

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New Hampshire Comprehensive Program Integrity Review

Final Report

November 2012

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the New Hampshire Medicaid program. The MIG conducted the onsite portion of the review at the New Hampshire Department of Health and Human Services (NHDHHS).

This review focused on the activities of the Surveillance and Utilization Review Unit (commonly referred to as the SURS unit) within the Office of Improvement and Integrity (OII), which is responsible for implementing program integrity activities. This report describes one effective practice, seven regulatory compliance issues and two vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified two partial repeat findings from its 2009 review of New Hampshire. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help New Hampshire improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of New Hampshire's Medicaid Program

The NHDHHS administers the New Hampshire Medicaid program. As of January 1, 2012, the program served 119,626 beneficiaries, all of them on a fee-for-service basis. At the time of the review, the New Hampshire Medicaid program had 21,800 enrolled fee-for-service providers. According to the State, Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2011 totaled \$1,419,496,199.

Surveillance and Utilization Review Unit

The SURS unit is dedicated to carrying out program integrity functions within the NHDHHS. At the time of the review, the unit had eight full-time equivalent (FTE) positions. These included one auditor, one investigator, two nurses, one data analyst, one program specialist on beneficiary fraud and abuse, one provider enrollment specialist and one administrator. One of the nursing positions was vacant.

The table below represents the total number of preliminary and full investigations and the amount of identified and recouped overpayments in the past four SFYs as a result of program

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integrity activities. These numbers only reflect the activities of the SURS unit; global settlements are not included.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2009	3	37	\$648,966.06	\$65,914.26
2010	3	19	\$7,735.64	\$98,646.91
2011	10	33	\$146,085.30	\$66,940.56
2012	1	19	\$120,915.11	\$275,547.74

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. New Hampshire only counts as preliminary investigations those cases which do not merit further scrutiny and which are dropped before the final investigation stage.

**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

*** These figures reflect overpayments identified and recovered through SURS unit program integrity activities. They do not include collections from audit, law enforcement and other program integrity activities occurring outside the SURS unit. The increased collection amounts in SFY 2010 and 2012 reflect the collection of overpayments identified in previous years. Both the fluctuation in the number of cases and overpayments identified were due to changes in staffing levels. They dropped sharply when nurse reviewers were lost and picked up when the State was able to hire replacements.

Methodology of the Review

In advance of the onsite visit, CMS requested that New Hampshire complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, program integrity and the MFCU. A four-person team reviewed State responses and documents provided in advance of the onsite visit. An interview with the MFCU was also conducted.

During the week of May 1, 2012, the MIG review team visited the NHDHHS offices. The review team conducted interviews with numerous officials from NHDHHS. In addition, the review team met with staff from the NHDHHS division that oversees the non-emergency medical transportation (NEMT) program. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the SURS unit as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, personal care services, and NEMT.

New Hampshire operates its Children's Health Insurance Program (CHIP) both as a stand-alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as New Hampshire's Title XIX program. The same effective practices, findings and vulnerabilities found in the Medicaid program integrity review also apply to the CHIP expansion program. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

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Unless otherwise noted, New Hampshire provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided by the State.

Results of the Review

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. New Hampshire reported its use of provider self-audits.

Use of provider self-audits

New Hampshire utilizes provider self-audits to enhance its overpayment recovery actions. The use of a provider self-audit is a benefit to the SURS unit in light of the unit's limitations in staffing and resources. The SURS unit routinely identifies questionable claims through data analysis or complaints and will request a self-audit from the selected provider by letter. On occasion, a provider may proactively conduct a self-audit.

The State's notification letter outlines the self-audit process and addresses the rights and responsibilities of the provider in conducting the self-audit. If the provider decides not to participate, the SURS unit will conduct a full audit of the claims in question. Also, if the provider participates and the results are not satisfactory, then the SURS reviewer will conduct an onsite audit. New Hampshire mentioned that the results of most provider self-audits are accepted by the State.

The provider must also present a corrective action plan (CAP). A follow-up review will be conducted in six months to one year to ensure that the provider is following the CAP. Although provider self-audits have been effective in New Hampshire, the practice is not utilized on a large scale. The SURS unit has required approximately one provider self-audit in each of the past four SFYs. The amounts recouped have been equal to roughly 5-10 percent of New Hampshire's annual program integrity recoveries during this time period.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to the surveillance and utilization control program, the collection of ownership and control and criminal conviction disclosures, the performance of complete exclusion and debarment searches, the reporting of all adverse actions taken on provider participation, and the posting of required exclusion notices. In addition, New Hampshire was not in compliance with Federal requirements on False Claims Act education monitoring.

