker and Manager Dashboard

Addresses findings: 1A, 1B, 1C and 3C and 4E

PCG recommends prioritizing two types of dashboard features in New HEIGHTS to automate case assignments and updates: 1) a worker dashboard with all the tasks assigned to that HSS and 2) a supervisor dashboard that includes a consolidated view of worker assignments. A worker dashboard would allow the worker to see the tasks they are responsible for working arranged by the order in which they are due. This feature will be particularly useful once HSS are responsible for managing a new application from initial intake through eligibility (see recommendation #3). Worker dashboards may be further developed in task-based systems to allow the worker to "pull" or select tasks on their own without requiring an assignment from a supervisor. The Supervisor dashboard should provide visibility for both assigned and y unassigned tasks and provide the option for monitoring task through-put and assigning tasks as needed. Further incorporating dashboard metrics (case statistics, staff performance, etc.) would give supervisors the ability to identify and address issues as part of a continuous quality improvement process. As part of the development and rollout of these dashboards, NH DHHS should consider incorporating the following features to support efficient case processing:

- Track the number of document requests made to applicants, so that it is easy for a worker to identify when they have completed two requests
- Update a case through a task or flag to identify when new documents have been submitted. If new applications are case-managed, the HSS would be alerted to update the case.

5. Auto Approval/Auto Denial

Addresses findings: 4D

PCG recommends working with the New HEIGHTS team to expand initial eligibility determination through automated mass-update runs in the following situations:

- When documents have been requested twice on case and no documents have been submitted after 10 days, the case should auto-deny.
- Approval should only be automated once both medical and financial eligibility have been added to the case. In other words, the system should not automatically approve the case until both the financial and the medical eligibility have been established.

This enhancement will reduce the number of tasks that need to be manually assigned to the HSS to process. It will also eliminate the delays that occur due to the sheer volume of these tasks and improve the timeliness of notifying applicants of the eligibility decision.

6. AVS GUARD Radius Expansion

Addresses findings: 4A

The limited number of results from AVS inquiries are due in part to the five-mile radius search parameter, which is the base search range included in the currents AVS contract. These search parameters are referred to a GUARD searches. Purchasing a higher AVS tier could help DHHS increase the number of AVS responses, although it would cost DHHS more and require an amendment to the current DHHS-Accuity contract. DHHS received an AVS Expansion Proposal from Accuity Asset Verification Services, Inc. which delineates options for DHHS to increase the number of Geographic Undisclosed Account

Radial Detection (GUARD) request searches from the current 3 to 4, 5 or even 6. Any GUARD increase could help DHHS improve upon its approximate 58% success rate for returning an account found in response to an AVS search. Increasing the number of GUARD requests would also strengthen program integrity by ensuring that searches more banks based on proximity to an applicant's home address, and the number of branches within the same zip codes. The pricing is based on provided in November 2025 and is tiered based on each additional level of search. Accuity quoted the following pricing for additional GUARD expansions:

TABLE 4: ACCUITY PRICING FOR ADDITIONAL GUARD SEARCH REQUESTS

Additional GUARD Searches	Total # of GUARD requests included in search	GUARD Expansion Price	Estimated Monthly Cost*
0	3	$0	$1,532
1	4	$0.62	$1,836
2	5	$1.23	$2,170
3	6	$2.00	$2,514

**Monthly cost assumes 491 applications per month*

This proposal is dated November 24, 2025, and was good for 120 days, so an updated proposal will need to be requested.

A second challenge reported by DHHS staff is that AVS often fails to return results from local banks and credit unions. The AVS system purchased by DHHS is guaranteed to search 18-19 different financial institutions. Most of these are large national or international banks, such as JP Morgan Chase and Santander. However, Accuity has indicated that NH can work with them to include more local banking chains in their standardized searches. **PCG recommends adjusting the financial institution search settings to include up to 9 local financial institutions and expanding the GUARD search to 2 or 3.** These enhancements will improve the effectiveness of each AVS search and reduce the burden on HSS to manually verify accounts.

7. Indexing or Re-indexing in Bulk
Addresses findings:4G

PCG recommends working with the New HEIGHTS team to identify system solutions to allow HSS to index or re-index documents in bulk. This would allow workers to easily identify and process duplicate documents and focus their time and energy on the documentation that requires review.

8. Cost of Care/ Patient Liability Screen Update
Addresses findings: 4F

The **Cost of Care (CoC) screen in the New HEIGHTS eligibility system should be redesigned to mirror the functionality of the Patient Liability (PL) screen** in order to reduce manual processing, improve accuracy, and better align with the overall eligibility workflow. The system should trigger a single, unified cost of care calculation after eligibility determination is complete. A redesigned screen should auto-populate relevant data, support start and end dates for medical expenses and enable automated tracking of spend down to eliminate the need for repeated manual updates. Additionally, it should include LTC-specific fields and coding (e.g., nursing facility status and patient liability adjustment categories) in drop-down menu format to ensure accurate calculations for this population. These modifications would allow HSS to easily identify and pull only relevant medical information into the LTC eligibility

determination process. Aligning CoC functionality with the PL screen, while improving system integration between medical and financial processes, will also streamline operations, reduce administrative burden, and ensure consistent, accurate eligibility outcomes and member communications.

9. Provider Portal
Addresses findings: 3A and 3B

The peer state interviews identified two states that operate web-based Provider Application portals in addition to their standard customer application portal. This allows approved Medicaid providers, such as skilled nursing facilities and home care providers to submit applications on behalf of their clients without needing to set up separate user profiles for each application. Through this portal, providers can submit initial applications, upload requested documentation and view the status of each application. **PCG encourages DHHS to explore the development of a provider portal** would allow the LTC team to reduce its focus on supporting individual providers and significantly reduce the volume of follow-up calls and emails from providers to check on the status of applications.

IMPROVE APPLICATION COMPLETENESS

10. Make Web Portal Accessible
Addresses findings: 6C

The online application requires the creation of an online account on the NH EASY portal. The process of creating an account on NH EASY is not accessible to individuals who use accessible technology like screen readers. Navigating through the account creation screens, including the security check and the requirement to select an image for additional security protections, is difficult and may take a significant amount of time for an applicant to complete if using accessible technology. **PCG recommends the NH EASY portal and online application for benefits be in compliance with the latest digital accessibility standards** ensuring everyone is able to apply for services even when they use screen reader technology.

