THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

FINANCIAL AND COMPLIANCE
AUDIT REPORT
FOR THE YEAR ENDED JUNE 30, 2002

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Reporting Entity And Scope

The reporting entity and scope of this audit and audit report is the Medical Assistance (Medicaid) program of the New Hampshire Department of Health and Human Services for the year ended June 30, 2002.

Medicaid, a federally-aided state program established under Title XIX of the Social Security Act, provides medical assistance to low income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. Within broad federal guidelines, states design and administer the Medicaid program under the general oversight of the Centers for Medicare and Medicaid Services (CMS). In New Hampshire, the Department of Health and Human Services (Department or DHHS) is the primary State agency responsible for administering the Medicaid program.

Organization

The Department of Health and Human Services was reorganized under the terms of RSA 126-A, effective November 1, 1995. The Department is under the executive direction of a commissioner who is appointed by the Governor, with the consent of the Executive Council, to a four-year term. The commissioner is authorized to nominate an assistant commissioner and division directors. The Medicaid program is administered by the following offices and divisions within the Department: Office of Health Planning and Medicaid; Office of the Commissioner; Division for Children, Youth and Families; Division of Family Assistance; Division of Elderly and Adult Services; Division of Behavioral Health; and Division of Developmental Services. The New Hampshire Department of Justice is responsible for the operation of the Medicaid Fraud Control Unit in the State.

At June 30, 2002, the Department employed approximately 3,500 employees and was organized into nine offices and seven divisions.

Responsibilities

The Medicaid program was established in 1965 as a federal-state entitlement program to provide health care to low-income individuals who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The purpose of the Medicaid Act is to enable each State…to furnish …rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care (42 U.S.C. § 1396). States develop state plans consistent with the requirements of the Medicaid Act in order to receive federal financial participation. Every state plan consists of a mix of required and optional categories of health services. Significant required categories of service include inpatient and outpatient hospital care, physician's services, skilled nursing facility services for persons over age 21, medical supplies and equipment, etc. Optional services provided by the New Hampshire

State Plan include, but are not limited to, prescribed drugs, home and community based services for individuals with disabilities and chronic medical conditions, clinic services, and dental services. In fiscal year 2002, New Hampshire's Medicaid program had expenditures of approximately $963 million for health care services and served an average monthly enrollment of approximately 84,000 recipients.

Funding

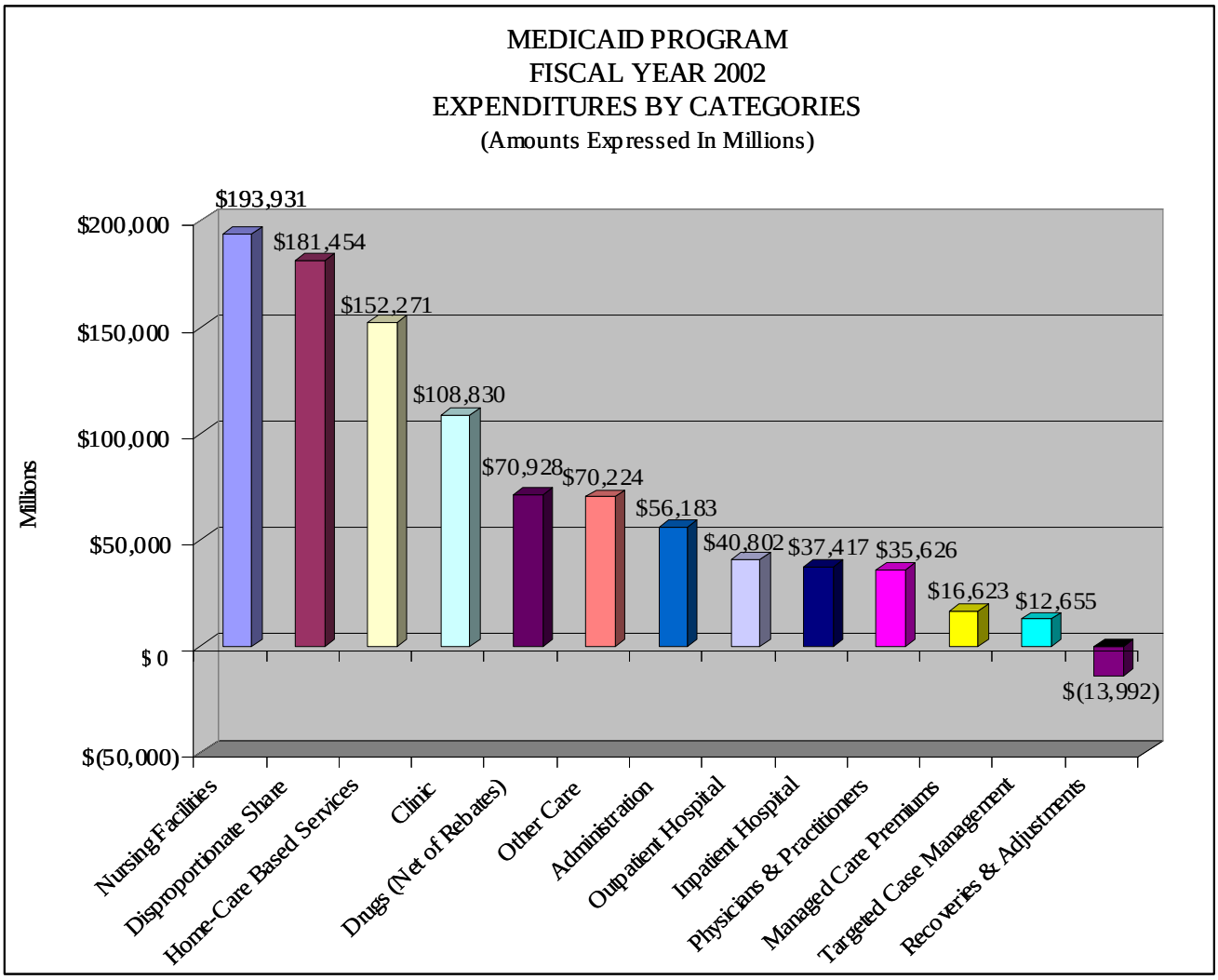
The federal, state, and local governments share Medicaid program costs. In general, the federal government contributes 50% of program medical and administrative costs and up to 90% of certain computer development and installation costs. Local revenues primarily include county contributions for skilled nursing facilities and other costs. The actual financial activity of the Medicaid program is accounted for in the General Fund of the State of New Hampshire and is summarized below. Fiscal year 2002 Medicaid program expenditures by category are shown graphically on page 3.

Summary Of Medicaid Program Revenues And Expenditures
For The Year Ended June 30, 2002

Revenues	
Federal Revenues	$ 487,511,740
Local Revenues	66,012,831
Total Revenues	**$ 553,524,571**
Expenditures	**$ 962,952,608**
Excess (Deficiency) of Revenues Over (Under) Expenditures	**$ (409,428,037)**

Prior Audit

The most recent prior audits covering the Medicaid program were the Statewide Financial and Single Audits performed for the year ended June 30, 2001. The appendix to this report on page 57, contains a summary of the current status of the observations contained in the 2001 State Management Letter and the 2001 Single Audit Report related to the Medicaid program. Copies of these audit reports can be obtained from the Office of Legislative Budget Assistant, Audit Division, 107 North Main Street, State House Room 102, Concord, NH 03301-4906.



Audit Objectives And Scope

The primary objective of our audit is to express an opinion on the fairness of the presentation of the financial statement of the Medicaid program for the year ended June 30, 2002. As part of obtaining reasonable assurance about whether the financial statement is free of material misstatement, we considered the effectiveness of the internal controls in place at the Department of Health and Human Services and tested their compliance with certain provisions of applicable State and federal laws, rules, regulations, contracts, and grants. Major accounts or areas subject to our examination included, but were not limited to, the following:

- Revenues and
- Expenditures.

Our reports on compliance and on internal control over financial reporting, and on management issues, the related observations and recommendations, our independent auditor's report, and the financial statement of the Medicaid program are contained in the report that follows.

Auditor's Report On Compliance And On Internal Control Over Financial Reporting

To The Fiscal Committee Of The General Court:

We have audited the accompanying Statement of Revenues and Expenditures of the Medicaid Program, a federal/State program primarily administered by The State of New Hampshire Department of Health and Human Services, for the year ended June 30, 2002, and have issued our report thereon dated February 19, 2003, which was qualified with respect to the lack of presentation of the financial position of the Medicaid program in the General Fund. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether the Medicaid program's financial statement is free of material misstatement, we performed tests of its compliance with certain provisions of laws, rules, regulations, contracts, and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*. However, we noted certain immaterial instances of noncompliance which are described in Observations No. 18 through No. 26 of this report.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Department's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statement and not to provide assurance on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could

adversely affect the Department's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statement. Reportable conditions are described in Observations No. 1 through No. 17 of this report.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statement being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, of the reportable conditions described above, we consider the matters described in Observations No. 1 and No. 2 to be material weaknesses.

This auditor's report on compliance and on internal control over financial reporting is intended solely for the information and use of the management of the Department of Health and Human Services and the Fiscal Committee of the General Court and is not intended to be and should not be used by anyone other than these specified parties.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

February 19, 2003

Internal Control Comments
Material Weaknesses

Observation No. 1: General Computer Controls Must Be Improved

Observation:

A federal review of the general controls in the Department's significant Medicaid information systems raises concerns that one or more of the Department's internal control components does not reduce, to a relatively low level, the risk that misstatements in amounts that would be material in relation to the financial statement of the Medicaid program may occur and not be detected within a timely period.

The State of New Hampshire's annual audits since 1997 have included management letter comments that the Department has not obtained any audits of the service organization responsible for the operation of the Department's Medicaid Management Information System (MMIS). Title 45 Code of Federal Regulations Part 95.621 requires that the state agency biennially report on its Medicaid system security reviews, including reviews of the independent service bureau's Medicaid processing. Due to the significant Medicaid expenditures in the State, as well as the repeat finding reported in the single audit, the U.S. Department of Health and Human Services, Office of Inspector General (DHHS-OIG) initiated a review during the summer of 2002 to assess the general controls of the Department's significant Medicaid related information systems including: (1) entity-wide security program planning and management, (2) access controls, (3) application software development and change controls, (4) segregation of duties, and (5) service continuity.

The DHHS-OIG utilized the U.S. General Accounting Office's Federal Information System Controls Audit Manual to assess whether the proper general controls were in place and operating effectively. General controls impact the integrity of all information systems and are critical to ensuring the reliability, confidentiality, and availability of data. The DHHS-OIG review disclosed that the general controls in the Department's information systems were less than adequate to protect Medicaid and eligibility data. Weak general controls, such as the ones found by the DHHS-OIG, do not in the DHHS-OIG view, effectively prevent:

- unauthorized access to and disclosure of sensitive information;
- malicious software changes that could interrupt data processing or destroy files;
- improper Medicaid payments or eligibility determination; and
- disruption of critical operations.

