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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 16-0018

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

December 19, 2016

Jeffrey Meyers, Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers,

Enclosed is an approved copy of New Hampshire's (NH) State Plan Amendment (SPA) 16-0018, received November 23, 2016 and entitled *"Recovery Audit Contract (RAC) Exception"* transmitted a proposed amendment to New Hampshire's (NH) approved Title XIX State Plan to reflect the state's current exception to the RAC contracting requirement. The approval of this exception expires on January 1, 2019, two years from the effective date.

Transmittal # 16-0018 -- Recovery Audit Contract (RAC) Exception
-- Effective January 1, 2017

If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Deborah Fournier, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 16-0018

2. STATE: NH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

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

7. FEDERAL BUDGET IMPACT:
FFY 2017 none; simply a transfer of responsibility
FFY 2018 none; simply a transfer of responsibility

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

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Section 4.5.1
Pages 36a, 36b, and 36c, TN 15-002
Pages 36a.1,36a.2,36a.3, 36a.4, 36a.5, 36a.6, TN 15-002

10. SUBJECT OF AMENDMENT:
Recovery Audit Contract (RAC) Exception

11. 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: comments, if any, will follow

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: Jeffrey A Meyers

14. TITLE: Commissioner

15. DATE SUBMITTED:
November 23, 2016

16. RETURN TO:
Dawn Landry
Office of Medicaid Business and Policy/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: November 23, 2016

18. DATE APPROVED: December 19, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Programs, Boston, MA

23. REMARKS:

FORM HCFA-179 (07-92)

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Revision:

State/Territory: New Hampshire .

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 (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.

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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 (MCO's) 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 October 1, 2016, 95.62% (177,273) of the total Medicaid recipients (185,391) were enrolled in managed care, with 137,384 recipients in Medicaid managed care and 39,889 recipients in marketplace managed care plans for which NH Medicaid paid the premium as allowed through its 1115 Premium Assistance Program (PAP) waiver. Based on the average recovery amount/year, this would result in an average RAC yearly recovery amount of only $6,500 for the remaining fee for service Medicaid population (8,118) 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 two MCO's. The external quality review organization, Health Services Advisory Group (HSAG), performs this function in NH, and has already conducted three annual audits. The most recent audit for SFY 2015-2016 demonstrated an average of 90.4% compliance with required elements.

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

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 MCO's, it includes the Program Integrity Managers;
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 MCO's;
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. Since the Department's MMIS system is relatively new with an implementation date of April 2013, claims processing is closely monitored. Once encounter data is accepted into the MMIS it will be "processed" as if it is a regular claim to identify what the potential payment would have been. This will further allow 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 ($6,500), it is apparent that it would not be feasible for contractors to bid on a RAC contract.

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4.5.1 Medicaid Recovery Audit Contractor Program

2. In addition to the standard edits and audits in the MMIS, the Department also utilizes Verisk – a prepay claim auditing system that reviews claims for compliance with specific NCCI edits as well as additional edits that the State has determined appropriate. Verisk 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. Our 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 Program Integrity Unit.

4. For in-state and border hospital in-patient reviews, the Department contracts with a QIO. When the QIO identifies inappropriate claims 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 Program Integrity 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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4.5.1 Medicaid Recovery Audit Contractor Program

e. Implementation of the EFADS is done with a dedicated Business Analyst in the PIU 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:

- An effective, current MOU (Memorandum of Understanding) which allows for a clear, effective working standard between the MFCU and the PI unit.
- Quarterly (and as necessary monthly) meetings to share case updates, new fraud alerts and any cross-training that may be necessary.
- Open communications resulting in an open environment for the sharing of information to more effectively work provider reviews

8. The Program Integrity 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 (completed every 3 years – last completed in NH in 2012). This review identified both Best Practices as well as vulnerabilities in the Program Integrity Unit which allowed the unit to strengthen its PI activities as a result of implementing a corrective action plan. The most recent review was performed in August 2016. Results are not yet available, but the PI unit will be responsive to the outcomes.

b. Legislative Annual Audit performed by KPMG. The Program Integrity 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 is also producing 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) to possibly identify additional areas in which to focus PI review efforts. By using this new, up-to-date 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 Program Integrity 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 Program Integrity Unit, since it is well known that a strict oversight of provider enrollment is the first step in the prevention of fraud, waste and abuse in the Medicaid Program.

b. Recipient Explanation of Medical Benefits (REOMB's): All REOMB forms with comments are returned to the PI unit for review. It was felt that the PI unit was the most appropriate unit to evaluate the results of the REOMB's to determine if there were potential occurrences of fraud, waste or abuse occurring.

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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 ensure the integrity of the Medicaid Program by ensuring that any unlicensed or disciplined provider is not providing services to our clients. The PI unit has also established a process to ensure that this same information is forwarded to the two NH MCO's.