11. Recommend Online Applications
Addresses findings: 6A

When applicants are able to access the portal and apply online, financial eligibility staff report that they tend to have better information, such as the correct contact individual and an understanding of why they are seeking services. They also do not need to enter the data into New HEIGHTS manually. **PCG recommends training community partners and providers who submit on an applicant's behalf, to use the online portal.**



12. LTC Application Manual for Providers and Applicants
Addresses findings: 3A

A number of Medicaid LTC applications are incomplete when submitted, increasing the demand on HSA and HSS time. PCG understands that New Hampshire is currently working on developing a LTC Medicaid Application Manual for service providers and applicants to assist with the completion of their application. **PCG supports the creation of this manual as a tool to help increase the number of completed applications** received, ensuring financial eligibility staff focus on the eligibility review.



13. Community Partner Training
Addresses findings: 6C

When individuals use assistance from community agencies to submit their applications, workers report that applications are more complete. Education and outreach of community partners including aging and disability resource centers (ADRCs), NHCarePath (e.g. the No Wrong Door system), and other community-based agencies, specifically on the use of the application online portal will increase rates of complete applications submitted. **PCG supports New Hampshire's ongoing work on training for community partners and providers** who submit an application on an individual's behalf to use the online portal.

14. Align Paper and Online-Based Applications
Addresses findings: 6B

PCG recommends aligning the paper and online-based applications to ensure individuals seeking Medicaid LTC experience a consistent application process and DHHS staff are able to review the eligibility of the applications consistently across the online portal and paper applications.

STAFF HIRING AND TRAINING

15. Fully Staff LTC and Expand the Trust Department
Addresses findings:5A, 4B

At the time of this report, the LTC unit had 5 unfunded positions. Ensuring these positions are funded in the next budget cycle will be critical to long-term success. Once the LTC process enhancements and system efficiencies identified through MEE have taken place, **the state should consider a workforce assessment to identify the number of HSAs, HSS and supervisors needed to manage the workload**. Compared to other states, 46 FTEs may be too low. Additionally, the Trust Unit currently consists of only one team member. This slows down the application processing speed and poses significant risk should the team member leave the position or be out of office for any period. It **is recommended that the team expand the Trust Unit to include additional staff.** Additionally, procedures should be well documented to facilitate new hire training and ensure continuity whenever staffing changes occur. To supplement support for the Trust Unit, DHHS may look into AI technologies that would allow Trusts to be reviewed and analyzed faster. Technologies that automate data extraction and flag language and clauses of concern for Medicaid eligibility could help the trust unit be more efficient. Datagrid's AI agents and Ocrolus' Document Intelligence both offer this capability.

16. Improve Training and Familiarity with the Medical Assistance Manual
Addresses findings: 5B, 5C

The current Medical Assistance Manual is a resource that details program rules and guidelines and includes references to relevant state and federal rules. This Manual is an important resource that allows LTC team members to daily navigate program rules and provide justification for decisions made on cases. Based on staff interviews, there is opportunity to increase familiarity and comfortability with navigating the Medical Assistance Manual. **PCG recommends that training around the Medical Assistance Manual be developed for new staff, as well as continuing education training for existing team members**. Additionally, to improve familiarity with and reference to the Manual, **PCG**

recommends that Manual references be built into New Heights, which would allow workers to pull up specific sections of the Manual based on the current screen they are in.

15. **Create a LTC Staff Procedure Manual to Supplement the Medical Assistance Manual to Better Link Policy to Case Processing Procedures**
    Addresses findings: 5B, 5C

While some procedure documents currently exist, they are not standardized and are informal. **PCG recommends developing a LTC Case Processing Procedure Manual.** This Procedure Manual should include current procedure documents and should also include any procedures which are not already documented. This manual will complement the Medical Assistance Manual and should clearly link procedure to specific sections in the Medical Assistance Manual.



16. **Expand and Enhance New Hire Training**
    Addresses findings: 5B, 5C

Currently, training focuses mainly on policy and high-level program overview. This material is important and should remain a part of the training curriculum. However, **PCG recommends that training should be expanded** in order to provide new hires with a full understanding of not only the programs and policies, but also the associated procedures and system operations.

Expanded training should include:

- Detailed instruction on how to use the New HEIGHTS system, including known needed workarounds and system issues
- Real case examples to demonstrate procedures in action
- Shadowing sessions with current employees

17. **Conduct a Comparative Pay Analysis for BFA HAS and HSS**
    Addresses findings: 5A

The Bureau of Family Assistance at DHHS is responsible for processing the applications for multiple public benefit programs through New HEIGHTS. While each program uses the New HEIGHTS process flow, the program requirements that drive each eligibility process are unique. LTC requires an understanding of Medicaid eligibility plus the added content knowledge of resource identification, asset limits, and post eligibility income calculations that vary based on living arrangements. Some states, such as Pennsylvania and Rhode Island, slightly higher pay for LTC eligibility workers combined with extra training, has improved recruitment and retention into these positions. **PCG recommends that NH conduct a comparative pay analysis of HSA and HSS to determine if there is an opportunity to enhance the compensation of LTC workers.**

18. **Career Pathway Programs**
    Addresses findings: 5A

PCG recommends DHHS develop structured career pathways as a long term strategy and sustainable solution to the persistent staffing challenges facing Medicaid LTC programs. Career pathways create structured, accessible entry points into the workforce while establishing clear opportunities for advancement. Internships, apprenticeships, and earn-while-you-learn models expand and diversify the candidate pool by engaging students, career changers, and individuals seeking stable employment with long-term growth potential, many of whom may not otherwise consider careers in LTC.

By defining progressive roles from entry-level to specialized or supervisory roles, career pathways help staff envision a future within the field, rather than viewing these jobs as temporary or transitional. Investing in a structured career pathway approach creates a stronger, more stable workforce while reducing long-term recruitment, vacancy, and training costs.

