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Centers for Medicare &Medicaid Services

Center for Program Integrity

New Hampshire Focused Program Integrity Review

Final Report

May 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of New Hampshire to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2012.

Background: State Medicaid Program Overview

The New Hampshire Department of Health and Human Services (DHHS) is located in Concord, New Hampshire. New Hampshire is a Medicaid expansion state and includes the Children's Health Insurance Program. The total number of recipients covered by the state's Medicaid program is 185,744. During August 2016, four percent, or 7,430 beneficiaries, were covered under a fee-for-service (FFS) delivery system and 96 percent, or 178,314 beneficiaries, were covered under a managed care delivery system. The state's Federal Medical Assistance Percentage for federal fiscal year (FFY) 2015 was 50 percent. The total FFY 2015 Medicaid expenditures were $1.7 billion**.** The state spent approximately $769.3 million on managed care contracts in FFY 2015.

Methodology of the Review

In advance of the onsite visit, CMS requested that New Hampshire and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A two-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of September 12, 2016, the CMS review team visited the DHHS. They conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with two MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 178,314 beneficiaries, or 96 percent of the state's Medicaid population, were enrolled in two MCOs during FFY 2015. The state spent approximately $769.3 million on managed care contracts in FFY 2015.

Summary Information on the Plans Reviewed

The CMS review team interviewed two MCOs as part of its review.

Most New Hampshire Medicaid recipients receive health care services through the Medicaid Care Management (MCM) program. New Hampshire is fairly new to the managed care market. New Hampshire's MCM program utilizes two health plans to manage health care for recipients. Those MCOs are New Hampshire Healthy Families (NHHF) and Well Sense Health Plan (Well Sense). Both MCOs have been in existence since December 2013. Previously, the DHHS program only utilized the FFS delivery system.

The NHHF is underwritten by the Granite State Health Plan, Inc. Granite State Health Plan is a wholly-owned subsidiary of the Centene Corporation. The NHHF contracts with DHHS to MCM members. The NHHF began operations in late 2013. The NHHF will open three additional markets, scheduled to commence in 2017. The SIU staff is comprised of five fully-dedicated FTEs: an investigator, an analyst, a clinician, a manager, and a compliance officer. The SIU's corporate headquarters is located in Missouri and one FTE is physically located in Bedford, New Hampshire.

Well Sense is a nonprofit MCO that also began operations in late 2013. The plan provides statewide access to primary care physicians, specialists, behavioral health providers, emergency services, and hospital care. Well Sense is operated by Boston Medical Center Health Plan, Inc., which also operates BMC Health Net Plan. The BMC Health Net Plan is a Massachusetts-based health plan offering Medicaid, qualified health plans, and senior care options to Massachusetts residents. The Well Sense SIU staff consists of the following positions: one manager, two investigators, one data and reporting analyst, and one coordinator. Each FTE in the SIU spends approximately 33 percent of their time dedicated to New Hampshire Medicaid managed care fraud and abuse activities; the SIU staff spends the remaining 57 percent of the on Massachusetts Medicaid fraud and abuse activities, and allocates ten percent of the time to fraud and abuse activities in its other lines of business in Massachusetts. Well Sense also contracts with several vendors to provide vision services, non-emergency medical transportation services, durable medical equipment management, pharmacy benefit management, and behavioral health services management.

Enrollment information for each MCO as of September 2016 is summarized below:

Table 1.

	NHHF	Well Sense
Beneficiary enrollment total	62,067	73,674
Provider enrollment total	13,135	7,211
Year originally contracted	2013	2013
Size and composition of SIU	5.0 FTEs	5.0 FTEs
Number of SIU FTEs fully-dedicated locally	5.0 FTEs	1.7 FTEs
National/local plan	Local	Local

Table 2. Medicaid expenditure data for New Hampshire MCOs

MCOs	FFY 2013	FFY 2014	FFY 2015
NHHF	*	$145.3 million	$342.6 million
Well Sense	*	$153.6 million	$362.1 million

*The MCO contracted with the state in December 2013.