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The State does not have an effective surveillance and utilization control program.

The regulation at 42 CFR 456.3 requires that the State implement a statewide surveillance and utilization control program that can safeguard against the unnecessary or inappropriate use of Medicaid services and against excess payment of Medicaid funds; assess the quality of those services; provide for the control of the utilization of all Medicaid services provided under the plan; and provide for the control of the utilization of inpatient services.

Program integrity functions in New Hampshire are the primary responsibility of the SURS unit, which resides outside the Medicaid agency. Although it does analyze provider billing patterns for unusual spikes and trends through ad hoc reports, the SURS unit is not capable of generating the kind of systematic, ongoing analyses that would be possible with an active surveillance and utilization control program. The SURS Administrator reported that of the eight authorized FTEs in the SURS unit, there is only one SURS reviewer to run ad hoc reports dedicated to fraud and abuse detection. The staff is currently unable to perform data mining, algorithm development or automated exception processing. Nor can it utilize sampling or more sophisticated techniques, such as predictive modeling, artificial intelligence or fuzzy logic.

Consequently, the State does not have a program in place to effectively and proactively analyze medical care and service delivery data due to lack of tools, staffing and an adequate MMIS. Most of its investigations are generated from complaints. Additionally, New Hampshire does not have current rules in effect to support case findings or provider appeals, and the State does not allow the SURS unit to extrapolate during audits of provider claims. The results can be seen in the relatively low numbers for overpayments identified and collected. Over the period SFY 2009-2012, the State averaged \$230,926 in overpayments identified while collecting an annual average of \$126,762. In contrast, Montana and Vermont, both slightly smaller Medicaid programs, averaged significantly more in both categories over the time period SFY 2007-2010. These two programs identified \$938,925 and \$1,621,383 on average in overpayments, while recouping an average of \$755,854 and \$1,555,424, respectively.

Furthermore, the State has not used its surveillance and utilization review (SUR) subsystem since the previous CMS review in Federal fiscal year 2009. The SURS unit manager stated the entire subsystem was deemed unusable and turned off after incorrect SURS reports were generated from data supplied by the Medicaid Management Information System (MMIS). During the review, the SURS unit manager noted that New Hampshire expects to procure a new SUR subsystem in December 2012.

New Hampshire currently runs its case tracking in a Windows 2002 Access database. Much of the State's internal software is of this vintage. Although a new SUR subsystem will be implemented, the other computer systems and software will remain. The State indicated that it was not sure if all internal system issues will be corrected with the arrival of the new subsystem because its internal software is outdated.

Recommendations: Implement a SUR subsystem that ensures the safeguards outlined in 42 CFR 456.3. Allocate resources that support a robust fraud and abuse detection program. These should include data mining and analytical tools which are commensurate with the capabilities of the new MMIS and SUR subsystem and which will strengthen the State's ability to comply with

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Federal requirement that the Medicaid agency conduct preliminary and full investigations prior to making MFCU referrals or undertaking administrative actions.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or “disclosing entity”), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or managed care entity. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

Since December 19, 2011, New Hampshire has had two active fiscal agents as it transitions to a new MMIS. At the time of the review, the new fiscal agent was only responsible for re-enrolling providers in the new system. It will assume responsibility for enrolling all providers effective January 1, 2013.

The current fiscal agent’s provider enrollment application is not in compliance with the requirements of 42 CFR 455.104 that went into effect after March 25, 2011 because it does not capture information on managing employees. The State’s new fiscal agent has developed two provider enrollment applications: one for individual providers and the second for groups or entities. The ownership section of the group provider enrollment application does not capture enhanced address information for business entities or for managing employees.

The 2009 CMS review found that NHDHHS did not ask for disclosure of ownership and control interest information from the fiscal agent and NEMT providers. As part of the State’s CAP, NHDHHS drafted special disclosure notices for use by the fiscal agent and NEMT providers which qualified as disclosing entities. However, the team found that neither form captures all the required information. The State’s Ownership and Control Statement for fiscal agents does not capture the name, address, and DOB of managing employees.