APPENDIX A– LTC BUSINESS PROCESS MAPS

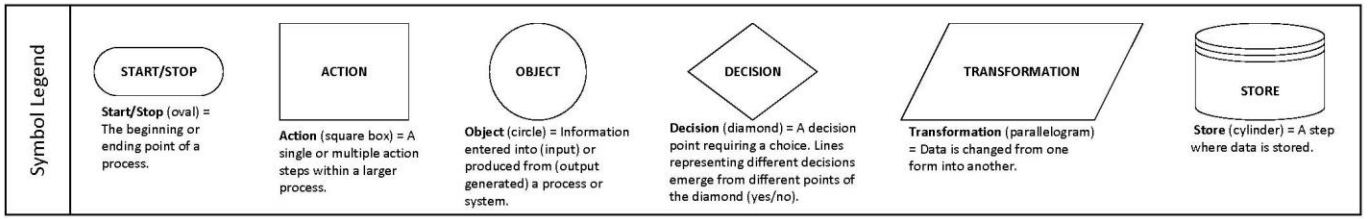
KEY AND SYMBOL LEGEND

Key

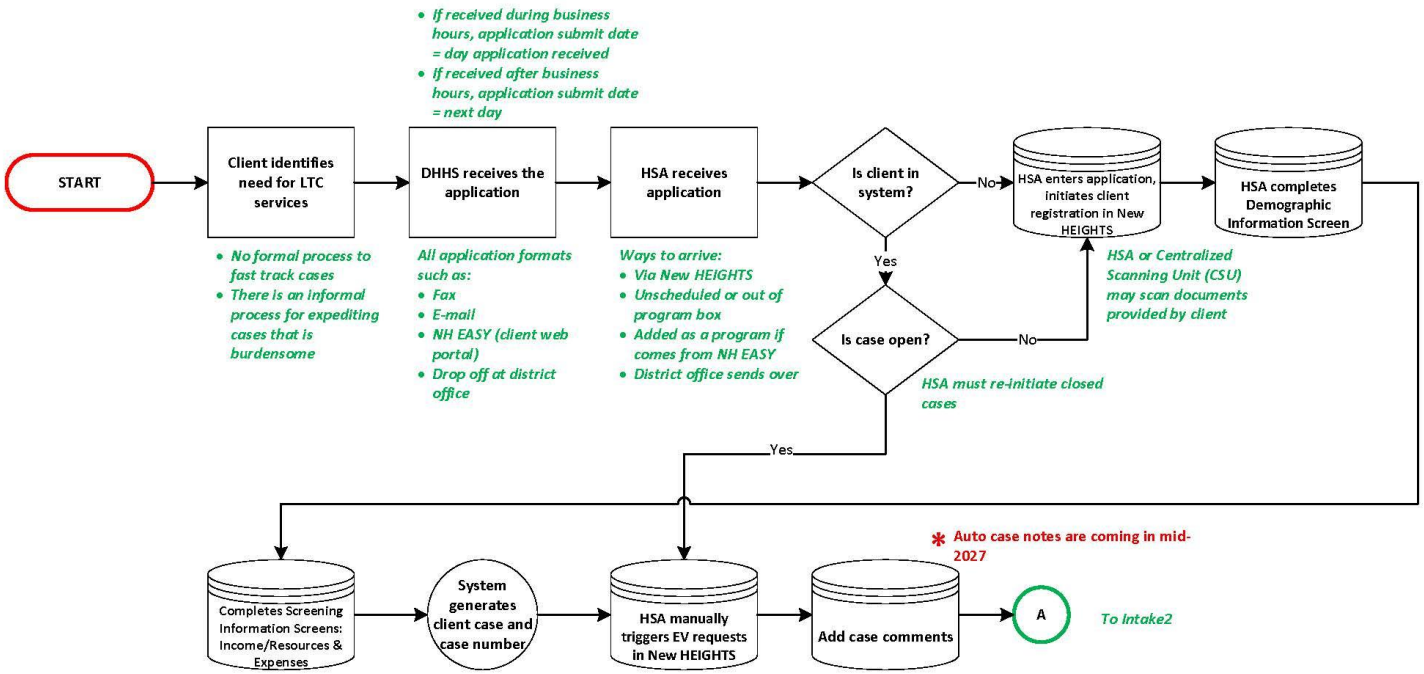
General PCG notes on task
* Improvements are planned or in process (system, business process, etc.)
! Improvement opportunity

Primary sources to create these process maps:

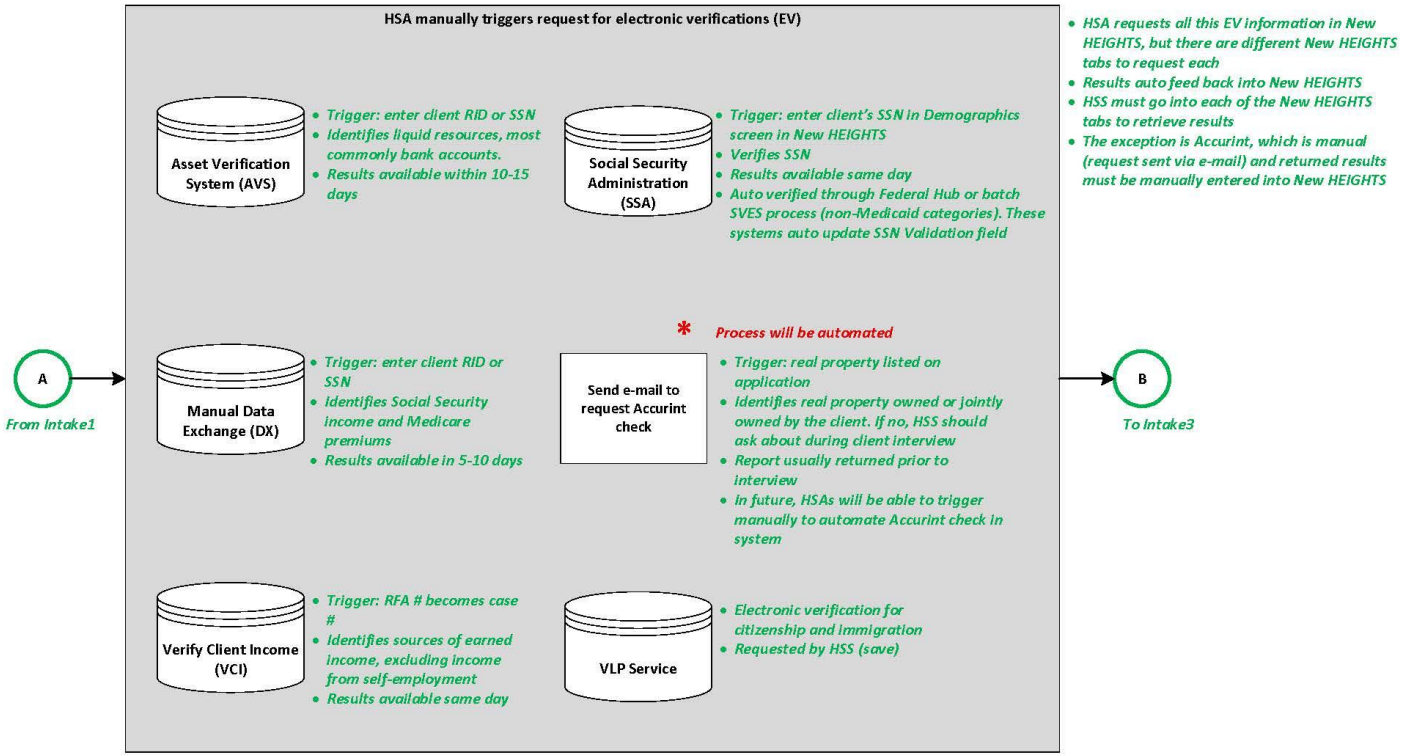
- *Overview of the LTC Process.pdf*
- *LMT Sponsor Report Out 8.2025.v2.pdf*
- *Job shadowing / meetings with NH DHHS staff*