State Oversight of MCO Program Integrity Activities

The New Hampshire Office of Medicaid Services Managed Care Operations is primarily responsible for providing state oversight of their managed care program. The Office of Improvement & Integrity (OII) is also responsible for providing program integrity oversight of the MCOs. The OII monitors and protects DHHS programs against fraud, waste, and abuse activities. The OII consists of the following units: Health Insurance Premium Payment Program; Child Care Audit Unit; Quality Assurance Unit; Reimbursement Unit; SIU; Program Integrity Unit; and the Third Party Liability Unit. There are a total of seven positions dedicated to fraud, wasted, and abuse activities. At the time of the onsite review, this fully-dedicated staffing level was filled by five FTEs responsible for performing the monitoring the activities of both the MCO and FFS delivery systems. Vacant positions have remained open for more than a year.

The DHHS is also responsible for its provider enrollment; this process is conducted internally, and it is not a delegated or contracted function. According to DHHS policy and state law, all providers must be enrolled in the New Hampshire Medicaid program, before they can be enrolled in any managed care provider network.

The CMS review team determined that the state does not have any written policies, standard operating procedures, performance metrics, interagency agreements, or auditing tools related to MCO oversight, and guidance regarding conducting reviews and audits of their providers. The state does conduct compliance reviews. The state relies on the MCOs' SIUs to conduct the majority of program integrity activities. The MCO model contract language is general regarding program integrity deliverables and activities specified.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud,

waste, and abuse by providers and MCOs. Section 26 of the DHHS's MCO model contract gives a broad overview of the program integrity tasks, practices, and efforts expected of the MCOs.

The MCOs submit monthly reports of fraud, waste, and abuse activity to the OII; these reports are forwarded to the MCO coordinator for review. The state relies on monthly reports as their primary oversight mechanism for the MCOs. The contract does include language which requires the MCO to report suspected provider fraud, waste, or abuse to DHHS.

New Hampshire's MCO contract states that the MCOs are required to report preliminary investigations, full investigations, suspected fraud, overpayments and involuntary provider terminations, provider enrollment safeguards, and all related program integrity activities to the OII on a quarterly basis. However, Well Sense does not report to the state or internally track the actual amount of overpayments to providers. In addition, Well Sense does not report to the state what portion of the overpayments are attributed to fraud, waste, and abuse, and what portion of the overpayments are systematic or improper payments made by the MCO.

Also, cost avoidance reports are neither required nor provided to the state by both Well Sense and NHHF; details regarding prepayment review and system edits are not reported to the state to indicate any proactive program integrity measures instituted by the MCOs to avoid improper payments. Well Sense reported that they primarily utilize system edits and some prepayment activities; however, evidence of these measures was not presented to the CMS review team during the onsite review.

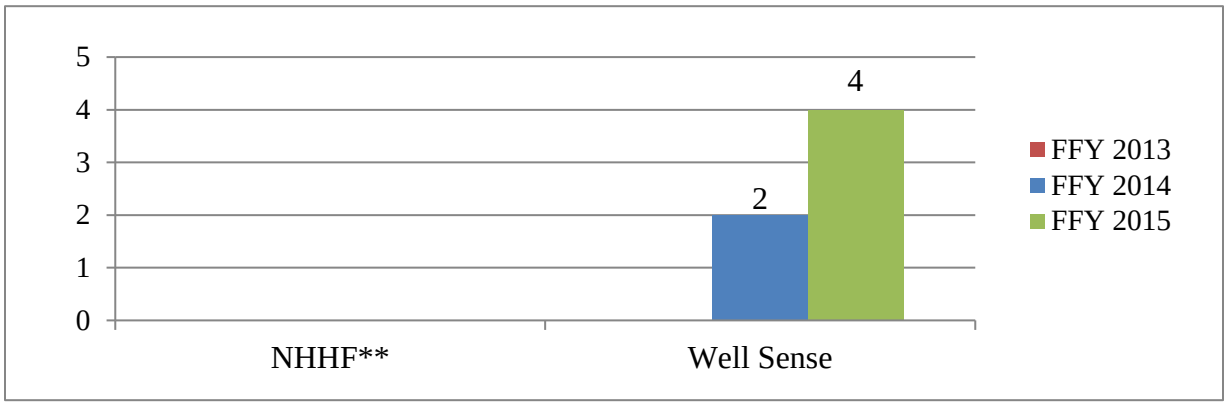
In addition, the CMS review team found no evidence of MCO training sessions being conducted. The state indicated that training sessions with the MCOs occur both periodically and spontaneously, if required. However, the state does meet with the MCOs monthly to discuss program integrity activities.