It was the DHHS-OIG assessment that the weaknesses noted in the general controls over the Department's Medicaid information systems are significant and could potentially compromise the integrity of the systems and the information produced from those systems.

Furthermore, the DHHS-OIG determined that the entity-wide security structure within the Department does not adequately ensure that security controls are adequate and operating

effectively. While the Department has most of the elements of an entity wide security plan, the elements are fragmented among the different components of the Department. This finding reiterates the March 2001 findings of a separate study commissioned by the Department to review its information systems security. The Department reports that as of January 2003, twelve out of the thirteen findings in that study related to information security management, all categorized as having a high or medium urgency to complete, have not been resolved. According to a Department outline of its efforts to address the recommendations found in the study, the solutions to these comments, for the most part, are being put off until the Department is able to implement information security changes required by the federal Health Insurance Portability and Accountability Act, potentially a couple of years away.

Timely correction of control weaknesses within the Department's information systems can help to reduce the risk of loss due to error, fraud, and other illegal acts, disasters, or other incidents that may cause its information systems to be unavailable.

Recommendation:

The Department must improve its controls over its Medicaid information systems. Central to that task must be an improvement in the Department's overall information security environment and structure. To be most effective and efficient, the Department's efforts must be focused, structured, formal, and coordinated. Department and contractor personnel must regard controls as a requirement established and demanded by the highest level of Department management. Controls cannot be seen as an add-on or a function to be incorporated into a system once the system is up and running. Controls must be coordinated with the design and implementation of systems and must be monitored for continued effectiveness and appropriateness as systems are modified. Management must not allow system controls to be bypassed during periods of staff shortages. Controls must be most effective when lack of staff or other resources causes strains on system operations. At these times, staff shortages may increase segregation of duties risks due to staff performing more than one incompatible function, requiring more reliance on system controls.

Auditee Response: Concur in part

The Department's intent is to leverage the effort required to meet HIPAA [federal Health Insurance Portability and Accountability Act] security requirements for personally identifiable health information to enhance security practices for all sensitive information. It is not the Department's intent to wait for a final HIPAA security rule implementation date before beginning work on improving data security. Department resources are currently defining security policies, procedures, implementation options and management mechanisms to meet HIPAA security regulations and to improve system security.

The foundation to any improvement in overall data security rests with the upgrade of the Windows 95 PCs to Windows XP and thereby establishing a realistic ability to limit access to the Department's basic IT infrastructure. This effort is underway and is scheduled to be completed in Q1 of SFY 2004. Also underway is the first revision to the Department's Technical Resource

Utilization Policy to create a unified and consistent approach to management and control of user accounts. The policy update will be adopted in Q3 SFY2003.

As noted by the US DHHS-OIG, "the Department has most of the elements of an entity wide security plan, the elements are fragmented among the different components of the Department." Bringing these elements together into a unified security policy is a high priority of the Department. Towards that end the Department will appoint a Security Officer, as required by HIPAA security rules, in Q1 of SFY 2004.

Further, the Department has already addressed a number of the MMIS security related findings from the OIG audit. In addition, we have allocated operational money in the MMIS budget to allow us to make additional security enhancements. The re-procurement of NH-AIM [the State's Medicaid payment system] will include requirements that reflect these as well as the OIG's findings.

Observation No. 2: Expenditures Should Be Charged To The Correct Accounts And Accounting Periods

Observation:

The Department on occasion bypasses transfer requests or other provisions for obtaining additional expenditure authority and charges expenditures to accounts with available appropriations, regardless of whether they are the proper budgeted accounts for the expenditure classes. In addition, the Department charged a fiscal year 2003 expenditure to fiscal year 2002 appropriations, reportedly to catch up with contract provisions.

- On June 26, 2002, the Department charged $1.5 million of fiscal year 2003 Medicaid client managed care premiums to fiscal year 2002 accounts. Approximately $1.3 million of that amount was charged to a lease account and to other accounts unrelated to the managed care expenditure. Reportedly, the Department wanted to make a catch up payment for the managed care premiums for Medicaid clients; however, it did not have sufficient appropriations remaining in the budgeted account. As there were available balances in the lease and other class lines, the Department charged the expenditure against those accounts. According to the Department, there was no time to request a transfer of appropriations as it wanted to make this payment prior to year end.

  The prepayment of the fiscal year 2003 liability with fiscal year 2002 appropriations required the State to record an adjustment to its financial statements at June 30, 2002. However, on a budgetary basis, the prepayment by the Department of the fiscal year 2003 premium with fiscal year 2002 appropriations essentially provided the Department with the ability to spend in excess of its fiscal year 2003 budgeted expenditure authority.

- The Division of Behavioral Health (the Division or DBH) charges expenditures among its accounts based on budgeted ratios and available appropriations and not on whether the expenditures were actually budgeted from the account. Charging expenditures to accounts

based on budgeted ratios and available appropriations, regardless of the nature of the expenditure, avoids budgetary controls and obfuscates the cost of providing DBH services.

The State's Medicaid payment system (AIM or NHAIM) categorizes Community Care Waiver and Community and Mental Health claims payments using fund codes K and H, respectively. The Division allocates the payments categorized as K and H into ten budgeted class-line accounts including: family support, case management, emergency intake, community support, and housing for mental health expenditures; and case management, day program, developmentally disabled waitlist, family support, and community residency for community care waiver expenditures. The Division allocates the fund K and H expenditures by applying a percentage of each to its respective class-line accounts, regardless of the actual nature of the underlying expenditure. The allocation percentages are based on the relative amounts budgeted for each class line. For example, an expenditure that actually paid for family support services would be allocated to and reported as expenditures in each of the five mental health expenditure class lines. If at anytime during the fiscal year the appropriations in any of the class lines are exhausted, the expenditures are charged to any class line within the Division's accounts that has appropriations remaining, regardless of whether the appropriations were for the purpose of the expenditure or not.

According to the Division, this method of allocating expenditures based on budgetary percentages goes back approximately 15 years to a legislative request to provide additional information on the Division's class 090 program expenditures. The effect of posting and reporting expenditures in this manner is to bypass the budgetary controls requiring approvals prior to transferring budgeted amounts and also causes the management information system to report expenditures not as they occurred but as they were anticipated by the budget.

RSA 9:19 states that no public funds appropriated by the general court shall be used for any other purpose than that for which they were appropriated. As funds are appropriated on the class-line account basis, the effect of the Department allocating expenditures on an available appropriations basis avoids the budgetary controls intended by the statute.

Recommendation:

The Department of Health and Human Services should charge expenditures accurately to the proper budgetary accounts. Expenditures should be charged to accounts based on actual amounts spent for budgeted services and not on a prorated amount of bundled services. If appropriations in a class line are not sufficient, the Department should request transfers of appropriations or supplemental appropriations as provided by statute. If sufficient detail information is not available to provide accurate charging of expenditures to budgeted class lines, then the Department should increase the number of fund codes or other information in NHAIM to provide the detail needed. The Department should not continue to post and report financial transactions as if there is a true and accurate determination of expenditures by budgeted class line if there is no true distinction being made in practice. If the Department determines that the level of detail that would be available if accurate postings were made is not necessary or would be too costly to keep track of and report, the Department should request that the expenditures be budgeted at a level that can be supported by available or reasonably obtainable management information.

Auditee Response: Concur

The Department agrees that payments were made from accounts other than the usual account used for making the monthly managed care payment. When funds are available at the end of a fiscal year, there is not sufficient time to request transfers through the Legislative Fiscal Committee and the Governor and Council to allocate the funds to the usual account. A solution to this problem would be to allow transfer requests to be brought forward in the thirteenth month period in order to reallocate the funds to the appropriate accounts.

The Department concurs with the recommendation that expenditures be budgeted at a level that can be supported by available or reasonably obtainable management information. Because the services people receive are individualized and ever-changing to meet their needs, the structure is artificial and does not reflect the way services and supports are delivered and subsequently billed by providers. Changes to the NHAIM system would, even if possible, be difficult and potentially cost prohibitive. Further, changes to NHAIM in all likelihood, do not address the root issue created by the current class structure. There are currently 25 procedure codes covering the types of service provided in Developmental Services alone. While some of these procedure codes map directly to a budgeted line item, i.e. case management, others do not. For example, procedure code X9841 (community support services) can be either a day, residential or family support service depending on the individualized service plan of the person receiving the service. In theory, in order to comply with the audit finding, the Division would have to add new class lines in the agency budget to support each type of service delivered, identify additional procedure codes to map directly to the added class lines and EDS [the State's Medicaid fiscal agent] would have to add new fund codes and re-map current codes. A further complication is that current changes to local coding occurring as a result of HIPAA [federal Health Insurance Portability and Accountability Act] implementation is still not finalized.

Further, this level of detail, while not enhancing the Division's ability to report and manage its resources, based on the adopted budget would require multiple transfers between line items as people's needs and services change frequently. A separate NHAIM reporting system can accomplish the objective.

The Department will seek the authority to collapse the current class lines into an umbrella class account including the appropriate object levels. The Department will work to effect this structural change during the current biennial budget process.

Finally, the Legislative and Executive branch have explained their expectations that the Department avoid pending claims at the end of the year and pay all claims to mitigate the carry over of expenses.

Other Reportable Conditions

Observation No. 3: Security Of Contracted Automated Data Processing Systems Should Be Subject To Regular Review

Observation:

The Department does not have regularly scheduled independent reviews of the effectiveness of the security and controls of its computer service organizations.

The Department contracts with an independent computer service bureau to act as a fiscal agent and process Medicaid claims and accumulate financial and statistical data using the Department's Medicaid Management Information System (MMIS). For the year ended June 30, 2002, the fiscal agent processed and/or recorded over $720 million of Medicaid payments through MMIS.

During fiscal year 2002, the Department contracted with a Pharmacy Benefits Manager (PBM) to process pharmacy claims on behalf of the Department. For the year ended June 30, 2002, the PBM processed approximately $60 million of Medicaid pharmacy claims through the PBM system.

Due to the significant amounts of transactions and dollars processed by the Department's fiscal agent and PBM, and the fact that the Department's internal control polices and procedures are physically and operationally separate from the fiscal agent's and PBM's, the Department should take appropriate measures to ensure that its operations are not negatively impacted by control weaknesses at these service providers. One commonly used method to gain that assurance is through the procurement of service auditor's reports performed in accordance with Statement on Auditing Standards No. 70, *Reports on the Processing of Transactions by Service Organizations* (SAS 70). In addition, federal regulations require the Department to have biennial Automated Data Processing (ADP) system security reviews.