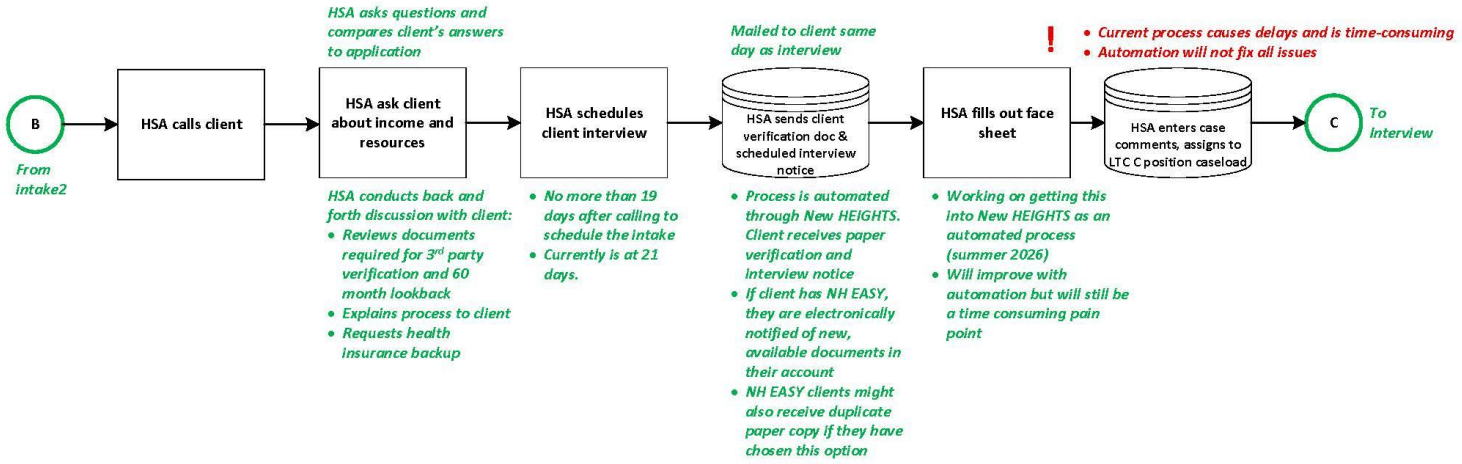
HSA APPLICATION/INTAKE 1



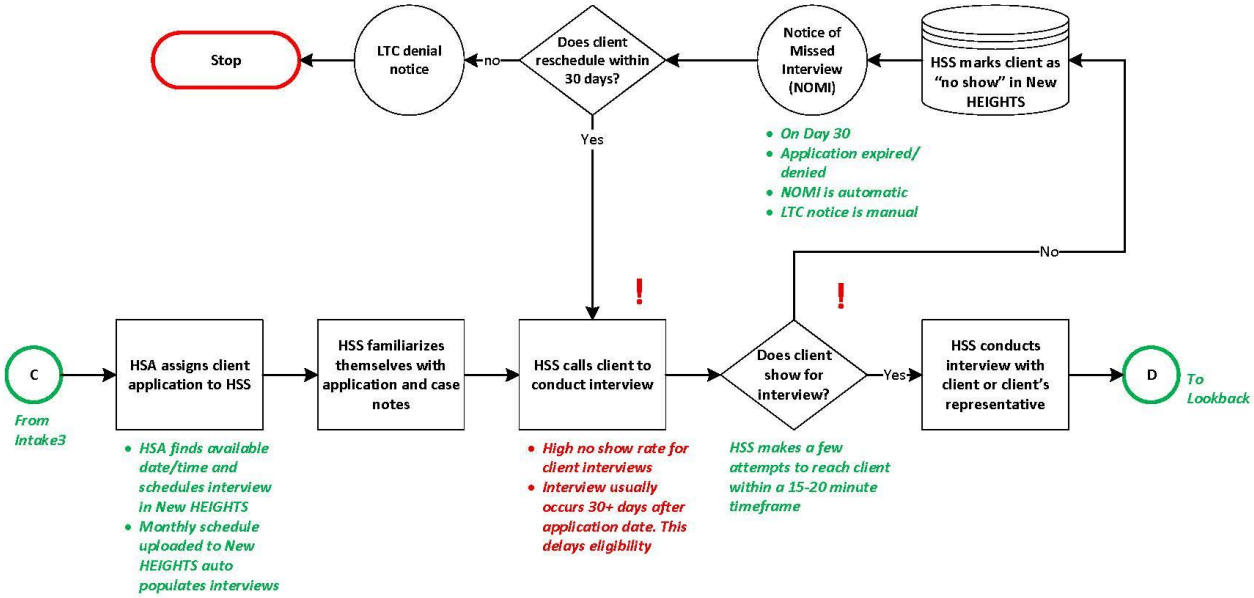
APPLICATION/INTAKE 2



APPLICATION/INTAKE 3

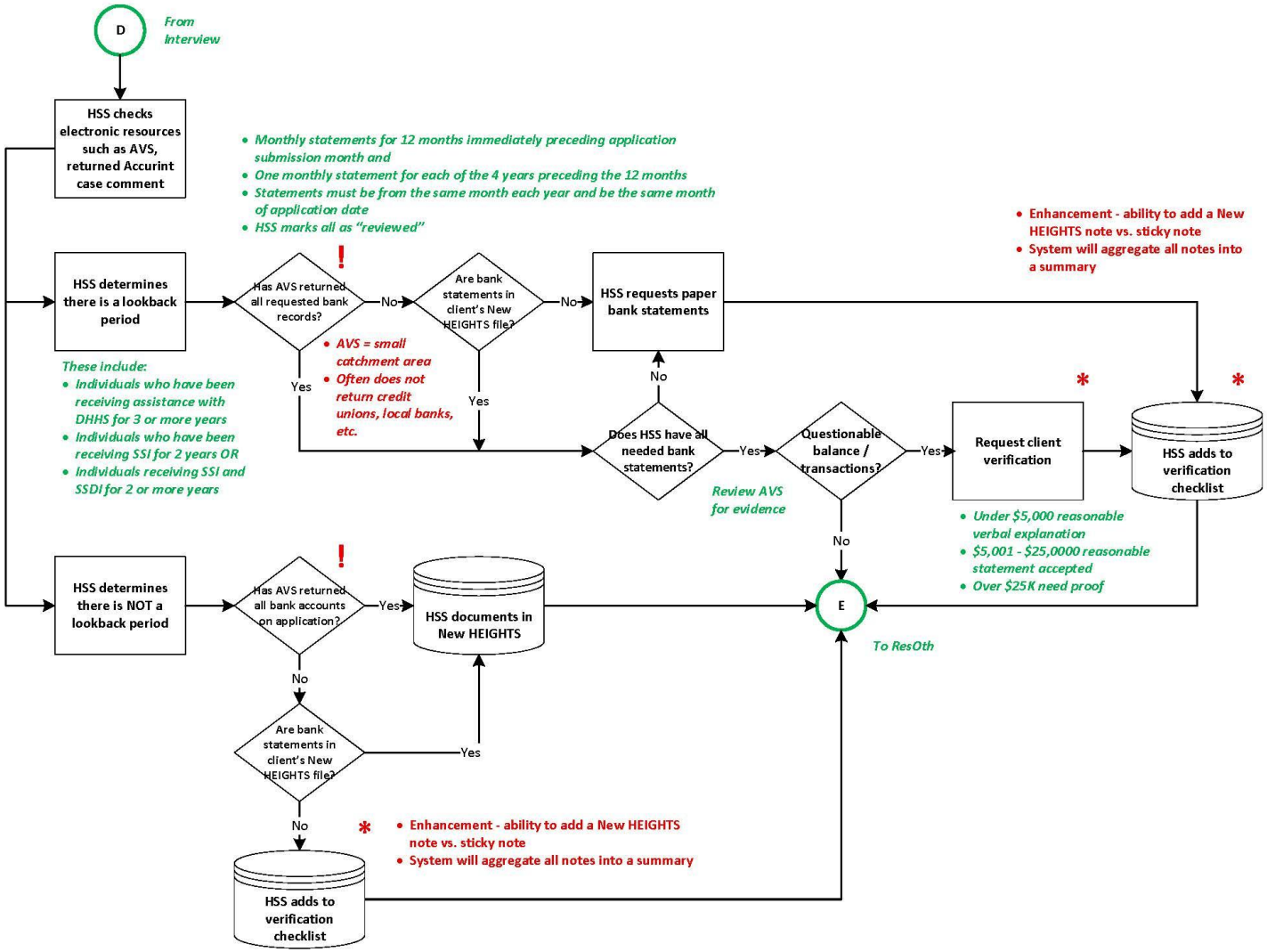


HSS INTERVIEW 1

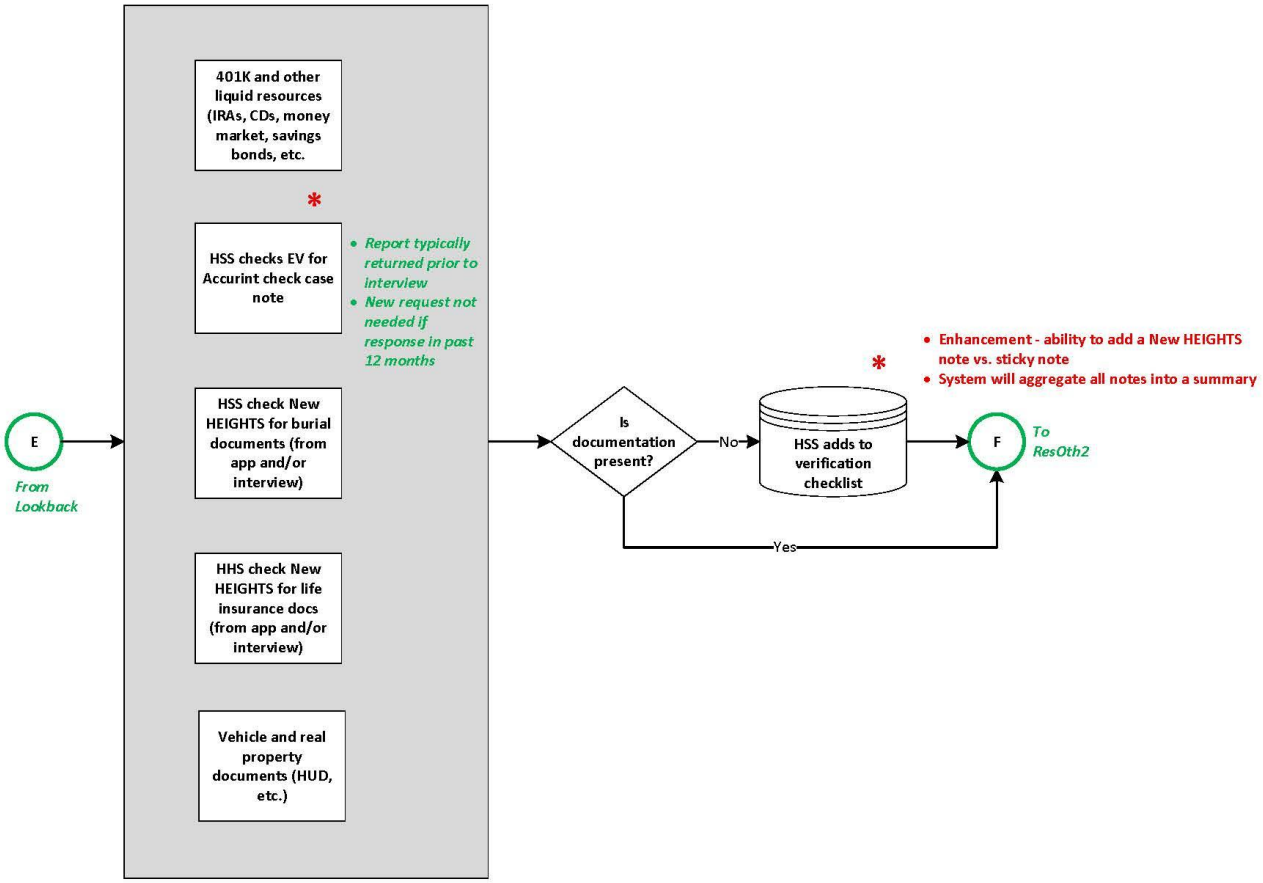


HSS RESOURCES – BANK ACCOUNTS AND LOOK BACK

