Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

New Hampshire Focused Program Integrity Review:

Medicaid Managed Care Oversight

May 2023

Final Report

Table of Contents

I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess New Hampshire's program integrity oversight efforts of its Medicaid managed care program for Fiscal Years (FYs) 2019 - 2021. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided by the state in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the state Medicaid agency and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified one finding that creates risk to the Mississippi Medicaid program related to managed care program integrity oversight. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. This recommendation includes the following:

MCO Contract Compliance

Recommendation #1: New Hampshire should ensure that all MCOs develop and maintain internal policies and procedures regarding overpayment documentation, retention, and recovery, consistent with § 438.608(d) and MCO general contract requirements.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **eight** observations related to New Hampshire's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, they identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages New Hampshire to ensure that the MCOs establish a Program Integrity Unit (PIU) or Special Investigations Units (SIU) with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. In addition, New Hampshire could consider the inclusion of contract language for investigative unannounced provider site visits and investigators physically located in New Hampshire.

Observation #2: CMS recommends that New Hampshire consider using its administrative action authority to apply liquidated damages to MCOs that have poor performance regarding its program integrity obligations under the MCO general contract. Use of this authority could encourage MCOs to maintain effective program integrity activities.

Observation #3: CMS encourages New Hampshire to establish regular, effective coordination and processes between the PIU and Bureau of Program Quality (BPQ) BPQ regarding the External Quality Review Organization's (EQRO's) annual reviews of the MCOs.

MCO Contract Compliance

Observation #4: CMS encourages New Hampshire to establish a process and metrics to oversee the cost avoidance measures and activities conducted by the MCOs during the review period. This could include obtaining evidence from MCOs in support of MCO statements that a decline in the overpayments identified, reported, and recovered is a direct result of cost avoidance activities or proactive measures, such as prepayment review.

Observation #5: CMS encourages New Hampshire to consider the inclusion of an effective mechanism to monitor, track, and validate the accurate reporting of overpayments identified or recovered by the MCOs.

MCO Investigations of fraud, waste, and abuse

Observation #6: CMS encourages New Hampshire to work with the MCOs to develop more case referrals and routinely provide specific program integrity training aimed at enhancing the identification and quality of case referrals from the MCOs. CMS also encourages New Hampshire to provide more frequent feedback to the MCOs regarding the quality of case referrals.

Observation #7: CMS encourages New Hampshire to ensure that MCOs have sufficient corrective action plan procedures in place and utilize them appropriately to address non-compliant Medicaid providers. Additionally, CMS encourages New Hampshire to ensure the full requirements of the corrective action plan are completely satisfied by the MCP providers.

Encounter Data

Observation #8: CMS encourages New Hampshire to utilize the MCO encounter data to analyze the MCO referrals, identify MCO provider abnormalities, and perform self-initiated managed care investigations.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts Focused Program Integrity Reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the New Hampshire Managed Care Program and the Focused Program Integrity Review

The Division of Medicaid Services within the New Hampshire Department of Health & Human Services (DHHS) is responsible for the administration of the New Hampshire Medicaid program. Within DHHS, a separate division the Division of Program Quality and Integrity (DPQI), is responsible for program integrity. The Medicaid PIU is the organizational unit within DPQI's Bureau of Program Integrity that is primarily tasked with oversight of program integrity-related functions for the Medicaid managed care program.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

During the review period, New Hampshire contracted with three MCOs to provide health services to the Medicaid population. As part of this review, all three MCOs were interviewed: AmeriHealth Caritas New Hampshire (AmeriHealth Caritas), New Hampshire Healthy Families (NHHF), and WellSense Health Plan (WellSense). NHHF is affiliated with Centene Corporation and provides coverage for Granite State Health Plan. WellSense also does business as Boston Medical Center Health Plan, Inc. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In April 2022, CMS conducted a focused program integrity review of New Hampshire's managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed other primary data. CMS also evaluated the status of New Hampshire's previous corrective action plan that was developed in response to a previous Focused Program Integrity Review of New Hampshire's managed care program conducted by CMS in 2017, the results of which can be found in Appendix A.