The auditor of the State's Comprehensive Annual Financial Report (CAFR) has raised this matter, regarding a review of the operations of the independent computer service bureau, in the State of New Hampshire's management letters since 1997 which have recommended the Department obtain annual SAS 70 reports covering the service bureau's activities.

Recommendation:

The Department should perform or cause to be performed on at least a biennial basis, system security reviews of its computer service bureau's and its PBM's ADP operations. While SAS 70 audits and reports on these operations could serve this purpose, it is not necessarily the only option available to the Department. The Department should work with its ADP operators to determine the most efficient and effective way to meet the federal requirement for system security reviews, the needs of the Department to obtain assurance on the security of its

operations, and the needs of the auditors of the State's CAFR, to obtain information on the ADP system's internal controls and the effectiveness of those controls.

Auditee Response: Concur

The Department concurs with the recommendation and shares the interest in assuring that adequate operational security and effective systems internal controls are maintained. The Department will pursue adequate funding to cover the costs for this service during the current budget cycle. The Department will work with its fiscal agent and PBM manager to determine the most efficient and effective mechanism for conducting this review, one possible alternative being the SAS 70 audit.

Observation No. 4: The Medicaid Fee Structure Should Be Reviewed

Observation:

The Department is unable to readily document the source of many of the fees paid to providers of Medicaid services. Apparently, the Department does not have a complete understanding of the source and basis of all of its Medicaid fees.

The Department reimburses most professional services using a schedule of fees for standard services that is maintained in the Department's Advanced Information Management (AIM) system, a component of the Medicaid Management Information System (MMIS). The fees for any services that are not included on the schedule may be based on provider specific fees or on Department preauthorization. Since 1994, changes to the rate schedule are documented and authorized by Department control memos which direct the MMIS staff to make changes to the rate schedule. A study commissioned by the Department found:

- While fees for specific procedure codes have been updated periodically, an aggregate analysis of the rate schedule has not been completed since the late 1980s to early 1990s.

- With the exception of fees updated within the past few years, there is little to no understanding within the Department as to how the current fees were derived.

- There is a wide variation in the relative fees paid for various types of services (e.g. office visits versus cardiac surgeries).

According to the study, this lack of understanding has made it difficult for the Department to evaluate the adequacy of their fee schedules and to compare the New Hampshire Medicaid fees to those of other payers. The significant amount of time that has elapsed since a full-scale analysis of the rate schedule has also resulted in reimbursement policies and procedures that deviate from generally accepted practices within the industry (e.g. Medicare policies).

Our audit found similar problems. As part of our test of a sample of 150 payments for Medicaid services, we requested documentation from the Department that would support the fees paid for

the tested services. While the Department through its control memo process readily supported the fees for a number of the test items, not all fees were readily supported as the Department could not document the fee for one test item and required over two months to provide the support for other test items. In addition, the support provided did not consistently contain cost analysis or other information establishing the basis for the fees.

Recommendation:

The Department must improve its policies and procedures for documenting its fee structure. In order to be able to efficiently establish and monitor the appropriateness of fees, information on the source and basis of the fees must be readily available for analysis and other monitoring and evaluation purposes.

Auditee Response: Concur

The Department concurs with this recommendation. In December of 2001, the Department commissioned a study of its provider reimbursement methodologies and rates. This study was completed in January 2003. As part of the baseline assessment, the Department contracted for a detailed inventory of provider reimbursements by specialty as well as recommendations regarding reimbursement methodology options for the future, for high volume provider types. As a result of this work, the Department now has a summary outlining the current methodology used for 31 provider types, information regarding fee updates and basis for rate development. Because some of these reimbursement schedules were developed many years ago, the historical knowledge may not have been available regarding the original rate methodology. The Department plans to update the Baseline Assessment annually in the future, in order to maintain an accurate history of changes to the provider fees.

Observation No. 5: Financial Transactions Should Be Recorded And Processed As They Occur

Observation:

The Department did not record and deposit in a timely manner drug rebate checks received during the period of May 23 through June 28, 2002. Over $900,000 of drug rebate checks received by the Department during this period were temporarily held in a locked file cabinet until they were ultimately recorded and deposited on July 8, 2002.

Department management intentionally did not record and deposit the checks, reportedly due to the Department not having complete account information to post the rebates. The effect of not recording and depositing these rebates when they were received was to move the Department's ability to use the funds from the rebates from fiscal year 2002 to fiscal year 2003. Had the Department recorded the rebates in the proper accounting period, 50 percent of the funds would have been subject to lapsing at the close of fiscal year 2002. As the rebates were recorded and deposited in fiscal year 2003, the funds were available to essentially increase the Department's fiscal year 2003 available budget for Medicaid drug purchases.

In addition, by delaying the recording and depositing of the rebate checks, the Department did not accurately report the status of the Medicaid program on its June 30, 2002 quarter-end financial status report to the federal Centers for Medicare and Medicaid Services.

Recommendation:

The Department should record and process all financial transactions as they occur. The recording and processing of transactions should not be intentionally delayed thereby avoiding State controls including the proper safeguarding of assets, cash management practices, accurate financial reporting, and controls over available budgets. The fact that the Department believed it appropriate to hold these checks unreported and under minimal security for this period indicates a lack of management's appreciation for a proper control environment.

Auditee Response: Concur

This was a special circumstance in which a new system was not fully operational to allow the Department to credit the checks to the appropriate accounts to ensure correct reimbursement to the general fund and to the counties, where the drug rebates apply to long-term care clients. The system to manage this will be fully operational by June 30, 2003.

Observation No. 6: Year-End Medicaid Accounts Payable Calculation Should Be More Efficient

Observation:

The Department's annual calculation of Medicaid accounts payable is an involved calculation that, while reasonably reliable, is inefficient and subject to clerical-type errors.

At June 30, 2002, the Department reported its Medicaid accounts payable for medical services to be $83 million. For financial reporting purposes, the Department manually estimates the accounts payable liability for Medicaid related medical expenditures as the expected amounts to be paid in the next fiscal year for client services provided in the current or prior fiscal years. The liability is calculated based on the total processed claims paid during the first couple of months of the new fiscal year for claims with dates of service prior to year end. The total of such payments is then increased by a lag factor to estimate the total amount that will eventually be paid for all claims with dates of service prior to the new fiscal year. The actual calculation of the liability involves the input of numerous amounts from several reports onto Department-generated spreadsheets.

Through a review of the Medicaid accounts payable calculation for June 30, 2002, we noted an error in the calculation and an unsupported adjustment amount. The error was corrected when the Department was notified but the Department was unable to adequately explain the necessity for a $5.6 million adjustment reducing the amount of the payable. It was the Department's contention that the manual calculation returned an inflated amount for one category of service and that an

adjustment to reduce the payable was appropriate; however, the Department was unable to document the appropriateness of the $5.6 million adjustment amount.

The Department's Medicaid Management Information System (MMIS) generates an Incurred Expense Report For Estimated Expenditures which includes paid amounts and a total estimated incurred amount by claim month of service. While the Department relies upon the report for claims payment information, due to concerns with the historical accuracy of the reported estimated incurred amounts, the Department does not use the reported estimated incurred amount as an estimate of its Medicaid liability.

A similar comment was reported in the fiscal year 2001 management letter for the State of New Hampshire. The Department responded to that comment that "it would revisit the possibility of using the system [MMIS] data next year, and will make a concerted effort to uncover any changes in payment trends that would effect the calculations."

Recommendation:

The Department should investigate whether using the MMIS calculated and reported liability amounts to report the payable at year end would result in a more reliable amount being reported.

If the Department decides to continue to calculate the liability for Medicaid manually, someone other than the preparer should review and approve the calculation.

Significant adjustments must be supported by appropriate documentation.

Auditee Response: Concur in part

The Department concurs with the Observation, but does not concur with the Recommendation. The Department managers and staff who prepare the report met several times and consulted with EDS [the State's Medicaid fiscal agent] technical assistance staff on the automated report entitled the 543 report. It was found that the calculated liability information was incorrect. One problem was that the totals on the report were truncated, so that the amounts were not printing correctly. Further the analyst reviewed the source code for the calculations and found that the formulas would most likely not produce a correct liability.

Department management did review the manual calculations a number of times and this was the reason for the adjustment. The liability for the particular category based on the lag factor would have exceeded the historical entire annual expenditure. The staff was unable to prove that this problem was caused by a $5.6 million processing error which was subsequently corrected. However, we believe using the lag factor would have produced an overstated accounts payable liability.

The Department is developing a Management Decision Support System for the Medicaid program. After the implementation of this system during SFY2004, the Department will develop a new automated accounts payable liability calculation using the reporting capabilities of this system. Because the Department of Administrative Services, Financial Reporting developed the

current liability calculation methodology, the DHHS will consult with them as changes to the methodology are made.

Observation No. 7: Contracts Should Not Be Amended Without Proper Approvals

Observation:

The Department changed certain provisions of its contract with its Pharmacy Benefits Manager (PBM) without obtaining approval from the Governor and Council or fully documenting a cost/benefit analysis that demonstrated the need for the change.

The Department signed a memorandum of understanding with its PBM early in fiscal year 2002, shifting the responsibility for check writing services to the PBM. The cost for this additional service was offset against contract savings from the Department, delaying the implementation of the disease management component of the original Pharmacy Benefits Services (PBS) contract. According to the Department, it was not ready to participate with the PBM in the full implementation of the contract as the Department needed to revise administrative rules and overcome certain obstacles to the disease management component of the PBM contract.

The Department could not provide documentation that it performed a formal cost-benefit analysis of engaging the PBM to perform the check writing function for its Medicaid pharmacy benefits program. While the Department receives reporting on certain costs of operating the check-writing component of the amended contract, it does not receive sufficient information from the PBM to fully analyze the costs and benefits of using the manager to disburse payments. The PBM invoices the Department approximately $10,000 monthly for direct costs of providing check writing for the Department's PBS. In addition, it is not clear that the Department sufficiently considered and responded to the increased control risk it accepted when it transferred the check writing responsibilities to the PBM.

Part 17 (Amendment) of the general provisions of the contract between the Department and the PBM states "[t]his agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Council of the State of New Hampshire."

The Department indicated that in its view, the memorandum of understanding signed by the Department and the PBM was not an amendment of the contract requiring Governor and Council approval because it did not change the expenditure total of the agreement. However, as the scope of services to be delivered by the PBM were changed by the subsequent agreement, it appears that the original contract was substantially changed and therefore the change should have been submitted for Governor and Council approval.