The investigative process for both NHHF and Well Sense follows the same protocols. Upon receipt of a complaint or other indication of potential fraud, waste or abuse, a request to conduct a preliminary investigation is submitted to the OII for approval. If this request is approved, the SIU investigator reviews background information and any available claims data. An indication of potential fraud requires the MCO's SIU to notify DHHS and await instructions on how to proceed. If the results of a full investigation indicate a credible allegation of fraud, the SIU refers the case to DHHS and awaits instruction from the state regarding how to proceed with the case. The state determines whether or not a case should be referred to the MFCU. If a full investigation indicates an overpayment that is not fraud-related, the SIU will recoup or collect the overpayment.

Table 3 lists the number of referrals that NHHF's SIU and Well Sense's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals reported by each of the MCOs is low compared to the size of the plan. The level of investigative activity has not changed over time. During the onsite review, the NHHF stated that there were nine preliminary investigations submitted to the state requesting permission to open due to credible allegations of fraud. However, the state denied permission, due to the MFCU already

having cases open on these providers. No other referrals were submitted to the state by the NHHF during the 3 FFYs reviewed.

Table 3.



*Both MCOs contracted with the state in December 2013.
**The NHHF submitted nine preliminary investigations to the state; the MFCU already had cases open on these providers.

During the onsite review, the team sampled NHHF cases. The sample included an unbundling case opened in July 2014. No fraud was involved; however, there was an overpayment identified. The NHHF did not send a notice out to the provider until May 2016, which was almost two years later. As of September 2016, the provider has not sent in a check for the overpayment. If the overpayment is not collected soon, NHHF plans to offset the provider's claims. The case remains open.

Another of the NHHF cases sampled was opened in April 2015 and involved billing for services not provided. Medical records were received by the MCO and the status of the case was pending/under review. Additional documentation also showed that CMS has reviewed this provider for possible swapping of patients with other home healthcare agencies. No indication of communication with the state has occurred to check for possible Medicare/Medicaid administrative actions against the provider. The case remains open.

Well Sense cases were also sampled. The sample included a provider rendering continuous, unauthorized services without a referral or authorization from the plan; this case was opened during May 2015. The amount of overpayment of $121.75. However, this provider should have never been paid for any services. The provider was not enrolled with the state's Medicaid program. All of the Medicaid MCO claims monies paid to this provider should be recouped.

Another Well Sense case opened in March 2015 involved unbundling of compounded medications with the intent to receive higher reimbursement for a lower quantity or separate billing of each compound drug. The provider was not enrolled in the Medicaid MCO program. Recoupment of claims paid to this provider should be pursued for all dates of service provider was not enrolled or was not eligible to receive state/federal funds.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. All of the MCOs provided the CMS review team with a copy of their compliance plans. A review of these plans revealed they were in compliance with 42 CFR 438.608.

The state does not have a process to review the compliance plan and programs.

As required by 42 CFR 438.608, the state does not review the MCEs' compliance plans and communicate approval/disapproval with the MCEs. In addition, the MCO contract states in Section 26.3.15 that the state will conduct annual onsite program integrity reviews. The MCO coordinator, along with the staff from the OII, have not reviewed the MCOs' compliance plans since 2014.

Encounter Data

The state collects and reviews encounter data, as required by the MCO contract. However, the state reported during the onsite review that they were presently unable to review encounter data due to system issues with the Electronic Fraud and Abuse Detections System (EFADS). Analysis of encounter data for patterns of fraud, waste, and abuse will be discussed with the MCOs, once the issues with EFADS are resolved. Corrective action plans are assigned to the providers with data indicating fraud, waste, and abuse. The state schedules monthly meetings with the MCOs, at a minimum.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state or report on overpayments recovered from providers as a result of fraud, waste and abuse investigations.

Overpayments recovered by the MCOs are minimal. In addition, New Hampshire does not include overpayment recoveries in their capitation rate setting process.

The table below shows the respective amounts reported by NHHF for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	*	*	*	*
2014**	11	11	$0	$0
2015**	35	35	$2,041	$0

*The MCO contracted with the state in December 2013.
**The MCO receives permission from the state to open all preliminary and full investigations.

The table below shows the respective amounts reported by Well Sense for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	**	**	**	**
2014	19	14	$68,643	$53,643
2015	19	15	$24,879	$24,130

*Preliminary investigations are developed into full investigations upon approval by the state.
**The MCO contracted with the state in December 2013.

