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State/Territory Name: NH

State Plan Amendment (SPA) #: 22-0027

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 13, 2022

Lori A. Shibinette, RN, MBA, NHA
Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire State Plan Amendment (SPA) 22-0027

Dear Commissioner Shibinette:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0027. This amendment proposes to renew the Recovery Audit Contract (RAC) Exception for a two-year period.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing Section 1902(a)(42)(B) of the Social Security Act. This letter informs you that New Hampshire's Medicaid SPA Transmittal Number 22-0027 was approved on December 13, 2022, effective January 1, 2023, to December 31, 2025.

Enclosed are copies of the approved CMS-179 summary page and approved SPA pages to be incorporated into the New Hampshire State Plan.

If you have any questions, please contact Joyce Butterworth at (857) 357-6375 or via email at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Henry Lipman, State Medicaid Director
Dawn Tierney, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0027
2. STATE: NH
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a)(42)(B) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Section 4.5.1:
Pages 36a, 36a.1, 36a.2, 36a.3, 36a.4, 36a.5, 36a.6, 36b, and 36c

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* TN 21-0026
Section 4.5.1:
Pages 36a, 36a.1, 36a.2, 36a.3, 36a.4, 36a.5, 36a.6, 36b, and 36c (21-0026)

9. SUBJECT OF AMENDMENT
Recovery Audit Contract (RAC) Exception

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Ann H. Landry

13. TITLE
Associate Commissioner

14. DATE SUBMITTED 9-29-22

15. RETURN TO
Janine Corbett
Division of Medicaid Services - Brown Building
129 Pleasant Street
Concord, NH 03301

FOR CMS USE ONLY

16. DATE RECEIVED **09/29/2022**

17. DATE APPROVED **12/13/2022**

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director
Division of Program Operations

22. REMARKS

Comments, if any, will follow.

Pen & Ink change to add identification of superseded SPA # in Box 8.

Revision:

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4.5.1 Medicaid Recovery Audit Contractor Program

Citation	**RAC Program**
Section 1902(a)(42)(B)(i) of the Social Security Act	____The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. __X_ The State is seeking an exception to establishing such program for the following reasons: See pages 36a.1 through 36a.6.
Section 1902(a)(42)(B)(ii)(I) of the Social Security Act	____The State/Medicaid agency has contracts of the type(s) listed in Section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: ____The State will make payments to the RAC(s) only from amounts recovered. ____The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

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4.5.1 Medicaid Recovery Audit Contractor Program

Continuation of page 36 re: "The State is seeking an exception to establishing such program for the following reasons:"

In accordance with 42 CFR 455.506(a), states may exclude managed care claims from review by Medicaid RAC's. Also, in accordance with 42 CFR 455.516, states may request to be excepted from some or all Medicaid RAC contracting requirements. New Hampshire requests an exception from all Medicaid RAC contracting requirements.

New Hampshire previously had a RAC contract with GOOLD Health Services (now Emdeon). At the time of the RAC reviews, there were no managed care organizations (MCOs) as part of NH Medicaid, and the RAC could review 100% of the Medicaid population. During the time that the RAC did complete reviews, the total amount of recoveries averaged $130,000/year. On December 1, 2013, NH implemented its managed care program. As of August 1, 2022, 98.33% (237,643) of the total Medicaid recipients (241,661) were enrolled in managed care. Based on the average recovery amount/year, this would result in an average RAC yearly recovery amount of only $3,214 for the remaining fee for service Medicaid population (4,018) if the RAC contract were to continue. Because NH is requesting that managed care claims be excluded from review, one can see that this leaves very few claims for review or recovery from the fee for service program.

Justification for MCO Exclusion

1. The NH Medicaid program currently has multiple processes in place to monitor the services provided by the three MCOs. The external quality review organization, Health Services Advisory Group (HSAG), performs this function in NH. The most recent audit covers SFY 2021, and it demonstrated an average of 98.6% compliance with required elements.