New Hampshire has a State-run NEMT program that allows beneficiaries, individuals outside the

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household, and privately owned businesses to provide transportation. All transportation providers, including privately owned businesses which are considered disclosing entities, must enroll in the Medical Transportation Program by completing an NHDHHS Medical Transportation Enrollment form (Form 14). While this form collects the applicant's SSN or Federal Tax I.D. Number, telephone number, and home address, it is not in compliance with 42 CFR 455.104 because it does not capture the DOB for the applicant. Nor does it solicit the full range of overlapping ownership, control and family relationship information required by the regulation. Finally, the form does not capture any managing employee information.

Recommendation: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities or fiscal agents regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or fiscal agents. Modify disclosure forms as necessary to capture all disclosures required under the regulation. The MIG made the same recommendation regarding collection of disclosures in the 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The new fiscal agent's individual provider enrollment application asks for criminal conviction information about providers in an Exclusion/Sanction section. However, it does not solicit such information for persons with ownership or control interests in the provider or agents or managing employees. The Medical Transportation Enrollment form used in New Hampshire's NEMT program also fails to capture health care-related criminal conviction disclosures from the drivers and privately owned businesses.

Recommendation: Develop and implement policies and procedures for the appropriate collection of disclosures from providers or fiscal agents regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers or fiscal agents, who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded

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Individuals/ Entities (LEIE) and the General Services Administration's Excluded Parties List System¹ (EPLS) no less frequently than monthly.

When information on provider names, persons with an ownership or control interest in the provider, and agents and managing employees is provided during initial enrollment or re-enrollment, New Hampshire's fiscal agents do not check the LEIE or Medicare Exclusion Database (MED) and EPLS. The State's SURS analyst checks those names against the MED on a monthly basis only for New England states. However, exclusion checks are not made against the EPLS at any time.

Furthermore, since the current provider enrollment application and the new fiscal agent's individual provider application do not capture managing employee information, neither State nor fiscal agent staff can check managing employees against the appropriate exclusion and debarment databases. This prevents the State's analyst and/or fiscal agent from checking managing employees against the LEIE (or MED) and EPLS upon initial enrollment or on a monthly basis.

In addition, New Hampshire's NEMT enrollment process does not involve checks against the LEIE (or MED) and EPLS for individual drivers, privately owned transport businesses and affiliated providers either at the time of enrollment and re-enrollment or on a monthly basis.

Recommendation: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

The State does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The 2009 CMS review found that NHDHHS did not report to the HHS-OIG adverse actions it takes on provider applications, relying on the MFCU to make all referrals. The MFCU was only reporting providers who were convicted on criminal charges. The NHDHHS now reports adverse actions it takes on provider applications for providers enrolled through their fiscal agent.

However, the Medical Transportation Program does not report to the SURS unit any program integrity-related adverse actions its staff takes on a provider's participation in the NEMT program. Program integrity actions are those related to fraud, integrity or quality. There are no

¹ On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf> for assistance in accessing the database at its new location.

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clear policies and procedures requirements directing Medical Transportation Program staff to report actions, such as the termination of drivers, to SURS staff. Therefore, the SURS unit is not in a position to report these actions to the HHS-OIG as the regulation requires.

Recommendation: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program. The MIG made the same recommendation in the 2009 review report.

The State does not provide notice of exclusion consistent with the regulation.

Under the regulation at 42 CFR 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in 1001.2005 and 1001.2006.

The State does not provide the full range of required notifications when it terminates² providers. There were several instances where the Medicaid agency notified HHS-OIG (via letter) when it terminated a provider. However, State representatives were not aware that they were required to notify the public, other State agencies, the State licensing board, beneficiaries, and others when a provider was removed from the program. In addition, State staff indicated that they do not have any policies and procedures pertaining to this regulation.

Recommendation: Develop and implement procedures to provide the full range of required notifications when the State terminates providers.

The State does not comply with its State plan regarding False Claims education monitoring.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least \$5 million under a State's Medicaid program have (a) established written policies for all employee (including management) about the Federal False Claims Act, whistleblower protection, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

New Hampshire has developed policies and procedures for implementing the compliance commitments the Medicaid agency has made in its State Plan section on False Claims Act education and whistleblower protections. In accordance with the State Plan, New Hampshire produces annual reports to identify those entities meeting the \$5 million threshold. However, the State has not complied with the following steps it committed to taking in the State Plan:

² For reporting purposes, CMS refers to State actions in accordance with this regulation as "terminations" whether the State calls them "terminations" or "exclusions."