Overall, the investigative activity, and overpayments identified and recovered are either low or nonexistent for the plans. During the onsite review, NHHF attributed low program integrity activity levels to being a newly contracted in December 2013 and low population levels; the MCO did not perform many investigations, nor did they identify or recover any monies overpaid. Also, NHHF indicated that the state's look back period on claims expired on these investigations. Although NHHF was contracted in December 2013, some indication of monies recovered would be expected in the following two FFYs. In addition, Well Sense stated that preliminary investigations are developed into full investigation upon receiving approval from the state to proceed. Well Sense did not receive approval from the state to pursue five preliminary investigations during FFY 2014 and four preliminary investigations during FFY 2015; these cases were never developed into full investigations.

Sampled cases evaluated during the onsite review revealed that the full investigations remained open for an average time period of one year. The team also discovered that some of the providers were enrolled with the MCO, but not enrolled with New Hampshire Medicaid program, deeming a provider ineligible for reimbursement with federal/state funds. The only exception would be the authorization of an emergency visit and/or the issuance of a temporary enrollment number the state; no evidence of either was found by the CMS review team during sampling.

The contract states that the MCOs must report program integrity activities; currently, the MCOs report only the number of provider overpayments recovered during the year. The NHHF reported investigating one provider for fraud, waste, and abuse quarterly. The CMS review team also learned that NHHF does not verify that services rendered by the provider were received by the beneficiaries in accordance with 42 CFR 455.20. Section 26.3.7 of the MCO contract states that the MCOs must verify provider services rendered were received by the beneficiary.

Payment Suspensions

In New Hampshire, Medicaid MCOs are not contractually required to suspend payments to providers at the state's request. The state confirmed that there is not any contract language mirroring the payment suspension regulation at 42 CFR 455.23. Only Well Sense had a payment suspension policy in place. Also, the state does not have a memorandum of understanding regarding the payment suspension process with the MFCU.

Also, the CMS review team found that DHHS does not suspend payments for providers with credible allegations of fraud nor have they historically directed the MCOs to suspend any

provider payments. At the direction of the MFCU, payments may be suspended. Typically, the state waits for the MFCU to accept or decline the case, prior to suspending provider payments.

The state is required to suspend payments when a credible allegation of fraud has been determined per 42 CFR 455.23. During case sampling, the CMS review team identified inconsistencies in communications between the state Medicaid agency and the MFCU. As a result of these interagency communication issues, cases remained opened for almost two years, and went without resolution or any administrative actions executed.

Terminated Providers and Adverse Action Reporting

The state's MCO contract does not include any provisions for adverse provider terminations. Both MCOs reported that the state has never provided direction or written notification regarding providers which should be terminated from the MCOs' networks.

Table 5.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
NHHF	2013 2014 2015	* 0 0	2013 2014 2015	* 0 0
Well Sense	2013 2014 2015	* 734 522	2013 2014 2015	* 6 7

*The MCO contracted with the state in December 2013.

Overall, the number of providers terminated for cause by both of the plans appears to be low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason.

Each MCO follows the process established by the state. The MCO must submit a provider termination log to the Office of Quality Assurance (OQA) within 15 business days of the tentative effective date of termination. Once received, the OQA notifies several program areas that the report is available for review. Upon review, the Office of Improvement and Program Integrity validates the termination of the providers for all Medicaid programs and MCOs; this information is uploaded to the Medicaid Management Information System. The MCOs' SIUs are notified via email of the termination.

The CMS review team requested provider notification samples from the state; however, the state was unable to provide any samples. During the onsite interviews, the CMS review team noted that Well Sense's SIU and the credentialing department did not always communicate regarding terminations. This lack of communication might potentially result in the MCO not terminating providers at the state's direction. Providers may potentially remain enrolled and continue to receive state/federal funds.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

As previously mentioned, the DHHS is responsible for its provider enrollment; this process is conducted internally, and it is not a delegated or contracted function. According to DHHS policy

and state law, all providers must be enrolled in the New Hampshire Medicaid program, before they can be enrolled in any managed care provider network. During the sampling of MCO case files, the CMS review team found that Well Sense enrolled providers into their MCO network that were never enrolled by DHHS; these providers are considered ineligible to receive state and federal funds, since they were never enrolled by the state.

The CMS review team found that the DHHS is checking the majority of the federal databases bases required; however, these databases are not being checked on a monthly basis. In addition, the state said that they do not check the SSA-DMF, due to financial and budgetary constraints. The state only checks the required federal databases during initial enrollment and re-enrollment.