During this review, CMS identified a total of eight observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse

that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

CMS determined that the oversight and monitoring requirements set forth at §§ 438.66 and 438.602 were addressed within the MCO general contract. Section 3.15.2.1 of the MCO general contract states that, "…the MCO shall establish a SIU, which shall be comprised of experienced fraud, waste, and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein." The contract continues in section 3.15.2.1.1, "…at minimum the SIU shall have at least two (2) fraud, waste, and abuse investigators and one (1) fraud, waste, and abuse coordinator." While AmeriHealth Caritas and NHHF met the contract requirements in regards to the number of investigators, the WellSense SIU covers both New Hampshire and Massachusetts. The WellSense SIU dedicates 27 to 33 percent of its time to New Hampshire Medicaid, and the remaining time to Massachusetts. CMS also observed that the MCO general contract does not address investigative unannounced provider site visits and investigators physically located in New Hampshire. To ensure effective oversight, the MCOs should maintain sufficient staffing levels to conduct a full range of program integrity functions, including the review, investigation, and recovery of overpayments.

In addition, New Hampshire has administrative action authority that allows the state to apply liquidated damages to MCOs based on poor performance under the MCO general contract, including the program integrity provisions. CMS observed that the administrative authority was not being utilized during the review period. The state reported that there has historically been apprehension towards the use of the administrative action authority as a tool to influence better MCO program integrity performance.

The BPQ within DPQI manages the contracts for the MCOs as well as the contracts with the EQRO, which is required to review one-third of the program integrity contract requirements annually. The EQRO also conducts a full compliance audit following the MCO's first year of contracting. The audits are announced and include pre-site and/or virtual, as well as post-site, activities. The state monitors the MCO's performance through Exhibit O (Quality and Oversight Requirements) reporting, EQRO audits, individual program area oversight of contract, and program integrity monitoring and oversight for fraud, waste, and abuse. CMS observed a lack of communication and coordination between the PIU and BPQ concerning the EQRO reviews. As a result of the lack of coordination, only six program integrity contract standards are reviewed every year, all without the involvement of the PIU.

Observation #1: CMS encourages New Hampshire to ensure that the MCOs establish a PIU or SIU with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. In addition, New Hampshire could consider the inclusion of contract language for investigative unannounced provider site visits and investigators physically located in New Hampshire.

Observation #2: CMS recommends that New Hampshire consider using its administrative action authority to apply liquidated damages to MCOs that have poor performance regarding its program integrity obligations under the MCO general contract. Use of this authority could encourage MCOs to maintain effective program integrity activities.

Observation #3: CMS encourages New Hampshire to establish regular, effective coordination and processes between the PIU and BPQ regarding the EQRO's annual reviews of the MCOs.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for New Hampshire is developed by the BPQ. The program integrity provisions of the contract are primarily overseen by the Medicaid PIU.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Sections 5.3.2.2.1.1 through 5.3.2.2.1.7 of New Hampshire's MCO general contract explicitly address the requirement that all seven compliance plan elements listed above be addressed. Each of the three MCOs submitted their compliance plan to DHHS annually for the three FY's reviewed. A review of the MCOs' compliance plans and programs found that each MCOs compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii).

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

CMS determined that the state met this requirement for the review period. However, CMS noted that the contract is not specific in providing detailed guidance for this program integrity activity. The three MCOs for this review were inconsistent with the number of beneficiary verifications conducted for the three FYs.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The state is compliant with this requirement. A review of the state's policy found that DHHS has written policies for NH Medicaid employees, contractors, MCOs, and agents that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

New Hampshire Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO general contract requires the MCOs to suspend providers once the state has determined a payment suspension should be imposed and no exception applies. Section 5.3.2.2.7 states, "A provision for the MCO's suspension of payments to a Participating provider for which DHHS determines there is credible allegation of fraud in accordance with this agreement and 42 CFR 455.23." The MCOs are required to document payment suspensions on the monthly FWA.02 per the MCO general contract Exhibit O, Quality and Oversight Reporting Requirements.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the

information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

CMS determined that the state did not adequately address the requirements at § 438.608(d). The MCO general contract Section in 5.3.3.4 states, "The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste and abuse, and for reporting and returning Overpayments as required by this Agreement." **While AmeriHealth Caritas and NHHF had such internal policies and procedures, WellSense did not have a policy and procedure addressing this contract requirement**. In addition, CMS observed that, although contract provisions addressed procedures for reporting overpayments in accordance with federal regulations, New Hampshire did not undertake activities to verify and validate MCO overpayment identifications and recoveries.