Recommendation:

All changes to Department contracts should be submitted for proper approvals. All requests for changes to contracts should be supported by proper analysis and documentation that evidences

the need for the change. Contract changes affecting the Department's controls should include consideration and documentation of plans of actions that would mitigate any increased risks to the Department.

Auditee Response: Concur

The Department concurs with the observation. Staff did not realize that actions taken constituted a contract amendment.

All material changes in scope of services regardless of changes in contract expenditure levels will be processed for all appropriate approvals.

Observation No. 8: Disproportionate Share Calculations Should Be Reviewed And Verified

Observation:

The data and calculations supporting the disproportionate share (DSH) payments made to the general hospitals in the State are not reviewed and verified by the Department prior to the Department making the payments.

Federal financial participation is available for aggregate payments to hospitals that serve a disproportionate number of low-income patients with special needs. The State Plan must specifically define a DSH hospital and the method of calculating the payment for these hospitals. The Department delegates the task of performing the specific details, methodology, and final DSH calculations to the New Hampshire Hospital Association (NHHA). There is no contract or written agreement related to the work performed on the Department's behalf by the NHHA. The NHHA performs this service on a good-will basis. Neither the NHHA nor the Department verifies the financial information submitted by the hospitals forming the basis of the calculation and the Department does not perform a review of the NHHA calculations to ensure accurate computations.

During fiscal year 2002, the Department made $149 million of DSH payments to 28 general hospitals operating in the State. As part of our review of DSH payments, we obtained copies of the NHHA spreadsheet and hospital data sheets supporting the fiscal year 2002 payments. A review of the supporting documentation revealed certain errors and other inconsistencies that indicate the accuracy of the calculations would have benefited from a more robust review and approval process. For example, the formatting of the spreadsheet used by the NHHA included "hidden columns" or columns that normally don't appear when the spreadsheet is used but which could contain information included in any spreadsheet calculations. One of the hidden columns contained irrelevant information from prior fiscal years that did not appear to affect the fiscal year 2002 calculations. When the NHHA employee was asked the reasons for having the hidden columns in the spreadsheet, the employee replied that they were unaware the spreadsheet contained the hidden columns with the extraneous data.

Other problems were noted from a review of a sample of five of the 28 hospital data sheets. One data sheet reviewed was labeled as unaudited information and did not agree to the corresponding data on the spreadsheet. The NHHA could not provide a copy of a revised "audited" data sheet to support the information on the spreadsheet but after some delay was able to locate a copy of an emailed spreadsheet from the hospital that contained the revised amounts. The revised spreadsheet caused an additional $1.79 million to be paid to the hospital versus the amount that would have been paid based on the original unaudited data sheet calculation (the Medicaid enhancement tax paid by the hospital was unaffected as the revised data did not affect the amount of the tax paid by the hospital). There was no explanation of cause for the revision to the reported amounts or indication that the accuracy of the amounts had been reviewed or verified.

A second data sheet reviewed had two associated errors. The dollar amount of the Medicaid charges was incorrectly transferred from the data sheet to the spreadsheet, with no resulting effect on the DSH payment, and the gross patient service revenue on the spreadsheet incorrectly included $511,043 of charity care, resulting in a Medicaid enhancement tax overpayment and DSH overpayment of $30,663.

A similar comment regarding the lack of Department verification of financial data submitted by the participating hospitals has appeared in the management letters for the State of New Hampshire since 1999. The Department's responses to these prior comments included a statement that the Department would perform a sample number of reviews annually and follow up with additional reviews if initial findings warrant it. To date, the Department has not implemented this review and follow-up procedure.

Recommendation:

The Department should implement policies and procedures to review and verify financial data submitted by the participating hospitals. The data sheet and spreadsheets documenting calculations should be reviewed and approved by the Department prior to the payments to ensure that payments made by the Department are appropriate and based on accurate information.

If the Department continues to use the services of the NHHA, the Department should formalize its agreement with the NHHA to ensure that the process remains controlled and reliable. Policies and procedures providing controls over the completion, review, and verification of hospital data should be established. Documentation requirements should be established to ensure that the basis for Medicaid enhancement taxes and DSH payments are adequately supported and provide an available and appropriate audit trail.

Auditee Response: Concur

The Department will set up a formal agreement for a review process with NHHA. This process will document requirements to ensure that the basis for the Medicaid enhancement taxes and DSH payments are adequately supported. Completion date is June 30, 2003.

Observation No. 9: Segregation Of Duties Controls Over Fee Setting Should Be Improved

Observation:

There are segregation of duties weaknesses in the Department's processes for keying fee changes into the Department's claims processing system and over the establishment and keying of fees by the Prior Authorization (PA) Unit.

The Department does not verify that a fee change is keyed correctly into its Advanced Information Management (AIM) Medicaid payment system prior to implementing the fee change. Currently, a control memo is prepared and approved by the Department prior to the implementation of most fee changes. A clerk keys the information from the control memo into the AIM system to implement the fee change. During fiscal year 2002, there was no consistent review process to verify that the fee change was input correctly. While MMIS staff report that print screens evidencing the change were emailed to responsible parties, one Department employee whose responsibilities include requesting fee changes indicated that they have never received a print screen or other documentation from MMIS staff to evidence the accuracy of fee changes.

Three employees in the PA Unit determine and key fees into the AIM system without anyone reviewing and approving the appropriateness of the determination and the accuracy of the input. Certain Medicaid procedure codes require manual pricing whereby the PA Unit staff individually review claims to: 1) determine whether a service should be covered, 2) determine what the Medicaid allowable fee should be, and then 3) key the fee into the AIM system without further review and approval required. The fact that a PA Unit employee can establish a covered service, establish a fee, and implement the fee without any review and approval controls presents a significant segregation of duties risk.

Recommendation:

Segregation of duties controls over changing rates in the Department's claims processing system should be improved so that a single employee is not responsible for establishing a covered service, setting the allowable fee, and also keying the fee into the AIM system.

All changes to fees in the AIM system should be reviewed for accurate input prior to implementation. Keying or other clerical errors should be subject to detection prior to going into production.

Auditee Response: Concur

We concur that the decision as to whether a service should be covered should be segregated from claims payment.

Given the current functionality, the AIM system can only price in accordance with absolute values. Any pricing determination, which requires a calculation, can only be done via human intervention. This is the rationale underlying manual pricing.

To implement segregation of duties would require a business process redesign including mechanisms to conduct a periodic sample audit to verify accuracy of manual pricing activity. This will be accomplished over the next six to nine months.

We concur that all changes to fees made in the AIM system need to be reviewed prior to implementation. A verification process will be developed by Medicaid's Business Operations and the Finance Unit. This will be accomplished over the next six to nine months.

Observation No. 10: Contractors Establishing Medicaid Rates Should Be Monitored To Ensure Accurate Rate Setting

Observation:

The Department performs only limited reviews of Medicaid rates recommended by consultants prior to implementing the rates for certain Medicaid service providers. The Department employs consultants to assist in setting rates for nursing home facilities and to perform cost settlement rate setting for outpatient hospitals, rural health clinics, etc.

The Department's consultant calculates a per-diem Medicaid rate for each of the 78 Medicaid nursing home facilities. The consultant performs these calculations every six months. The Department reports that it recalculates two or three of the consultant-established rates to review for clerical accuracy and to verify that there were no other apparent errors in the consultant's rate setting calculations. However, the Department was not able to document that it had performed these test calculations during fiscal year 2002 or provide other evidence that it actively monitored the rate setting process for the nursing home facilities.

The Department contracts with the regional federal Medicaid fiscal agent to review and audit cost reports from outpatient hospitals, rural health centers, and certain other clinics providing Medicaid services. The cost reports are used to establish Medicaid payment amounts and as a basis for cost settlements. While the Department reports that it reviews the provider cost settlements and monitors recovery of overpayments, it only performs limited review and monitoring of the work performed by the fiscal agent. While the Department may become aware of errors that result in underpayments through providers challenging cost settlements, it is less likely that the Department will become aware of errors in cost settlements that result in the overpayment of providers.

Recommendation:

The Department should increase its review and monitoring of the Medicaid rate setting and settlement functions performed by its consultants. As a primary component of the cost of the State's Medicaid program, rate setting and settlement activities performed on behalf of the Department should be closely monitored to ensure accuracy and compliance with the Department's plan and to ensure that the Department recovers all it is due.

Auditee Response: Concur in part

Nursing Home – The Department concurs in part. The Department does review nursing home rates that are calculated by the contractor to ensure their accuracy. It does this by checking rates for a sample of the nursing homes. In addition, for the February 1, 2003 rate setting, the contractor has begun the process of transferring the rate setting process to the Department. Department staff participated in the reconciliation, modeling and rate setting calculation. Prior to the Department fully taking over this process, the Department and the contractor will do the entire process in parallel. After the Department takes over the process the Department will use the contractor for quality control of the Department's work.

Hospital Outpatient, Rural Health and Community Health Centers – The Department concurs in part. The Department used the services of Public Consulting Group to review the accuracy of the outpatient hospital and Federally Qualified Health Center settlements performed in SFY02. The Department concurs that these rate setting and settlements activities performed by consultants should be closely monitored. The Office of Health Planning and Medicaid does not have staff auditors or consultant dollars available for this function. The Office will work with the Department to establish a workplan to address this need.

Observation No. 11: Monitoring Of Drug Rebates Must Be Improved

Observation:

The Department does not have adequate policies and procedures in place to monitor the collection of rebates on drugs purchased by its Medicaid program. During fiscal year 2002, the Department collected $17.3 million in rebates and reported $13.6 million in rebates receivable at June 30, 2002.

The federal Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established the Medicaid drug rebate program under which states are authorized to collect rebates from drug manufacturers for drug purchases reimbursed under the Medicaid program. In order for a manufacturer’s drugs to be eligible for reimbursement under Medicaid, the manufacturer is required by OBRA 90 to enter into a rebate agreement with the federal Centers for Medicare and Medicaid Services and pay quarterly rebates to the states.

Exhibit A, Section 15 of the Department’s contract with its Pharmacy Benefits Manager (PBM), directs that the PBM will be responsible for the management of the Department’s OBRA 90 drug rebates. A few of the specific responsibilities of the PBM include management of all Medicaid drug rebates and dispute resolution from July 1, 1994 forward, implementation of accounting functions for drug rebates, and implementation of dispute resolution functions.