Also, the CMS review team found that the state does not check disclosure/ownership status on managing employees for individual providers. Individual providers who enroll with the New Hampshire Medicaid program did not report disclosure/ownership and criminal conviction status for their managing employees per 42 CFR 455.104 and 42 CFR 455.106.

The MCOs do check some of these federal databases, although there is no contractual obligation to do so.

Recommendations for Improvement

- The DHS should ensure that the state and the MCOs build program integrity units with sufficient resources and staffing commensurate with the size of their managed care programs to conduct the full range of program integrity functions including the review, investigation, and auditing of provider types where Medicaid dollars are most at risk.
- The state should develop written policies and procedures, or an interagency agreement(s) outlining the state unit(s) responsible for program integrity activities and the related oversight functions.
- The state should review and amend the MCO model contract's language to ensure full compliance with all of the requirements in 42 CFR 438.
- The state should consider the inclusion of additional performance tools to assess MCO program integrity activities, beyond the scope of the monthly MCO-generated fraud, waste, and abuse reports. Some oversight measures that the state should consider implementing to establish more specific parameters and performance metrics are: in-depth MCO program integrity focused reviews, MCO rating systems, annual MCO onsite visits, increasing deliverables, and overseeing contractual obligations. Also, the state should strengthen its oversight of the MCOs by conducting monthly or bi-monthly meetings with the MCOs' SIU staff to improve communication.
- The DHHS should ensure that the MCOs have systems in place to internally track and report the actual amount of overpayments to providers on a quarterly basis, as required by contract. Additional data elements should be added to these reports to provide an accurate summary of the number of full investigations opened and to determine if an overpayment should have been identified, calculated, and collected. Also, the MCO tracking systems should capture detail regarding what portion of the overpayments are attributed specifically to fraud, waste, and/or abuse.
- The state should encourage the MCOs to explore establishing cost avoidance measures or strengthen existing cost avoidance activities to assist in preventing overpayments to providers and decrease the necessity for recovery efforts.
- The state should obtain evidence from its MCOs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place. Some tangible examples of cost avoidance include a walk-through of the Medicaid Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted and resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples, etc. from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.
- The DHHS should assess the quantity and quality of MCO referrals received. Also, the state should enhance existing MCO case referral policies and procedures to include specific guidelines for referring cases. The DHHS should ensure that the MCOs are identifying cases where a credible allegation of fraud exists by meeting with the MCOs to discuss and define what constitutes a suspected fraud case referral
- The state should ensure that all SIU and MCO support staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by Medicaid

providers, and that MCOs refer all Medicaid suspected fraud and abuse cases to the state and conform to the fraud referral performance standards.

- The state should establish a process to review the MCOs' compliance plans and programs in accordance with the requirements at 42 CFR 438.608. The state's process should include the communication to the MCO of approval or disapproval of the compliance plan.
- The state should ensure that any issues are resolved with its EFADS system and resume the review of encounter data for patterns of fraud, waste. Continue efforts to improve the state agency's ability to analyze information from surveillance and utilization review systems and encounter data reported by MCOs.
- The state should assess the length of time which MCO cases remain open. Timeliness related to investigative case management directly impacts potential criminal and/or administrative actions, and possible recovery efforts conducted by the state, MCO, or other law enforcement agencies. The state should routinely review the status of active cases with the MCOs.
- The state should improve communications with the MCOs to ensure that potential MCO network providers are enrolled in the New Hampshire Medicaid program and are eligible to receive state and federal funds.
- The state should ensure that services rendered by providers were received by the beneficiaries in accordance with the MCO contract and the requirements at 42 CFR 455.20.
- The DHHS should direct their MCOs to immediately suspend payments for providers with credible allegations of fraud. The state should not wait for the MFCU to accept or decline the case, prior to suspending provider payments. The state is required to suspend payments when a credible allegation of fraud has been determined per 42 CFR 455.23. The state should then refer the case to the MFCU.
- The state should include provisions in its MCO contract addressing adverse provider terminations. The state should provide clear direction and/or written notification regarding providers which should be terminated from the MCOs' networks. Also, the state should ensure that they are receiving notifications from the MCOs regarding termination action taken against providers in the plans' networks.
- The state should search the LEIE, EPLS, SSA-DMF, and NPPES upon contract execution, and check the LEIE and EPLS monthly thereafter by the name of any person with an ownership or control interest, or who is an agent or managing employee. The state should amend the standard MCO contract to ensure all contracted individuals and entities are searched for exclusions in accordance with 455.436. Furthermore, all Medicaid managed care providers should be trained to search their employees for exclusion from federal programs.
- The state should require providers to report disclosure/ownership and criminal conviction status on their managing employees.