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- Posting the "Proof of Compliance" form on the website for use by self-reporting entities, as well as entities that are identified by the State as meeting the \$5 million threshold.
- Sending a targeted notice annually to those entities that the state identifies as having met the \$5 million threshold.
- Monitoring the return of "Proof of Compliance" Forms and sending out follow-up reminders as necessary.

In addition, during the onsite visit, SURS management told the review team that they had not yet begun compliance reviews in accordance with the State Plan. Therefore, no compliance reviews of qualifying entities have taken place to determine if appropriate policies and procedures had been established and incorporated into employee handbooks. The SURS managers indicated that resource issues had thus far held the State back. They stated that they expected a yearly verification and compliance process to be fully in place soon.

Recommendation: Develop and implement policies and procedures to ensure that appropriate providers are meeting the False Claims Act education requirements stipulated in the statute and the New Hampshire State Plan.

Vulnerabilities

The review team identified two areas of vulnerability in New Hampshire's Medicaid practices. These include lack of oversight over the NEMT program and failure to use the State's permissive exclusion authority.

Lack of effective coordination between the SURS unit and the NEMT program.

The State's SURS unit, which maintains the responsibility for program integrity functions within the State, does not oversee the staff who handles NEMT program operations. The SURS unit does not have access to the NEMT claims processing system, and there has been no program integrity guidance or policy communications between the SURS unit and the staff who oversees the NEMT program.

New Hampshire uses a system called BRIDGES to capture all NEMT claims data. The information contained in BRIDGES cannot be accessed by the SURS unit; therefore the SURS unit is unable to routinely monitor NEMT claims. The SURS unit staff does not have the opportunity to look at trends or spikes in the billing patterns of, or run ad hoc reports on, NEMT providers. As a result, they are generally unaware of the activities of NEMT providers.

Furthermore, the State acknowledged having inadequate written NEMT policies and procedures relating to program integrity functions. The absence/shortage of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or provider enrollment staff and staff who oversees the NEMT program.

Recommendations: Develop and implement written policies and procedures for program integrity functions within the NEMT program. Provide the SURS unit with more information on

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program integrity issues in the NEMT program and greater access to NEMT claims and utilization data. Consider processing NEMT claims through the MMIS.

Not utilizing permissive exclusion authority in the NEMT program.

The regulation at 42 CFR 1002.210 requires that the State institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003.

The staff who oversees the NEMT program has very little communication with the SURS unit. They do not report problem drivers to the SURS unit when program integrity issues are discovered. Therefore the State cannot use its authority to terminate drivers from New Hampshire Medicaid.

The NEMT staff informed the review team that they give problem NEMT providers a warning letter and education only. They were not aware that such providers could be terminated for cause. This lack of communication between the State SURS unit and the NEMT program staff contributes to the lack of program integrity oversight over the NEMT program and prevents the SURS unit from exercising its permissive exclusion authority within this program. The State provided documentation that it makes use of its permissive exclusion authority in other parts of the Medicaid program.

Recommendation: Develop and implement policies and procedures on initiating provider exclusions within the NEMT program or integrate guidance on exclusions in the NEMT program into existing policies and procedures.

Conclusion

The State of New Hampshire applies an effective practice that demonstrates program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of seven areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two areas of vulnerability were identified. The CMS is particularly concerned over the uncorrected partial repeat findings. The CMS expects the State to correct them as soon as possible.

To that end, we will require New Hampshire to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of New Hampshire will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If New Hampshire has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of New Hampshire on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

**Official Response from New Hampshire
December 2012**



**Nicholas A. Toumpas
Commissioner**

**Stephen J. Mosher
Chief Financial Officer**

**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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December 11, 2012

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Robb Miller, Director of the Division of Field Operations

Via email: Robb.Miller@cms.hhs.gov.

Dear Mr. Miller:

In response to the letter from Angela Brice-Smith dated November 19, 2012, you will find on the following pages our response to the New Hampshire Comprehensive PI Review Final Report. Our response includes a summary of the recommendations and our corrective action plan to address the condition identified in the finding.

There were nine issues to address. Corrective actions have already been implemented for four of the issues and corrective actions are identified for the other five and will be implemented with the new Medicaid Management Information System scheduled to go live in April 2013.

We thank you for the collaborative manner in which the review was conducted and your support in our joint objective of maintaining an effective program integrity function for the Medicaid program.

Yours sincerely,

Sherry Bozoian, RN
Administrator, Program Integrity Unit
(603) 271-8029

Enclosure