The PBM manual, New Hampshire Rebate Procedures, Section 1.1 states in part “…at a minimum [the PBM] generates and forwards rebate invoices, conducts dispute resolution and updates and maintains labeler accounts receivable file.” Section 1.7 of the manual details information relating to collection procedures of disputed and past-due amounts. Per the manual,

"…it is appropriate for a Dunning Notice to be sent to the labeler reminding the labeler of its account balance and the need to make immediate payment. In the event the labeler does not respond to the first Dunning Notice, a second Dunning Notice is sent to the labeler advising the labeler of its current balance and further collection efforts to be taken by the state." While the manual details that the PBM system generates a list of labelers at 38, 68, 105, and 210 day overdue intervals, the Department reports that it is able to obtain reports at 45, 90, and 210 day intervals.

Neither the Department nor the PBM has actively monitored collection of rebates or pursued overdue labelers. Reportedly, the Department has never retrieved and utilized the past-due accounts receivable reports available from the PBM. When asked, the Department did not know what the delinquent balances were nor was the Department able to provide an aging of its drug rebates receivable. Neither the Department nor the PBM has ever sent out Dunning Notices referred to in Sections 1.1 and 1.7 of the PBM manual. In fact, it is unclear who is responsible for issuing the Dunning Notices.

Recommendation:

The Department must establish policies and procedures for collecting drug rebates. The scope (and limits) of the PBM's responsibilities for processing drug rebates on behalf of the Department must be established and understood. The Department must establish policies and procedures within its own organization to both monitor the activities of its PBM contractor on its behalf and also to perform appropriate accounting and reporting of current and past-due drug rebates receivable.

Auditee Response: Concur

The Department concurs with these recommendations. The Department worked with First Health [PBM] to develop Dunning Letters and has access to Dunning Reports and Dunning form letters from the First Health System. These letters had not been sent to the pharmaceutical manufacturers. The Department is now in the process of working with First Health to ensure these letters are issued on a consistent basis and will audit that function. Each quarterly invoice sent to pharmaceutical manufacturers does include not only the present quarter's rebate portion but also any past due rebate that is due.

Observation No. 12: Analysis Of Pharmacy Benefits System Denied Claims Should Be Performed

Observation:

The Department has not investigated the reasons for a significant increase in the number of denied claims in its Pharmacy Benefits System (PBS). As each denied claim results in a processing cost to the Department, excess denied claims represent wasted resources.

A review of six PBS remittance advices indicated that denied claims represented 39% of the total claims submitted for adjudication (total of paid and denied). When asked, the Department responded that it has not placed a priority on determining the reason for the apparently high rate of denied claims and had not run an available denied claims report until asked to do so by the auditors. A claims and cost report provided by the Department indicated that for the approximate eight month period during fiscal year 2002 that the PBS was in place, there were 2.1 million pharmacy claims made, of which, 866,000 or 41% were denied claims. A comparable months period in fiscal year 2001, prior to the implementation of the PBS, had a 15% denied claim rate. It is the Department's contention that most of the increases in denied claims are the result of errors by the pharmacies caused by impatience or lack of training on the PBS operations.

The Department is charged $0.306 per claim by the Pharmacy Benefits Manager (PBM) for each denied claim. The total paid by the Department to the PBM related to denied claims during the less than eight-month operating period during fiscal year 2002 was approximately $265,000 or 28% of the total amount paid to the PBM.

Per exhibit B of the contract between the Department and the PBM, multiple submissions of up to four claim lines per transaction shall be counted by claim line rather than by transaction. The Department believes if a claim is submitted and denied multiple times, each denial is treated as a claim line and payment to the PBM would be made. It is unclear whether the contract limits these payments to a maximum of four denials for the same prescription. Per the contract and letter of understanding between the Department and PBM, the PBM would receive $0.306 for each denial, up to four denials per prescription transaction. Denials over four would not be charged to the Department. The Department has not instituted any control procedures to determine if the PBM is in compliance with charges relating to claims in excess of four denials per prescription transaction.

Recommendation:

The Department should perform an analysis of causes of the significant increase in the number of PBS denied claims. If it is determined that the increase in denied claims is due to lack of education and training being provided to the pharmacies, the Department should require the PBM to increase its pharmacy education and training efforts as provided for in the PBM contract.

The Department should design and implement appropriate control procedures to ensure that the PBM is billing the Department in accordance with contract procedures.

Auditee Response: Concur in part

The Department concurs with the first recommendation and agrees to perform an analysis regarding the causes of the increase in the number of PBM denied claims. The Department will formulate an action plan by December 31, 2003, should it determine that based on this analysis, education, training or other interventions would be effective in the reduction of denied claims.

The Department concurs in part with the second recommendation. The Department currently performs a detailed review and reconciliation of the PBM's bi-weekly financial reports and

monthly invoices on a per transaction basis. Invoices are monitored to ensure appropriate billing as outlined in the contract. The Department will, however, review historical invoices quarterly, as they relate specifically to the multiple submission provisions outlined in Exhibit B, Section 1, paragraph 3 of the PBM contract.

Observation No. 13: Mechanism To Monitor Usual And Customary Charges For Pharmaceuticals Should Be In Place

Observation:

The Department does not have a mechanism in place to ensure that it is paying the lowest charge, fee, or rate charged by a provider for pharmaceuticals.

RSA 126-A:3, III provides that "…no provider shall bill or charge the department more than the provider's usual and customary charge, as defined in this paragraph." Subparagraph III(b) continues "…the term "usual and customary" means the lowest charge, fee, or rate charged by a provider for any product or service at the time such product or service was provided." The statute provides certain further explanations and exceptions to the application of paragraph III.

The Department does not have a mechanism to hold providers to billing in accordance with RSA 126-A:3, III. While due to market confidentiality issues the Department may not have ready access to rates charged by providers to other payers, there are steps that the Department could use to ensure that providers are notified of the applicability of the statute and the need for the providers to comply.

Recommendation:

The Department should take reasonable steps to ensure that providers are aware of and comply with the billing requirements of the statute. For example, the Department could require that all invoices require certification of compliance with the statute's billing requirements prior to the Department making payment.

Auditee Response: Concur

The Department concurs. The Department is in the process of conducting an analysis of its pharmacy reimbursement, to include usual and customary pricing. In addition, the Department has also begun preparation for pharmacy auditing which will begin in February 2003, to ensure compliance with program requirements and billing practices. The Department agrees to notify the pharmacies of the requirements under the RSA 126-A:3,III.

Observation No. 14: Controls Over The Operation Of The Pharmacy Benefits System Should Be Improved

Observation:

The Department has not properly monitored the performance and results of its control processes to ensure that the Pharmacy Benefits System (PBS) is operating as intended. During fiscal year 2002, the Department incurred $101.2 million in Medicaid pharmaceutical expenses (gross of rebates).

In November 2001, the Department contracted with a Pharmacy Benefits Manager (PBM) to administer the Department's Medicaid PBS. Prior to that contract, the Medicaid pharmacy claims were processed and paid through the State's Medicaid payment system (AIM) like all other State Medicaid claims. With the contract, certain payment information is loaded from the PBM to the AIM system to update client history. As part of its control procedures over the contract, the Department instituted a reconciliation of the biweekly PBM invoice to supporting Department information.

A review of a judgmentally selected reconciliation (check date of February 2, 2002) indicated that the Department did not accurately or completely perform the reconciliation of the pharmacy provider payments. Key numbers did not reflect the current billing cycle as figures were inappropriately carried forward from the previous cycle. Control totals, which should have reconciled to the invoice amount, did not reconcile and no explanations of the discrepancies were noted. The invoice amount was subsequently reviewed and paid by the Department apparently without question. While the errors noted in the review of the reconciliation did not affect the amount paid, the fact that the errors were not detected by the Department in its reconciliation process indicates that the reconciliation is a less than effective control process.

The Department's reconciliation process did not include a reconciliation of AIM to the PBM invoice for the first six and a half months of the eight months that the PBM contract was in place during fiscal year 2002. The biweekly updates to AIM performed by the PBM were only reconciled for the last one and a half months of fiscal year 2002. The check register provided by the PBM as supporting documentation with the biweekly invoice is not reviewed by the Department to determine whether all payments are made to eligible providers and/or clients.

Because the Department's reconciliation process, including review of supporting reports and information is not performed in a complete and accurate manner, the Department can take only limited assurance from the control procedures that the PBS is operating as intended.

Recommendation:

The Department should improve its control procedures for its PBS.

Reconciliations should be performed in a complete and accurate manner. Supporting reports and information should be reviewed in that reconciliation process. The completed reconciliations should be reviewed and approved by supervisory Department personnel to ensure that any

significant reconciling items that may be noted on the reconciliations do not indicate problems with the operations of the PBS.

Auditee Response: Concur in part

We concur in part. For the month tested, the reconciliation process was not yet in place. The PBM implementation, went live in November 2001. Staff were largely involved with making sure providers could access the network and that aspects of the switch from "pay and chase" to "cost avoidance" were being worked out with providers.

In March of 2002, the Department required First Health to put two operations staff on site to deal with a variety of control related issues, not the least of which was the financial reconciliation.

By May 2002, MMIS Staff, First Health and the Departments Finance Unit, working together were able to retrieve data provided by the First Health Financial System in a format that could be reconciled by the Finance Unit.

The Department now reconciles check write invoices bi-weekly, the monthly invoice, and the system will only process payment for eligible providers.

The Department feels it has satisfied the recommendation of this finding.

Observation No. 15: Data Failing Control Edits Should Be Corrected To Prevent The Need To Force Transactions

Observation:

The Department allows its Pharmacy Benefits Manager (PBM) to override system controls to pay claims that fail edit checks. The PBM does not correct data but does list overridden transactions on a report to the Department.

A review of a member-submitted drug reimbursement claim noted that the Department inaccurately prepared a worksheet regarding a client's request for reimbursement for a prescription. An edit check at the PBM detected the error on the Department prepared worksheet and caused an initial denial of the claim. Upon review by the PBM, the cause of the error was determined, the edit was overridden, and the claim paid. However, the error in the data was not corrected and the error remains in the claims history for the client. The error in the client's claims history will also result in an error in the Department's drug rebate invoicing which could result in disputed and delayed collections of rebate amounts.

The fact that the PBM can override controls without initiating a correction of erroneous data increases the risk that system controls may not provide the level of confidence intended by the Department that improper claims will be detected and rejected. In addition, uncorrected data errors can complicate reconciliation procedures and negatively impact the Department's ability to properly monitor the operation of the pharmacy benefits system.

While the Department reports that since March 2002 it performs a high-level review and correction of edit data reported by the PBM, the Department's review is not sufficiently detailed to detect causes of errors or situations requiring the correction of the data.

Recommendation:

The Department should review its protocol for detecting and correcting errors with its PBM. The Department should increase its monitoring efforts over the PBM supplied error reports. The reports should be reviewed to determine causes of errors and to ensure that error checks are working as intended.