To maintain effective oversight of overpayment identification, reporting, and recoveries by MCOs, it is a promising practice that states obtain evidence from MCOs in support of MCO statements that a decline in the overpayments identified, reported, and recovered is a direct result of cost avoidance activities or proactive measures, such as prepayment review. CMS observed that the state was not overseeing the cost avoidance measures and activities conducted by the MCOs during the review period. In addition, WellSense did not have any cost avoidance methodologies in place during the review period.

> **Recommendation #1:** New Hampshire should ensure that all MCOs develop and maintain internal policies and procedures regarding overpayment documentation, retention, and recovery, consistent with § 438.608(d) and MCO general contract requirements.
>
> **Observation #4:** CMS encourages New Hampshire to establish a process and metrics to oversee the cost avoidance measures and activities conducted by the MCOs during the review period. This could include obtaining evidence from MCOs in support of MCO statements that a decline in the overpayments identified, reported, and recovered is a direct result of cost avoidance activities or proactive measures, such as prepayment review.
>
> **Observation #5**: CMS encourages New Hampshire to consider the inclusion of an effective mechanism to monitor, track, and validate the accurate reporting of overpayments identified or recovered by the MCOs.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely

affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. The state has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by § 455.21(c)(3)(iv). Additionally, the state does meet with the MFCU monthly to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. The state PIU has developed a monthly meeting with each MCO as well as a quarterly combined meeting and an annual training seminar. The monthly meetings are attended by the MCO staff, the compliance department, subcontractors, MFCU, and program integrity staff and SME depending on the topics being discussed. The quarterly meetings are attended by all MCOs, subcontractors, MFCU, and the program integrity staff to be able to collaborate on current and potential investigations across the Medicaid program.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

New Hampshire has a process in accordance with §§ 438.608(a)(7) and 455.13-17. Section 5.3.4.1.3 of the MCO general contract outlines the process in which MCOs are to refer suspected fraud, and abuse to the state. The contract states, "When the MCO or its subcontractor has concluded that a credible allegation of fraud, or abuse exists, the MCO shall make a referral to DHHS PIU and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by DHHS." The PIU has educated the MCOs in regard to the definition of fraud, waste, and abuse. DHHS meets monthly with the MCOs regarding investigations. However, CMS observed a lack of quantity and quality case referrals from the MCO SIUs, as described in the following section.

Observation #6: CMS encourages New Hampshire to work with the MCOs to develop more case referrals and routinely provide specific program integrity training aimed at enhancing the identification and quality of case referrals from the MCOs. CMS also encourages New Hampshire to provide more frequent feedback to the MCOs regarding the quality of case referrals.

MCO Oversight of Network Providers

CMS evaluated whether each New Hampshire MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

New Hampshire's MCO general contract requires that each MCO have an established process to monitor its providers for non-compliance with contractual agreements and medical governance standards. A promising practice for MCOs to maintain such oversight is to implement corrective action plans for its network providers. However, neither AmeriHealth Caritas nor WellSense conducted any corrective action plans during the review period, and NHHF conducted only one corrective action plan during the review period. Additional information about each MCO's program integrity activities is described below.

All three MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources, including but not limited to claims, hotline calls, referrals from subcontractors, referrals from DHHS, DHHS algorithms, and data mining. A preliminary investigation is completed to see if the case should be opened by the SIU. When a case is opened as a result of the preliminary investigation, a referral is sent to the state and a full investigation is conducted.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements.

Figure 1 below describes the number of investigations referred to New Hampshire by each MCO.