Section 2: Status of Corrective Action Plan

New Hampshire's last CMS program integrity review was in May 2012 and the report for this review was issued in November 2016. The report contained seven findings and two vulnerabilities. During the onsite review in September 2016, the CMS review team conducted a thorough review of the corrective actions taken by New Hampshire to address all issues reported in calendar year 2012. The findings of this review are described below.

Findings

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

   Status at the time of the Review: Corrected

   The DHHS has established a Surveillance Utilization Review Subsystem/Program Integrity Unit (SURS/PIU).

2. ***The state does not capture all required ownership and control disclosures from disclosing entities.***

   Status at the time of the Review: Not corrected

   The state does not require the collection of managing employee disclosure information for individual providers.

3. ***The state does not capture criminal conviction disclosures from providers or contractors.***

   Status at the time of the Review: Not corrected

   The state reported that their NEMT broker, CTS, is contractually responsible for checking their employees/subcontractors for criminal conviction disclosures. No provisions are found in the state's NEMT model contract in accordance with 42 CFR 455.106. Only disclosure provisions related to protected health information and financial disclosures are mentioned. In addition, the state currently has no checklist, policies, or procedures to ensure oversight of the contract with the broker, and that criminal conviction and ownership interest disclosure checks are performed for NEMT providers as required per 42 CFR 455.106.

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

   Status at the time of the Review: Corrected

   The state and the MCOs are now conducting complete searches of individuals and entities excluded from participation in Medicaid.

5. ***The state does not report all adverse actions taken on provider participation to the HHS-OIG per 42 CFR 1002.3(b)(3). (Uncorrected Partial Repeat Finding)***

   Status at the time of the Review: Not Corrected

   The state only reports provider terminations. No other adverse actions are reported.

6. ***The state does not provide notice of exclusion consistent with the regulation at 42 CFR 1002.210 and 42 CFR 1002.212.***

   Status at the time of the Review: Not corrected

   During the onsite review, the state provided the CMS review team with policies and procedures that were developed and implemented; however, no evidence was provided to indicate that notices of exclusion consistent with the regulation are provided.

7. ***The state does not comply with its state plan regarding False Claims Act education monitoring according to Section 1902(a)(68) of the Social Security Act.***

   Status at the time of the Review: Corrected

   The state confirmed that it is now in compliance and provides *False Claims Act* education and monitoring. The state presented the team with two documents consisting of provider education notices and provider compliance forms completed by the state on providers.

Vulnerabilities:

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

   Status at the time of the Review: Not Corrected

   The provider relations coordinator is not consistently communicating and coordinating activities with the SURS/PIU. The state was unable to recall their most recent interaction with the NEMT coordinator.

2. ***Not utilizing permissive exclusion authority in the NEMT program.***

   Status at the time of the Review: Not corrected

   The NEMT model contract does not contain language to address federal exclusion of officers and managing employees convicted of certain offenses. No evidence of any PIU guidance, existing policies, or procedures regarding reporting or referring excluded providers was presented during the onsite review. In addition, no current meetings and/or communications between the PIU and NEMT program were occurring.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for New Hampshire to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to New Hampshire are based on its identified risks include those related to managed care program integrity. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review team identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROGRAM PLANNING & INTEGRITY

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Centers for Medicare & Medicaid Services
Laurie Battaglia, Director of the Division of State Program Integrity
Investigations and Audits Group, Div of State Program Integrity
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Ms. Battaglia:

Attached please find New Hampshire's corrective action plan, provided in response to your letter dated May 23, 2017, from the final report of the New Hampshire Focused Program Integrity Review.

New Hampshire's corrective action plan addresses the recommendations contained in the May 2017 final report, and responds to the corrective action plan items identified during the 2012 review which remain uncorrected. Our plan identifies how the Program Integrity unit will establish processes to avoid reoccurrence of these deficiencies, including timeframes for each recommendation with the specific steps we will take. Any areas that the unit has already taken action to correct have been identified in the attached report with supporting documentation listed.

If you have any questions or concerns please contact Karen Carleton, RN Program Administrator for Program Integrity at 603-271-8029.

Sincerely,

Karen Carleton, RN
Program Administrator

KC/tvp

Enclosure