Auditee Response: Concur

The Department concurs with this finding but would like to note that, member based processing accounts for .002% of approximately 5000 claims and if half of these were over ridden then approximately .001% of approximately 2.5 million claims may contain misinformation relative to the NDC codes [National Drug Codes] which does present minor corruption to the database and may cause rebates to be missed or inappropriately claimed.

The override processing mentioned occurred primarily while the State staff was still learning the system and the business requirements of the member claim program. State staff did data entry on the backlog of member claims. NDC codes sometimes where entered when missing and errors did occur. In each case reviewed the amount paid was correct, although the NDC code used to override the edit was in error.

However, if overrides are required to "force the system" then a review of the edit that forced the override will be put on a control memo, and the edit investigated and changed if necessary, under a controlled change process. Any ability to override an edit or audit is detailed by business requirements and is documented. The State program staff directs these requirements.

As to the ability to correct erroneous data, the data should not be changed in the system but an adjustment claim associated with the original claim should be able to be entered. The Department will discuss this with First Health to see if this functionality currently exists. If not the contract language will be revised to add this functionality.

As to increased monitoring of the error reports, this will become much simpler as the incidence of errors/overrides diminishes and offsetting transactions define the fix.

Completion date is June 30, 2003.

Observation No. 16: Effective Change Control Process Should Be Established For The Pharmacy Benefits System

Observation:

The Department has not established an effective change control process over its Pharmacy Benefits System (PBS) to detect and reduce the risk caused by security features being inadvertently or deliberately omitted or "turned off" thus allowing processing irregularities or the introduction of malicious code.

The Department has contracted with a Pharmacy Benefits Manager (PBM) to provide, operate, and manage a PBS on behalf of the Department. The PBM provides the Department and other customers with a standard PBS which can be amended based on individual customers needs pursuant to the contracts between the PBM and the Department or other customer. According to the Department, the contract does not detail control procedures for system programming changes and the Department has not established a comprehensive understanding with the PBM on how to ensure the Department and provider have an effective change control process over the PBS. While the Department reports that it has initiated certain control procedures with the PBM, including control memos to initiate and approve programming changes to the PBS, the Department reported that there have been instances where the PBM has instituted changes to the PBS without notifying the Department prior to the change. While reportedly most of the unauthorized changes were for issues affecting the standard programming of the PBS, effecting all customers of the PBM's service, some of these unauthorized changes would be considered as having significant control concerns to the Department, for example losing password authorization.

The lack of an effective change control process over the PBS presents a significant risk to the Department that changes it has not approved may be enacted without its knowledge. The fact that the Department has chosen to contract with a PBM to provide and operate a PBS for the Medicaid program does not relieve management of its duty for effective oversight of the system. During fiscal year 2002, approximately $60.1 million of payments were processed on behalf of the Department by the PBM.

Recommendation:

The Department should establish an effective change control process for its PBS. Policies, procedures, and techniques should be implemented to ensure that all programs and program modifications are properly authorized, tested, and approved and that access to and distribution of programs is carefully controlled. Because the Department is relying on a PBM for many of these functions, the Department will need to ensure that it has an effective system to review and approve the actions of its PBM that affects the integrity of the processing done on behalf of the Department.

Auditee Response: Concur in part

The Department concurs in part. DHHS implemented change control procedures for the PBM system shortly after its initial deployment in November 2001. DHHS informed the PBM vendor "First Health Services" of a preferred change control process that the State requested to be followed. The PBM vendor was informed that "NO" system changes were to be implemented without express consent from the State project manager responsible for PBM. All change requests to the system are logged and properly prioritized via a "control memo" process that is currently used to monitor all system requests. All State requested modifications are entered by a State resource into this system and any technical changes required by "First Health Services" are also entered into this system and prioritized and tested accordingly prior to being deployed to the Production environment. The PBM vendor is responsible for requesting permission to implement any system change at least 1 week in advance via this process unless the technical change is deemed an emergency situation. In an emergency situation the vendor is still required to contact the State project management responsible for the PBM system in order to explain the detail of the emergency situation. DHHS also requires the vendor to provide fully documented "Flash Reports" that explain the cause of any technical or systems related problems encountered in production in order to properly plan for similar situations in the future.

However, DHHS acknowledges that system updates have been implemented into New Hampshire's PBM production environment by the vendor without express permission from the State project manager responsible for PBM. The vendor's technical solution supports multiple States and on occasion technical requests that were implemented for other States have impacted the New Hampshire production environment. In order to try to prevent this in the future New Hampshire now requires that the PBM vendor inform us of any instance where another State is being brought up in their technical environment and also to inform us of any modifications that may be implemented for other States that may impact our environment. The State will continue to aggressively monitor its existing change control process and will take necessary actions to deter the vendor from implementing any systems changes into New Hampshire's production environment unless appropriately directed.

Observation No. 17: Payments For Prescription Drugs Should Be Monitored

Observation:

The Department is not able to monitor whether payments made on its behalf by its Pharmacy Benefits Manager (PBM) are cashed and determine whether the PBM payment process is efficient and on terms beneficial to the Department.

The Department's PBM is responsible, based on a revision of the PBM contract, to disburse payments to pharmacies and Medicaid clients to pay for covered Medicaid pharmacy benefits. The PBM processes invoices from participating pharmacies and requests for reimbursement from Medicaid clients and notifies the Department of the amount owed. The Department wires the total amount owed to a PBM bank account and the PBM makes the payments. Any payment amounts that are not claimed (checks cashed) by providers and Medicaid clients remain in the

PBM account. Reportedly, the Department has made repeated requests to the PBM to provide information on payments made that remain unclaimed but the contractor has not provided this information. Amounts remaining unclaimed in the account could signify problems in the payment processes that could require Department attention and also represent poor cash flow management. Moreover, unclaimed balances potentially accumulate interest which, if unclaimed by the Department, would accrue to the benefit of the PBM.

During the fiscal year ended June 30, 2002, the Department forwarded $60.1 to the PBM account for payment of Medicaid prescription benefit claims.

Recommendation:

The Department should require the PBM to provide additional information on its payment of pharmacy benefit claims, including information on the actual clearing of payments from the PBM account. The Department should consider funding the PBM accounts based on the clearance pattern of the payments to provide that only the funds necessary to pay claims on the account are in the account at any time. Payments made by the PBM contractor on behalf of the Department that are not claimed should be reported to the Department to ensure that appropriate action is taken for prompt and accurate payments and that any interest that can accrue on the balances in the account is properly credited to the Department.

Auditee Response: Concur

The Department concurs with this finding. Although the recommendation is a good first step, which the Department will undertake, the Department will also require First Health to move all unclaimed checks to a separate account and report to the Department from that account. Further, once a check has been unclaimed for 90 days, those funds should be returned to the Department and placed in the Provider Payments account. Should the provider make a subsequent claim for the funds, a check will be reissued on the next available check run.

Federal Compliance Comments

Observation No. 18: Medicaid Allowability Of Services Provided By Expanded Case Management Should Be Documented

Observation:

Expenditures reported by the Department for the purpose of expanded case management at the State's ten community mental health centers (CMHCs) are not sufficiently documented or explained to demonstrate that the costs are for allowable services in necessary and reasonable amounts. Accordingly, the amount reported as the federal portion of the expanded case management expenditures is being questioned.

- According to the Department, the expanded case management costs relate to uncompensated care provided by the CMHCs. However, the services provided to support the expanded case management payment amounts are not adequately documented and the basis for and the method used by the Department to calculate and report the services provided by the payments are not reasonably explained. The Department considers the State General Fund grants made to the CMHCs to be entirely eligible for federal Medicaid program participation. For each of the ten CMHCs, the Department divides the amount of the center's General Fund grant by the number of case management units billed by the center to arrive at a "case management increase per unit" to be used for payment and reporting purposes. While the reporting by the Department ties the payments to the covered Medicaid clients through the use of this case management increase per unit calculation, there is no documentation to support that the entire amount of the General Fund grant is used for Medicaid eligible purposes. To the contrary, some of the General Fund grant money apparently pays for ineligible Medicaid services such as peer support programs, raising questions as to whether the federal Medicaid participation in these payments is appropriate.

- During fiscal year 2002 the Department reported that it paid the State's CMHCs $12.6 million for expanded case management under the Medicaid program. Half of this amount, or $6.3 million, was drawn as the federal share of the expenditures and deposited as unrestricted revenue in the State's General Fund. The actual mechanism used by the Department to process the transactions made in September 2001 and May 2002 included a payment to each of the CMHCs, which also initiated a draw of the matching federal funds. Nearly simultaneously, each CMHC repaid the original payment amount to the Department. The CMHCs did not retain any of the Department's payments nor did they receive any of the federal draw. This method used by the Department to record the repayments by the CMHCs reversed out the original Department payment as if it had never occurred. The reversals of the fiscal year 2002 transactions led to financial reporting errors on the Department's year end federal reporting and also required the preparation of adjusting journal entries for the State's annual report.

Questioned Cost: $6,301,241

Recommendation:

The services provided by the Department's expanded case management payments should be documented including evidence that the services are reasonable, allowable, and necessary. If the costs of these services are to be considered for federal Medicaid participation, the documentation must also evidence that the costs are reasonable, allowable, and necessary in accordance with federal Medicaid rules and regulations. The Department should define what is covered by the expanded case management payments and establish with the Centers for Medicare and Medicaid Services (CMS) that the payments are within federal Medicaid guidelines.

If it is established between the Department and the CMS that the payments are in compliance with the federal Medicaid program, the Department should establish a better method for drawing the federal participation amount. Transactions should not be made and then backed out of the accounting records to cause a draw of federal revenue yet leave no net effect on the State's accounts.

Auditee Response: Concur in part

The Department agrees that the mechanism used to transact the payments could be improved by establishing a separate account with a federal and general fund appropriation sufficient to make the payment. This would eliminate the need to utilize non-matching general funds paid to the CMHC's in the calculation and would establish clearly that non-matched general funds are available to establish the enhanced rate in accordance with federal authority. While currently the recording of the expense transactions are not apparent, the revenue deposited in the State's unrestricted revenue account is clear.

The State's General Fund grants made to the CMHCs are unmatched general funds. Because these funds are used for purposes other than Medicaid match, they are available to provide a rate adjustment for Medicaid case management services. This rate provides for additional payments to the State for specific Medicaid clients receiving case management services. If other non-matched general funds were available, these could be used to provide for this rate adjustment. In other words, the fact that these funds are not already used as match, allows them to be available for the rate adjustment calculation.