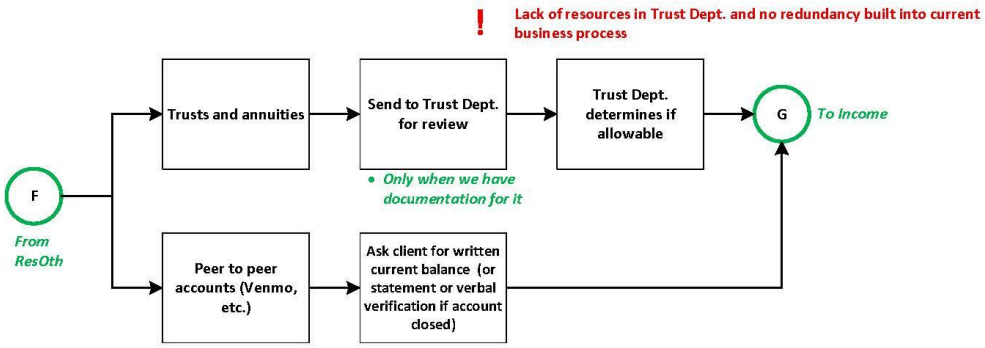
This process is used to determine if resources are under $7,500 for the past five years
- *This comes first in interview process, HHS starts here (driver flow)*
- *Look back is its own process, bank accounts and other resources fall under ResOth*