2. The Department's Program Integrity (PI) Unit, as part of the Department's contracts with the MCOs, has a strong program integrity oversight of the three MCO plans, which includes:

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4.5.1 Medicaid Recovery Audit Contractor Program

a. Monthly PI/MCO meetings to discuss issues, concerns and potential cases. The attendance for the monthly meetings for the state side includes the PI Liaison, the Director of the Medicaid Fraud Control Unit (MFCU), the attorney for the PI Unit, the PI Unit Business Analyst, and the Administrator for the PI Unit. For the MCOs, it includes the Program Integrity Managers, the Special Investigation Unit managers, the Compliance Officer, and investigators;

b. A well-defined, formalized program integrity process;

c. A referral form developed by the PI Unit that the MCO must use when referring a provider to the PI Unit for approval for the MCO to review;

d. Pharmacy encounter data has been added to the PI reporting system, EFADS, and implementation of access to the rest of the encounter data occurred in July 2015, which further enabled the PI Unit staff to validate the program integrity efforts of the MCOs;

e. If the MCO has not reviewed a state-identified, potentially problematic provider within six months, then the State PI Unit has the authority to step in and review the MCO provider;

f. Every MCO provider must also be enrolled in the NH Medicaid Program, for which the PI Unit is charged with reviewing all Moderate and High Risk providers, as well as any Limited Risk provider with a history of actions taken against them.

3. The Department's MMIS system was implemented in April 2013, and claims processing is closely monitored. Once encounter data is accepted into the MMIS, it is "processed" as if it is a regular claim to identify what the potential payment would have been. This further allows the PI Unit to monitor the MCO activity by "pulling" the encounter data into the EFADS (Fraud and Abuse Detection) system to evaluate the services for appropriateness.

Justification for RAC Exception

1. As noted above, once the managed care populations are eliminated from the RAC reviews, the potential recovery is so small ($3,214), it is apparent that it would not be feasible for contractors to bid on a RAC contract.

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2. In addition to the standard edits and audits in the MMIS, the Department also utilizes Cotiviti– a prepay claim auditing system that reviews claims for compliance with specific National Correct Coding Initiative (NCCI) edits, as well as additional edits that the State has determined appropriate. Cotiviti generates reports to the PI Unit when any provider "hits" an excessive number of edits.

3. The Department also contracts with a pharmacy benefits manager (PBM), Magellan. Medicaid Pharmacists work closely with the PBM establishing policies and procedures, as well as overseeing claims. The PBM does both concurrent and retrospective claims review, and makes appropriate referrals to the PI Unit.

4. For in-state and border hospital in-patient reviews, the Department reviews a random sampling of paid claims. When it is identified that inappropriate claims were paid for services, the PI Unit, the fiscal agent, and the provider are notified. The fiscal agent then processes a recoupment and the provider is instructed to submit a corrected claim. The PI Unit then begins a monitoring process and undertakes any further recoupments if the provider fails to submit a corrected claim or continues to submit an incorrect claim.

5. The PI Unit conducts all of the reviews on the non-MCO cases and, as previously mentioned, may also review problematic providers that have not been reviewed with the past six months by the MCO.

6. The types of actions that the PI Unit may take as a result of provider reviews include the following:

a. Recoveries of any improper payments;

b. Cost avoids by (a) identifying errors in claims processing by the MMIS and (b) by recommending changes to program areas when providers are performing inappropriate services;

c. The PI Unit is very focused on provider education as part of their review. Education may be done by the PI Unit in either individual or group settings. Also, the PI unit may refer the case to the Provider Relations Unit of the fiscal agent for additional training in areas such as proper claims submission;

d. As required by federal regulations, any occurrences of potential fraud are referred to the MFCU for further action after suspension of payment due to the credible evidence of fraud;

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e. Implementation of the EFADS is done with a dedicated Business Analyst in the PI Unit who develops and runs reports identifying potential areas for review. The Analyst also focuses on identifying any types of "patterns" in claim submissions that would help prevent any future inappropriate payments, or may indicate areas of potential fraud, waste, or abuse.

7. The PI Unit has a strong working relationship with the MFCU, resulting in the frequent coordination of provider case work. Coordination includes:

a. An effective, current MOU (Memorandum of Understanding), which allows for a clear, effective working standard between the MFCU and the PI Unit;

b. Quarterly (and, as necessary, monthly) meetings to share case updates, new fraud alerts, and any cross-training that may be necessary; and

c. Open communications resulting in an open environment for the sharing of information to more effectively work provider reviews.