The Department is confident the costs are allowable. The documentation that provides a description of case management services is consistent with other services descriptions in the State Medicaid Plan. The federal reviewers have been satisfied with the current documentation. The Department will continue to work with CMS to make sure documentation is fully maintained.

Observation No. 19: Provider Licenses And Enrollment Agreements Should Be Kept Current

Observation:

The Department does not require up-to-date copies of documentation establishing provider eligibility, including copies of current licenses and enrollment agreements, to be on file prior to paying providers for services rendered to Medicaid clients.

The files for 33 out of 110 billing providers reviewed (30%) did not contain a current license or a valid enrollment package. Out of the 33 files noted above, 26 (79%) had out-of-date licenses and four (12%) did not contain a valid enrollment application or provider agreement. Three out of the 33 files noted (9%) did not have any license and the Department could not provide documented criteria as to why these three providers did not need to be licensed to provide Medicaid services. One (3%) file could not be located and as a result the enrollment status of this provider could not be established. Accordingly, the federal portion of the payments to this provider is being questioned.

Per Title 42 Code of Federal Regulations Parts 431.107 and 447.10, providers of medical services must be licensed in accordance with federal, state, and local laws and regulations to participate in the Medicaid program. Additionally, per Title 42 Code of Federal Regulations Part 455 subpart B, the providers are required to make certain disclosures. The disclosures are generally made in the provider enrollment application and agreement.

According to the Department, it has limited ability to force providers to submit timely updates of licensing or enrollment documentation and the filings of updated licenses are sometimes delayed by overburdened licensing organizations. As the Department considers having the largest number of providers to be in the best interest of the Medicaid clients, the Department is hesitant to disbar providers that are not current in filing required enrollment documentation.

Questioned Cost: $700,000

Recommendation:

The Department should improve its file maintenance procedures to ensure that provider enrollment files remain a useful resource for determining provider eligibility for supplying covered services to Medicaid clients. Documentation of required provider disclosures should be maintained in the files either on the provider enrollment applications and agreements or through other suitable documents.

The Department should work with the medical provider licensing organizations to determine whether there is a more efficient method of obtaining timely updates of provider licenses.

The Department should document its criteria for determining which if any providers are exempt from licensing and provider agreement requirements. The provider file for each exempted

provider should cite the criteria that the Department used to establish the provider's exemption from licensing and/or other provider agreement requirements.

Auditee Response: Concur in part

The Department concurs in part. The Department does require documentation establishing provider eligibility, licenses and enrollment agreements for new providers. The Department has been reluctant to close providers if their paperwork is not received since we have a fairly fragile Medicaid Provider Network, given our level of claim reimbursement.

The Department will redefine the process for maintaining current licenses. As a first step, we will create a provider database that contains sufficient information to establish an electronic "tickler system" This will require that as the database is loaded, every effort is made to define those providers without the required paperwork. It will also contain data on why a provider is exempt from licensing

This system will then produce a monthly list of those providers that require re-enrollment. They will be processed six months in advance of their end date. This will provide an electronic control of who needs to be re-enrolled.

The second issue is the time consuming nature of getting the providers to process their paperwork to the Department in a timely fashion. The Department will work through the licensing organizations to establish a more global solution.

Completion date is December 31, 2003.

Observation No. 20: Client Eligibility Files Should More Accurately And Completely Document Client Status

Observation:

Approximately seven percent of the client eligibility files selected for testing were missing, incomplete, or otherwise noncompliant with the Department's program guidelines. As the paper eligibility files provide the primary documentation of client resources including income, assets, insurance, etc., if the initial or redetermination of client eligibility status is made on incomplete information, it is possible that client eligibility determinations may be made in error.

The State Plan and the Department's internal policy manuals require clients to disclose demographic, resource, income, other insurance coverage, medical necessity and other information in order to become and remain eligible for coverage under the Medicaid program operated by the Department. Information provided by clients is verified and documented by a caseworker.

The Department maintains a paper file for each Medicaid client to document the client's eligibility for the program. The file is established upon the client first seeking participation in the

Medicaid or other State assistance program administered by the Department and is updated at regular intervals with redeterminations of continued or changed eligibility status. Information necessary to establish initial and continued client eligibility is documented in the file including client family census, resources, insurance coverage, etc. The files are established and eligibility determinations are initially made by caseworkers in the Department's district offices. Information from the files is keyed into the Department's New Heights computer system, which is used by the many sections of the Department to access client eligibility information and to provide client eligibility information to the Department's claims payment system.

Audit tests included a review of a sample of 150 client eligibility files. In 11 of the files selected for review (7%) we noted instances where the Department failed to comply with its Medicaid program requirements.

- Three files selected for review (2%) could not be located by the Department.

- Four of the files reviewed (3%) did not contain documentation to support a determination of whether the clients met the Medicaid program resource and income limit criteria as the clients' original/redetermination applications were missing resource and/or income information. Additional documentation for one was subsequently obtained that established client eligibility. The Department was not able to obtain additional documentation to support the eligibility of the other three cases.

- Three of the files reviewed (2%) lacked documentation to support whether the Department had performed adequate reviews of the resource and income claims by the client. In two of the files the clients' claims were not verified timely and in the other file the client's income was not verified when the redetermination was done. Based on the Department's subsequent verification efforts it appears these clients may not meet eligibility criteria.

- Four of the files reviewed (3%) did not contain evidence that the signor of the determination/redetermination application was an authorized representative of the client.

- One file reviewed (<1%) did not contain a redetermination application for the tested date of service. A review of a subsequent redetermination application dated close to the dates of service indicates that the client was over the income limit and therefore was changed to a different eligibility program.

Questioned Cost: $36,636

Recommendation:

The Department should improve its file maintenance procedures to ensure that client eligibility files remain a useful resource for determining client eligibility for coverage under the Medicaid program.

The Department should maintain sufficient documentation to support its Medicaid eligibility determination.

The Department should ensure that applicants adhere to current application requirements in order to become eligible for participation in the Medicaid program. Caseworkers should follow and comply with Department policies and procedures requiring the review and verification of critical client supplied information.

Auditee Response: Concur

The agency has in place a number of ongoing practices to determine if policy and procedures are being followed and to measure staff performance. The agency will discuss the observations at the February 18, 2003 Joint Administrative and Line Supervisors Meeting, and supervisors will be instructed to review and reinforce them with their eligibility and support staff.

Supervisors will be instructed to remind staff of and continue to enforce current policy and procedures by taking the following actions:

- review with support staff the current procedures for purging data over 3 years old from case files to ensure that material and documents are not inadvertently destroyed;
- hold workers responsible for all records in their caseload, and reinforce placing an "out" card to denote who has a case file if it is removed from another worker's area;
- continue to conduct reviews of Medicaid cases as part of ongoing performance and annual evaluation of staff, in order to identify and address deficiencies, conduct individual training sessions or require attendance at formal refresher trainings. During federal fiscal year 2002, 7,471 Medicaid cases were reviewed. Supervisory reviews will continue to focus on accurate eligibility decisions, complete case documentation of all factors, especially income and resources, organized case files, and complete forms, especially mail-in redeterminations. With current caseloads at 383 per worker, or 497 per fulltime equivalent (which takes into account the worker's experience level), and a worker to supervisory ratio of 7:1, it is not possible to review every case action.

The agency is revamping its existing New Hire Training, with roll-out March of 2003, and also has been conducting a series of Professional Skills Trainings, both for over 15 years. The following have been and will continue to be addressed:

- how to maintain an organized work area,
- how to organize and maintain an orderly and complete case record,
- the reason for and importance of verification in the eligibility process, and
- how to review submitted documents in order to clarify any conflicting or missing information.

The agency will review its current policy regarding authorized representatives to determine if more latitude is needed in certain circumstances, especially for nursing facility cases. Some clients may be physically or mentally unable to give another power of attorney or name an authorized representative by signing Form 778. Court action to appoint a guardian or conservator may not be feasible. Others, "acting on behalf of the applicant" step forward to make application for Medicaid or complete a redetermination form, such as a family member or social worker from the facility. The agency will determine if a modification to rules or clarification of current policy is warranted to address these situations.

While the Department recognizes the importance of accuracy and will continue with its ongoing efforts to measure performance and take corrective actions as needed, it should be noted that federal QC results of Medicaid reviews for FFY'02 resulted in a reportable 0.3016% error rate with the national tolerance at 3.00%. NH has been below tolerance for over the last 21 years.

Observation No. 21: Controls Over Third Party Liability Should Be Improved

Observation:

The Department's process for ensuring that Medicaid pays a claim only after all other liable parties have previously paid is inefficient and lacks certain controls.

Title 42 Code of Federal Regulations Part 433.138 requires state Medicaid agencies to take reasonable measures to determine the legal liability of third parties who are liable to pay for services furnished to Medicaid recipients under the states' plans. Generally, this is accomplished by the agencies obtaining health insurance information from each applicant during the initial application and at each redetermination process and using that third party liability information to ensure that the state's Medicaid program is the payer of last resort and pays on claims only after all other payers have made payments. A state Medicaid agency must reject a claim and return it to the provider for determination of the amount of liability, if the agency has established the probable existence of third party liability at the time the claim is filed.

The Department has established a Third Party Liability (TPL) Unit, which is responsible for collecting, verifying, and maintaining third party liability information. The TPL Unit personnel rely upon client insurance information input into the Department's eligibility system by Department caseworkers for initial, and subsequent changes to, client insurance coverage. The TPL Unit manually compiles a database and weekly report of changes to client insurance coverage reported by the eligibility system. Information in the database and report are verified with insurance carriers and then input into the Department's Advanced Information Management (AIM) system, a component of the Medicaid Management Information System (MMIS).

During a review of client eligibility files, it was noted that according to the Department's computerized eligibility system a recipient had third party liability insurance coverage yet the insurance company was not billed prior to Medicaid making payment on a covered service. When the case was brought to the attention of the Department, it was determined that the TPL Unit had overlooked the client's insurance status and a safety net in the MMIS also did not detect the insurance coverage. Further review indicated that during the period of coverage for this client, Medicaid paid on six claims that incorrectly had not been previously billed to the client's insurance carrier. In addition, the Department determined that the MMIS Third Party Liability Suspect Report that forms the TPL safety net contains a programming error causing the report to overlook clients who have coverage from more than one listed insurance policy.

The Department could not determine how significant the programming error is and how much it paid for Medicaid services that should have been paid for by third parties. The Department did note that the error in all likelihood has been present in the TPL Suspect Report since 1994.

Questioned Cost: Undetermined

Recommendation:

The Department should improve its TPL policies and procedures. The manual processes performed by the Unit should be reviewed to determine whether the processes could be automated to reduce the potential for overlooked or other erroneous data. The Department should revise the programming for the TPL Suspect Report to ensure that the report provides the safety net intended. The Department should continue its review of the past errors to determine whether it has the ability to recover any Medicaid funds that were paid in error.