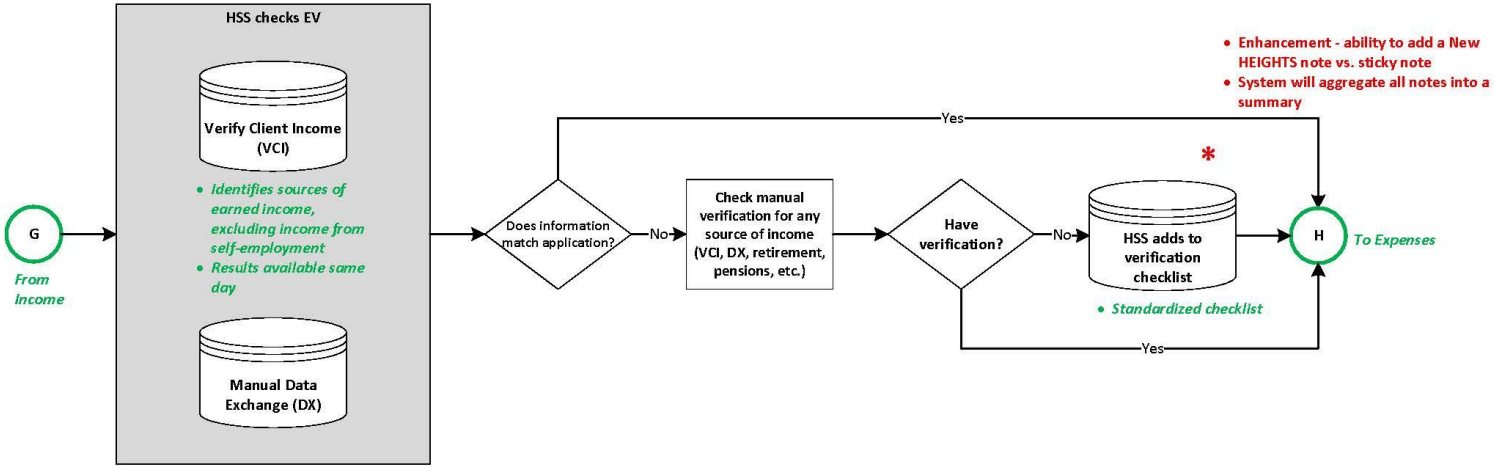
HSS RESOURCES – OTHER



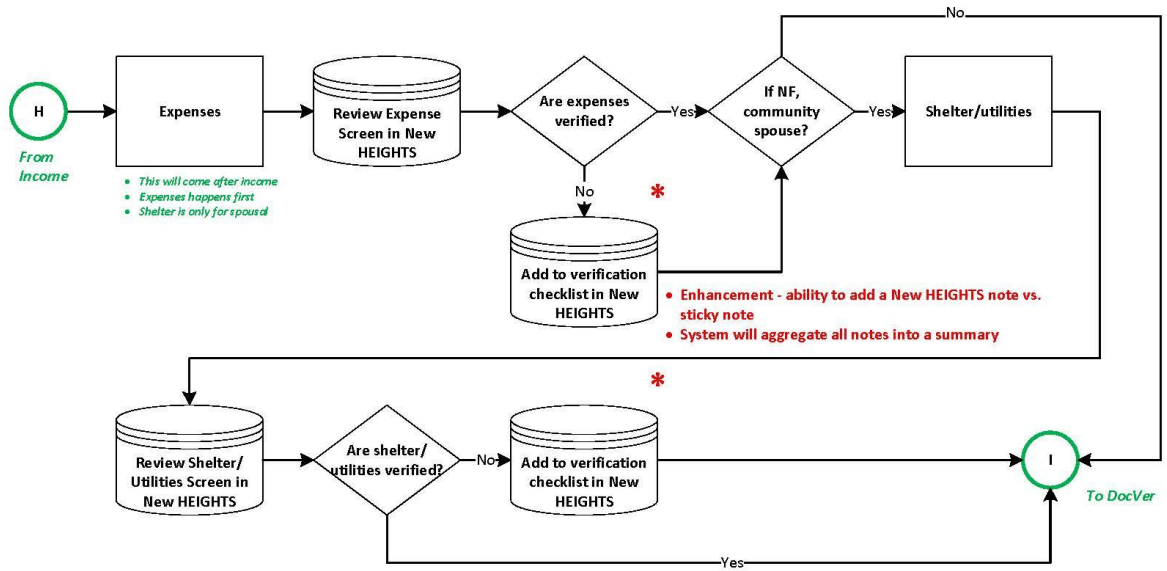
HSS RESOURCES – OTHER



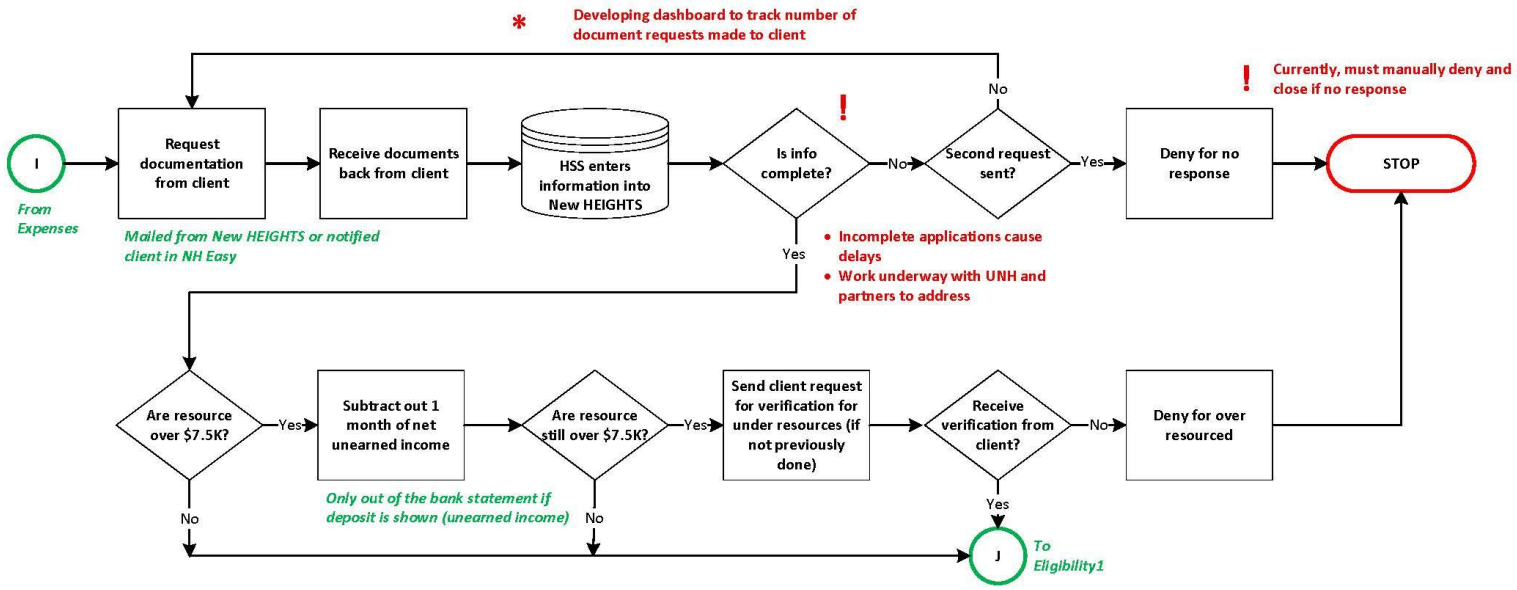
HSS INCOME VERIFICATION



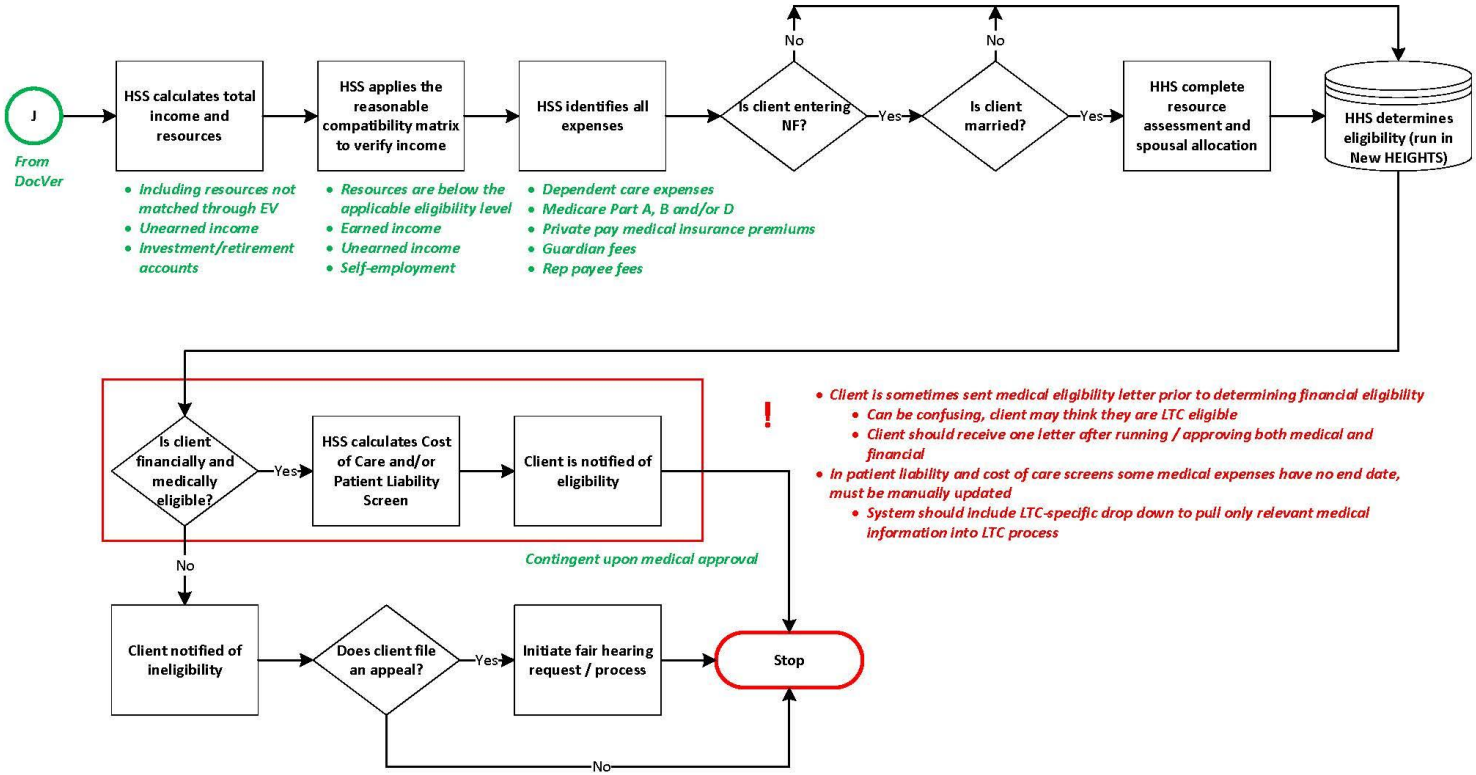
HSS RESOURCES – EXPENSES



HSS DOCUMENT VERIFICATION



ELIGIBILITY 1



APPENDIX B – INTERVIEW REQUIREMENT REFERENCES

CHAPTER He-W 800 ELIGIBILITY FOR MEDICAL ASSISTANCE
He-W 801.06 Definitions
(j) "Personal interview" means a conference between the applicant, recipient, or AR and the department staff member, in order to:
(1) Discuss all circumstances which have a bearing on eligibility;
(2) Advise the applicant, recipient, or AR of the eligibility requirements and their rights and responsibilities; and
(3) Afford applicants, recipients, and ARs an opportunity to ask any questions about the department's programs.
He-W 802.03 Telephone Application.
(c) All the application requirements that apply when an individual submits a written application shall apply when an individual requests assistance via (a) above, including:
(1) Verification requirements described in He-W 806;
(2) Interview requirements described in He-W 636.01 and He-W 644.01;