Figure 1. Number of Investigations Referred to New Hampshire by each MCO

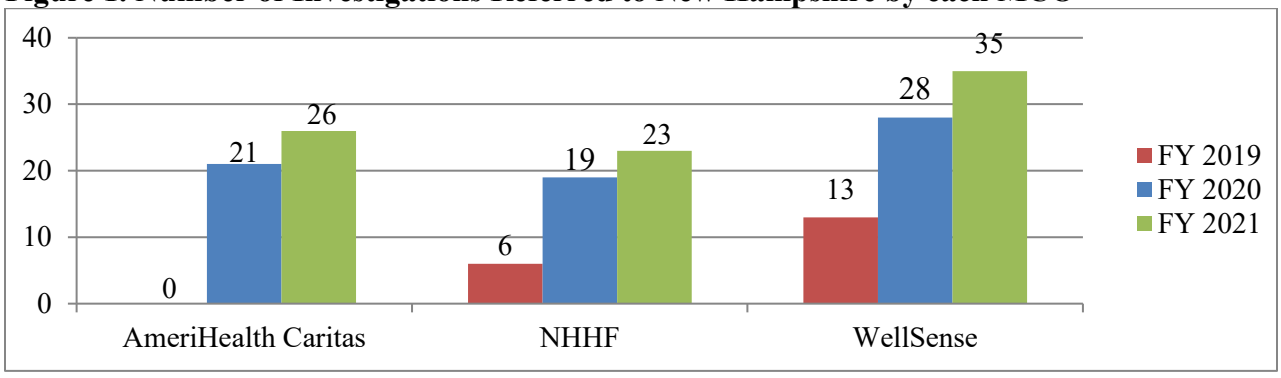

Table 1, below, describe each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table1: MCO Recoveries from Program Integrity Activities

AmeriHealth Caritas' Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	0	0	0	0
2020	22	22	0	0
2021	26	26	$70,583.44	$70,583.44

NHHF's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	6	6	$557,846.46	$15,367.92
2020	19	19	$464,087.54	$36,427.45
2021	28	28	$382,354.09	$99,236.48

Well Sense's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	17	17	Not provided	$21,584.58
2020	33	33	$6,867.75	$17,493.62
2021	34	34	$173,081.88	$25,292.76

Observation #7: CMS encourages New Hampshire to ensure that MCOs have sufficient corrective action plan procedures in place and utilize them appropriately to address non-compliant Medicaid providers. Additionally, CMS encourages New Hampshire to ensure the full requirements of the corrective action plan are completely satisfied by the MCP providers.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter

data. Additionally, § 438.242 further states that MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the New Hampshire MCO general contract and each of the MCOs, CMS determined that New Hampshire was in compliance with § 438.242. Specifically, the contract language states the MCOs must have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and disenrollment for other loss of Medicaid eligibility.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. New Hampshire was in compliance with § 438.602(e) for the review period.

While it is not a requirement, regularly analyzing the encounter data submitted by MCOs will also allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. New Hampshire does not have a process to regularly analyze MCO encounter data for program integrity purposes. The MCO general contracts require all encounter data be submitted weekly, within fourteen (14) calendar days of claim payment. The encounter data is collected, stored, and adjudicated in the NH Medicaid Management Information System (MMIS). New Hampshire utilizes a claims data mart to store the data for analytical purposes and is accessed through Cognos. However, CMS observed a lack of communication between the PIU and the BPQI regarding the MCO encounter data, which hinders the state from investigating the MCOs program referrals.

> **Observation #8**: CMS encourages New Hampshire to utilize the MCO encounter data to analyze the MCO referrals, look for MCO provider abnormalities, and perform self-initiated managed care investigations.

IV. Conclusion

CMS supports New Hampshire's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and eight observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications

and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with New Hampshire to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

New Hampshire's last CMS program integrity review was conducted in September 2016, and the report was issued in May 2017. The report contained 18 recommendations. The findings from the 2016 New Hampshire focused program integrity review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid Program Integrity Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for New Hampshire MCOs

New Hampshire MCO Data	AmeriHealth Caritas	NHHF	WellSense
Beneficiary enrollment total	34,512	82,146	91,929
Provider enrollment total	9,351	11,709	59,308
Year originally contracted	2019	2013	2013
Size and composition of SIU	3	3	6
National/local plan	National	National	Local

Table C-2. Medicaid Expenditure Data for New Hampshire MCOs

MCOs	FY 2019	FY 2020	FY 2021
AmeriHealth Caritas	$1,117,781	$92,413,702	$230,468,960
NHHF	$376,412,618	$459,618,254	$491,281,065
WellSense	$437,163,124	$521,451,335	$549,168,902
Total MCO Expenditures	$814,693,523	$1,073,483,291	$1,270,918,927

Appendix D:

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	New Hampshire should ensure that all MCOs develop and maintain internal policies and procedures regarding overpayment documentation, retention, and recovery, consistent with § 438.608(d) and MCO general contract requirements.	**x**	

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)