Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New Hampshire Comprehensive Program Integrity Review

Final Report

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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 review team conducted the onsite portion of the review at the offices of the New Hampshire Department of Health & Human Services (NHDHHS). The review team also visited the offices of the Medicaid Fraud Control Unit (MFCU) and the fiscal agent.

This review focused on the activities of the State's Surveillance and Utilization Review Unit (SURS), which is responsible for Medicaid program integrity. This report describes three effective practices and three regulatory compliance issues in the State's program integrity operations.

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 the State Fiscal Year (SFY) ending June 30, 2008, the program served 108,750 recipients, all of them on a fee-for-service basis, with Medicaid expenditures totaling $998,564,785. The Federal medical assistance percentage for New Hampshire during that same time period was 50 percent. The State had 17,000 enrolled providers, with about 70 percent of the providers actively submitting claims.

Surveillance and Utilization Review Unit

The SURS Unit, located within the Office of Improvement and Integrity Fiscal Unit, is dedicated to the program integrity function within the NHDHHS. The unit consists of one full-time SURS administrator and seven full-time equivalent staff. At the time of the review, two positions in the unit were vacant; a consultant and one temporary clerical position. The New Hampshire SURS Unit maintains an array of responsibilities that include, but are not limited to: (1) auditing billings to the Medicaid program for occurrences of fraud, waste or abuse, (2) managing the pharmacy lock-in program, (3) developing a new provider enrollment application/agreement, (4) conducting provider and recipient educational presentations upon request, (5) sending control memos to the fiscal agent for corrections/updates/changes to the Medicaid Management Information System (MMIS), (6) receiving action information from various licensing boards, (7) conveying excluded provider information from the Medicare Exclusion Database to the fiscal agent, (8) processing provider appeals, and (9) serving as a resource and research point of

contact for other program units which require clarification of coverage and billing issues. The average overpayment collected by the SURS Unit in the past three SFYs as a result of program integrity activities was $1,931,747.

Methodology of the Review

In advance of the onsite visit, the review team requested that New Hampshire complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of October 20, 2008, the MIG review team visited the NHDHHS, fiscal agent, and MFCU offices. The team conducted interviews with numerous NHDHHS officials, as well as with staff from the State's provider enrollment contractor and the MFCU. The team also conducted sampling of provider enrollment applications, case files, 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, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and non-emergency medical transportation (NEMT). New Hampshire's State Children's Health Insurance Program operates as a stand alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review. Unless otherwise noted, NHDHHS 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 that NHDHHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These include practices of open communication and cooperation with internal components and external partners and the co-location of State staff with the fiscal agent.

Open and inclusive communications

The SURS Unit indicated that it maintains effective communication with the MFCU and fiscal agent. This type of communication offers opportunities for cross-training and has made the varied expertise of all parties available in developing the new provider enrollment and SURS sub-systems of the State's MMIS.

Relationship with the Policy Unit

The SURS and Policy Units have an effective working relationship that allows for smooth collaboration when State rules and/or policies and procedures have to be changed

or enhanced as new provider fraud and abuse issues come to light. For example, the two units cooperated successfully in persuading the New Hampshire Legislature to require wheelchair transportation providers to show proof of insurance, vehicle inspection, and compliance with the Americans with Disabilities Act. There are no artificial barriers between organizational units which limit the ability of the program integrity staff to gather information and work cohesively to resolve fraud and abuse problems.

Co-location of staff at contractor's site
The State Medicaid Business Office staff is co-located with the fiscal agent and is actively involved with the provider enrollment process on the front end. This arrangement helps ensure that possible processing errors or incomplete applications are identified quickly during the enrollment process and that corrective action is promptly requested.

Regulatory Compliance Issues

The State is not in compliance with three Federal regulations related to required attestation, disclosure and notification activities.

New Hampshire does not ensure that providers attest that information provided on claim forms is accurate.
The regulation at 42 CFR § 455.18 requires that providers attest to the accuracy of information on all claim forms. The regulation at 42 CFR § 455.19 permits an alternative to attestations on claim forms: the State may print attestation language above the claimant's endorsement on checks or warrants payable to providers.

The NHDHHS uses the CMS 1500 and UB-04 claim forms for billing purposes. The UB-04 does not provide an area for the provider to sign certifying that the information is true, accurate, and complete. As an alternative to providing the required attestation and provider signature on the claim form, New Hampshire could include an attestation on the checks or warrants that it issues to providers. The State indicated to the review team that it currently pays providers by check rather than electronically. However, the State's checks do not contain the required attestation. The SURS Unit Director indicated that the State Treasury Department would not sign off on incorporating the required language due to space constraints. This finding was also cited during CMS' review of New Hampshire's program integrity operations in 2004.

Recommendation: Develop and implement procedures to include the required signed provider attestation for all paper claims submitted to the Medicaid program. As an alternative, revise the checks and warrants payable to providers to include appropriate language pursuant to 42 CFR § 455.19.

New Hampshire does not require disclosure of ownership and control information by the fiscal agent and NEMT providers.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person 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. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The NHDHHS requirement for conducting business with the State as a fiscal agent is a Certificate of Good Standing from the Secretary of State that verifies no monies are owed. The Department does not require that the fiscal agent disclose the full range of ownership and control information stipulated in 42 CFR § 455.104 and the review team could find no evidence that the fiscal agent provided this information.

In addition, NEMT in New Hampshire may be provided by members of the recipient's household or other volunteer drivers (both individuals and companies) who are not credentialed by the fiscal agent. The NHDHHS does not capture ownership information on these transportation providers because they are paid outside the MMIS.

Recommendations: Modify the fiscal agent contract to require submission of the required ownership and control information and collect the required disclosures. Also modify the NEMT provider enrollment application to mirror the same ownership and control information captured on providers credentialed by the fiscal agent.

New Hampshire does not report to the Department of Health & Human Services Office of Inspector General (HHS-OIG) adverse actions it takes on provider applications.
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Interviews with the State and a sampling of provider enrollment records indicated that the NHDHHS does not report to the HHS-OIG actions it takes on provider applications for participation in the program. According to the SURS Administrator, the Department relies on the MFCU to make all referrals. However, the MFCU only reports providers who are convicted on criminal charges to HHS-OIG. It does not report providers who are denied entry into or are forced out of the New Hampshire Medicaid Program in the absence of criminal convictions.

Recommendation: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers' participation in the program.

CONCLUSION

The State of New Hampshire applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- open and inclusive communications between SURS, the MFCU, and the fiscal agent,
- the effective working relationship between SURS and the Policy Unit, and
- the co-location of State staff with the Medicaid fiscal agent.

CMS supports the State's effective practices and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. To that end, we will require the NHDHHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter.

The corrective action plan should address how the State of New Hampshire will ensure that the deficiencies will not recur. The corrective action plan 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 will take more than 90 calendar days from the date of the letter. If NHDHHS has already taken action to correct compliance deficiencies, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of New Hampshire on building upon effective practices and correcting its regulatory compliance issues.