PART He-W 844 Technical Requirements for Adult Medical Assistance
He-W 844.01 Personal Interview.
(a) A personal interview between the individual or authorized representative (AR) and a department staff member or contracted employee shall be required for:
(1) Each initial determination of eligibility for adult category medical assistance; and
(2) Each regularly scheduled redetermination of eligibility for all adult category individuals except for:
a. Individuals who receive in and out medically needy medical assistance pursuant to He-W 878.01;
b. Individuals residing in independent living arrangements and not receiving SNAP benefits; and
c. Individuals residing in nursing facilities or swing-bed hospitals, as defined in 42 CFR 413.114(b), and receiving payments for nursing care or who are only eligible for medical services other than a payment for nursing care.
(b) When required for nursing facility, choices for independence (CFI), home and community-based care for the developmentally disabled (HCBC-DD), home and community-based care for individuals with an acquired brain disorder (HCBC-ABD), and home and community-based care for in-home supports (HCBC-IHS) cases, a department staff member shall conduct a personal interview with one or more of the following:
(1) The individual;
(2) A representative of the nursing facility or swing-bed hospital as defined in 42 CFR 413.114(b);
or
(3) The individual's relative or AR.
(c) A personal interview shall be conducted for all adult category cases, including those exempted above in (a)(2), as a result of reported changes or the discovery of conflicting information related to eligibility.
(d) A personal interview shall be required once during a 12-month period for any adult category case on a more frequent redetermination of assistance schedule pursuant to He-W 684.02(d).
(e) The individual or the individual's AR shall review the summary of the information provided during the interview with the department's representative who conducted the interview, and:
(1) Make any corrections to the information; and
(2) Sign the summary attesting to the truthfulness and accuracy of the information provided.

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APPENDIX C – PEER STATE MATRIX

State	Type of Eligibility System	Name of Eligibility System	Waiver Type	Entity Responsible for Eligibility	Case-based or Task-based?	AVS system
Georgia	Deloitte integrated eligibility system	Georgia Gateway - Consumer and Provider Portal	1915(C)	County	Task-based	Requests are sent through Gateway after eligibility is determined. Reliably receives bank account numbers and balances for the customer's bank accounts that includes CDs, checking, savings
Pennsylvania	Deloitte integrated eligibility system	COMPASS (portal for applications) COMPASS Community Partner (for providers) E-SIS (eligibility system)	1115 Waiver	State	Case-based	AVS requests are done at application. Reliably receive information on banks. Experience difficulty receiving information from credit unions. No information on life insurance, vehicles, or other resources.
Rhode Island	Deloitte integrated eligibility system	RI Bridges	1115 Waiver	State	Task-based	PCG system is integrated with Bridges. AVS flags one-time transfers of more than $4,000, over a 60 month period. Bank Statements are only requested when there is a flag. Pain points include the address based off a SNF address and not the home address.
Maine	Demographic similarities and strong existing relationship with the NH DHHS team	My Maine Connection (application portal) MaineCare (eligibility system(	—	State	Task-based	Uses PCG Mostly fully integrated with the eligibility system Reliably receive information on bank accounts Difficulty receiving car or vehicle information, difficulty distinguishing trusts and annuities, difficulty with smaller banks

State	Application Overview	Do they have a backlog? What is average processing time?	Look Back Policies/ Procedures	System Feedback
Georgia	Paper applications are available, but most is steered to the online Gateway portal. This is a single, web-based application that exists that directs applicants to an LTC eligibility pathway based on questions about requested services.	Information not available at time of interview	AVS request is submitted at the point of application. During the interview process, the worker addresses 5 year look back, and they look for property on some of the state's property websites. AVS results are used to identify discrepancies with what is self-reported. Cases with discrepancies will generate a task and a worker will determine what the issue is and request more verification if needed.	One of the biggest pain points with the system is trying to get changes done on a timely manner. Ensuring that case managers are reviewing the information because Gateway pre-populates things in the worker portal and making sure that workers don't just go with whatever's there instead making sure that they review thoroughly the information Staff shortages and staff turnover User acceptance training and having policy changes be misunderstood.
Pennsylvania	LTC specific application can be submitted by mail, through the online portal or in person	No real backlog, average processing time is 16.8 to 18.8 days for approvals	Request of monthly bank statements for the past 2 years and semi-annual bank statements for 3 years before that. This is waived if individual is on SSI or enrolled in a state Medicaid plan.	Issue with not being able to separate LTSS and Medicaid eligibility Issues with retro periods, system does not save data from month to month and workers have to input all data by hand Issues with getting changes to the LTC and Waiver programs due to little resources and a small population Issues with prioritization and resource availability

Rhode Island	LTC specific applications are submitted on paper although they can be submitted through an online portal as well	A backlog of 195 Backlog includes financially complex cases Total average time to process applications is 45 days	State relies on AVS to flag potential transfers. Requests bank statements if transfers are identified,	The biggest pain points are with automatic updates re-opening cases – Mass Updates, COLA. They work well for Medicaid and snap but not LTSS, especially if it impacts patient liability. Reopens cases that were closed for lack of documentation, etc. This is because LTSS is part of the Medicaid hierarchy, so Bridges is always trying to select the Medicaid they are eligible for. It also always picks up the date of the first Medicaid application. Also, level of care approval process is time consuming and challenging
Maine	One application for multiple programs that includes specific questions when applying for LTC. ME has centralized intake for paper applications or via My Maine Connections portal online	Backlog of 3500 tasks for the past 2 months Average processing time for determination of new applications is 45 days	Changed its look back policy from 5 years to 12 months	Issues with task-based management system not functioning like it is supposed to Issue when a task is complete in a denial and is marked as complete, moved out of the eligibility staff's cue and the individual submits the missing documents later the staff will not be notified and will never know that happened

State	Integration with Other systems	Number of Eligibility Workers	Number of applications per month	State Office Responsible for LTC Financial Eligibility	State Contact
Georgia	All eligibility work is in Gateway portal	550 eligibility workers for Medicaid aged, blind and disabled	Information not available at time of interview	Department of Human Services	Taesha Ward, Director of Program and Community Supports: taesha.ward3@dch.ga.gov
Pennsylvania	All eligibility processes can be found within E-SIS, they may use different modules but all within the same system	4000 total eligibility workers across the state, not able to distinguish specific staff working on LTC eligibility	12,000 applications received/month	Office of Income Maintenance	Scott Cawthern, Chief of Staff scawthern@pa.gov
Rhode Island	Bridges, Wellsky (case management), AVS and MDS (connects to MH Medicals) Somewhat integrated	36 total: 28 ETs, 27 social workers, 6 Financial II ET	400 to 500 applications/month	Department of Human Services	Rose Leandre, LTSS Administrator rose.leandre@dhs.ri.gov
Maine		43 staff in the team, 33 eligibility workers	700 applications/month	Department of Health and Human Services	Jessica Drenning, Senior Program Manager 207.822.2143 | Cell: 207.592.3811.