8. The PI Unit is periodically reviewed by a number of federal and state agencies to ensure compliance with all program integrity regulations. Some of the outcomes of recent audits include:

a. CMS Program Integrity Oversight (last completed in NH in 2020; a new CMS review was done in March 2022, although the formal report has not yet been released). The 2020 review identified both Best Practices as well as vulnerabilities in the PI Unit, which allowed the Unit to strengthen its PI activities as a result of implementing a corrective action plan. The most recent audit was performed in September 2020, and this is a follow up e-mail from CMS regarding the supporting documentation submitted in response to the State's FY 2020 Managed Care Program Integrity Outcome Review requested by CMS on September 29, 2020. The Department reviewed the responses and materials and found them to be helpful in determining the State's level of program integrity activity since the last onsite managed care review. No additional action was required by the State at that time.

b. Legislative Annual Audit performed by KPMG. The PI Unit has historically met or exceeded all guidelines that were evaluated by KPMG, with no major audit findings being issued.

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c. EFADS System, which was part of the MMIS certification. The EFADS system is used by the PI Unit on an ongoing basis. The PI Unit's dedicated Business Analyst continually runs all required EFADS reports to validate functionality, which also produces potential areas for review by the PI Unit. The Analyst also continually runs hundreds of different report scenarios in addition to the standard required reports to (1) ensure functionality and (2) possibly identify additional areas in which to focus PI review efforts. By using this fraud detection system, the PI Unit is able to quickly identify new areas for review.

d. PERM Audits. The PI Unit is fully involved in the PERM audit process. The PI function is to review claims that have been identified by the PERM auditors as potential overpayments or erroneous payments. The PI reviewer thoroughly investigates each claim, and either supports the PERM findings or presents policy, rules, etc., to refute the PERM. This role in the PERM audit process is another tool for the PI Unit to use to potentially expand a provider review based on improper claims submission.

9. There are a number of additional PI Unit functions that impact and enhance program oversight:

a. Provider Enrollment Screening: With the implementation of enhanced provider screening on enrollment, a new position was created in the PI Unit whose single function is to review all providers in the Moderate and High Risk categories. The PI Unit advocated to have this position placed in the PI Unit, since it is well known that strict oversight of provider enrollment is the first step in the prevention of fraud, waste, and abuse.

b. Recipient Explanation of Medical Benefits (REOMBs): All REOMB forms with comments are returned to the PI Unit for review. The PI Unit was determined to be the most appropriate unit to evaluate the results of the REOMBs to determine if there were potential occurrences of fraud, waste, or abuse.

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c. Board Actions. Notifications of any professional board actions taken against any provider type are forwarded to the PI Unit for the necessary, appropriate action that should be taken. Board actions could include simple documentation of a reprimand all the way up to a permanent loss of license in the State of NH. This notification listing is another tool that the PI Unit uses in order to take appropriate action to secure the integrity of the Medicaid Program by ensuring that any unlicensed or disciplined provider is not providing services to Medicaid beneficiaries. The PI Unit has also established a process to ensure that this same information is forwarded to the three NH MCOs.

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State/Territory: New Hampshire

4.5.1 (cont.) Medicaid Recovery Audit Contractor Program

Citation	**RAC Program**
Section 1902(a)(42)(B)(ii)(II)(aa) of the Social Security Act	The following payment methodology shall be used to determine State payments to Medicaid RAC's for identification and recovery of overpayments (e.g., the percentage of the contingency fee): ____The State attests that the contingency fee paid to the Medicaid RAC will not exceed the highest rate paid to Medicaid RAC's, as published in the Federal Register. _____The State attests that the contingency fee paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC's, as published in the Federal Register. The State will only submit FFP up to the amount equivalent to that published rate. _____The contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC's, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902(a)(42)(B)(ii)(II)(bb) of the Social Security Act	____The following payment methodology shall be used to determine State payments to Medicaid RAC's for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):

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4.5.1 (cont.) Medicaid Recovery Audit Contractor Program

Citation	**RAC Program**
Section 1902(a)(42)(B)(ii)(III) of the Social Security Act	____The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902(a)(42)(B)(ii)(IV)(aa) of the Social Security Act	____The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV)(bb) of the Social Security Act	____The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902(a)(42)(B)(ii)(IV)(cc) of the Social Security Act	____Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.