Auditee Response: Concur

The Department concurs with the recommendations.

The Department concurs that continuous process improvement of its TPL policies and procedures is important and will continue this work.

The TPL unit has only one major process with a manual component, which is the validation of TPL coverage. The Department has investigated automated systems and has not found an automated process that functions more efficiently or effectively than the manual process currently in place. The Department will continue to evaluate opportunities to automate this manual process.

The Department concurs with the recommended revision to the TPL Suspect Report. The system change has been programmed and is presently being tested. The Department will work to identify and recover any Medicaid funds paid in error due to the incorrect program logic in the TPL Suspect Report.

Observation No. 22: New Hampshire Hospital Disproportionate Share Calculations Should Be Better Controlled

Observation:

A number of errors were noted in the Department's calculation of New Hampshire Hospital's (NHH) Disproportionate Share (DSH) expenditures. The expenditures are used by the Department to support funds drawn as federal participation in the NHH DSH payments.

Errors noted in the Department's calculations included:

- dates of service to patients outside of the allowable period;
- patients improperly included twice;
- physician costs improperly included twice in the calculation;
- calculation errors involving dates; and
- inconsistent data input, for example inconsistent determination of the last date of service.

Based on discussions with Department personnel involved in the data collection and calculation process, the errors appear to be due to a number of reasons including lack of training for Department personnel responsible for input of data into spreadsheets and other clerical-type errors that went unnoticed. In addition, the fact that the calculation requires the use of more than five different spreadsheets substantially increases the potential for erroneous interpretation and posting of data.

The lack of an effective review and approval function over this calculation significantly increases the risk that errors that may occur could go undetected, as happened with the fiscal year 2002 calculation. While some of the errors noted above were either of inconsequential dollar effect or offset each other, the double counting of physician costs resulted in a $131,833 overpayment of NHH DSH and an overdraw of $65,917 federal participation in that overpayment. The federal portion of the overpayment is therefore a questioned cost.

Questioned Cost: $65,917

Recommendation:

The Department should improve its controls over its determination of NHH DSH expenditures. The Department should review its fiscal year calculations of NHH DSH amounts to determine the cause of the number of previously undetected errors in the calculations. Controls should be established that reduce to a reasonable level the risk that similar errors in the calculations could be made that would not be detected in the normal course of business. There should be an appropriate segregation of responsibility in the calculation process to ensure that calculations are properly reviewed and approved. The data collection and calculation process should be adequately documented to ensure that employees who perform the functions have access to proper data definitions, policies and procedures, etc. to ensure that they gather correct information and make accurate calculations.

Auditee Response: Concur

The Department concurs with the observation and recommendations. The Director will assign auditors from the Division of Behavioral Health (DBH) staff to review the New Hampshire Hospital (NHH) Disproportionate Share calculations to determine the source of errors.

By September 1, 2003, the staff person who has calculated the NHH Disproportionate Share payment in the past will create a Policy and Procedure Manual documenting the data collection and calculation process.

Before the NHH Disproportionate Share calculation for FY-03 is made in December 2003, the Director will segregate the responsibility for the calculation process. In the past, one staff person bore most of the responsibility. NHH patient day information and cost data from the NHH Medicare Cost Report constitute the key inputs in the NHH Disproportionate Share calculation. Beginning with the FY-03 NHH Disproportionate Share calculation, these key inputs will be provided by different entities. Patient day data will be calculated, reviewed, and presented in final form by the DBH Billing Office. The Medicare Cost Report will be completed by NHH

staff. The staff person assigned to do the NHH Disproportionate Share calculation will have his work reviewed by the audit staff and the Financial Manager prior to final submittal.

Observation No. 23: Federally Required Quality Control Reporting Should Be Submitted

Observation:

The Department appears to be out of compliance with certain federal regulations requiring reporting of quality control activities.

The Department operates a Medicaid Eligibility Quality Control Unit (MEQC) in accordance with requirements specified by the federal Centers for Medicare and Medicaid Services (CMS). The reporting requirements are in federal regulations including Title 42 Code of Federal Regulations (CFR) sections 431.800 through 431.865. The MEQC program is intended to reduce erroneous expenditures by monitoring eligibility determinations and claims processing.

- 42 CFR 431.814 (h) requires submission of a monthly list of cases selected to be reviewed in the sample. The report is to be submitted prior to the review of the cases. According to a federal CMS auditor, the Department submits a monthly list but there was no documentation at the Department to indicate that lists were submitted. According to the Department's MEQC, it was their understanding that the lists were no longer required by the CMS.

- 42 CFR 431.816 requires monthly progress reports on negative case reviews completed during the month. The MEQC was unclear whether it was required to or had submitted the reports.

While the Department reported that it had not received comments from the CMS regarding reporting deficiencies, it is not clear that the Department is meeting the MEQC reporting requirements.

Recommendation:

The Department should review with the CMS what reports are required to be submitted by the Department's MEQC Unit. The MEQC Unit should submit required reports on schedule and retain evidence of having submitted the reports. If CFR's related to the MEQC are no longer required, the Department should maintain documentation that supports the reporting changes authorized by CMS.

Auditee Response: Concur

We concur with the findings. The Department is now forwarding the monthly list of selected cases with a cover letter and will maintain these letters on file for documentation.

In regard to the second finding, the regulatory citation is obsolete but has not been removed. CMS has not required these monthly review disposition lists for approximately 10 or more years.

The Department has requested that CMS provide documentation of that instruction and will maintain the documentation on file in the future.

Observation No. 24: The Organizational Independence Of The Surveillance Utilization Review Unit Should Be Increased

Observation:

The activities of the Medicaid Surveillance Utilization Review (SURS) Unit are under the control of the director responsible for the Medicaid program, which provides for less than optimal operational independence for the SURS Unit.

The Department's SURS Unit reports to the administrator of legal services and policy who reports to the division director responsible for the operations of the State's Medicaid operations. Because the activities of the SURS Unit are under the control of the director responsible for the Medicaid program, overarching policy decisions, for example the Department's policy of maintaining and expanding the enrolled provider base, may inappropriately influence operations of the SURS Unit.

To be most effective, the personnel responsible for performing utilization reviews and identifying suspected fraud should be organized sufficiently outside the control of other Medicaid operations so they may objectively perform their functions.

Recommendation:

The Department should consider changing its current organizational structure to provide additional operational independence for the SURS unit. To be most effective in their functions, the SURS Unit should report to Department management who are not primarily responsible for, if not outside the influence of, the Medicaid program.

Auditee Response: Do Not Concur

The Department does not concur with the recommendation to change the organizational structure of the SURS Unit to a section of the Department independent of Medicaid.

Federal law requires that the Medicaid agency must have "control of the utilization of all Medicaid services."(42 CFR Part 455.13, 42 CFR Part 456.1 and 456.3). To undertake this function "The Medicaid agency must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments." This function specifically requires the Medicaid agency be responsible for the SURS function. There is no legal conflict of interest for the Medicaid agency to be responsible for utilization control and management. In fact, the federal government recognizes the inherent expertise and ability of the Medicaid program to be able to monitor and correct any inappropriate use of Medicaid services. To meet federal law, the SURS function must be part of

the Medicaid agency, and belong within the organizational structure that is responsible for the control of the utilization of all services, and that is the Medicaid agency.

There are two additional safeguards: 1) The Administrator, of the SURS, Policy and Legal Units is a lawyer that dually reports to the Department's Chief Legal Counsel who oversees the legal functions throughout the Department and 2) the Office of Health Planning and Medicaid does not have responsibility for all Medicaid operations, i.e. Behavioral Health, Elderly and Adult Services and Developmental Services.

State Compliance Comments

Observation No. 25: Expired Administrative Rules Should Be Revised And Readopted As Appropriate

Observation:

A number of administrative rules related to licensing health care facilities and home health care providers have expired and have not been readopted by the Department.

RSA 151:9 and 9-a require the commissioner of the Department to adopt administrative rules, pursuant to RSA 541-A, relative to standards for licensing and classifying residential care and health facilities including home health care providers. As noted below, a number of rules subject to RSA 151:9 and 9-a have expired and have not been readopted.

RSA	RULE	DESCRIPTION	Expired
151:9	He-P 801	General Requirements for all Facilities	12-8-00
	He-P 802	Regulations for General Hospitals	6-22-00
	He-P 803	Nursing Home Regulations	10-21-99
	He-P 804	Residential Care Homes	3-26-99
	He-P 805	Supported Residential Care Facilities	3-26-99
	He-P 806	Out Patient Clinics, Walk-in Centers, Drop-in Centers, Emergency Care Centers, Rehabilitation Clinics, and Community Health Clinics	Portions expired 3-26-99
	He-P 807	Residential Treatment and Rehabilitation Facility	12-2-99
	He-P 808	Laboratories and Laboratory Services	12-20-99
151:9-a	He-P 809	Home Health Care Providers	9-23-99
	He-P 810	Birthing Centers	9-23-99
	He-P 811	Dialysis Centers	3-24-99
	He-P 812	Ambulatory Surgical Centers	Portions expired 3-26-99
	He-P 814	Community Residences at the Residential Care Home and Supported Residential Facility Level of Care	11-25-98
	He-P 816	Educational Health Centers	Portions expired 10-21-99
	He-P 817	Collection Stations	1-24-00
	He-P 818	Adult Day Care Providers Regulations	3-26-99
	He-P 819	Case Management Services	9-23-99
	He-P 821	Equipment Management Organization Provider Regulations	10-21-99
	He-P 822	Homemaker Provider	9-23-99
	He-P 823	Hospice Care Provider Rules	10-21-99

	He-P 824	Hospice House at the Supported Residential Level of Care	10-21-99
	He-P 825	Regulations for Special Hospitals- Substance Abuse	6-22-00
	He-P 826	Regulations for Special Hospitals- Psychiatric	6-22-00
	He-P 827	Regulations for Special Hospitals- Rehabilitation	6-22-00
	He-P 828	Regulations for Freestanding Hospital Emergency Facilities	6-22-00
	He-P 829	Regulations for Health Promotion, Disease Prevention, and Screening Clinics	9-22-00

The Department is operating under the expired rules pending adoption of revised rules.

In addition, N.H. Admin. Rule He-W 571.06 related to prior authorizations should be amended as the rule is not in concurrence with current requirements stated in the Medicaid State Plan. According to N.H. Admin. Rule He-W 571.06, a prior authorization is required for rentals of durable medical equipment. However, the Medicaid State Plan and a provider bulletin dated August 27, 1998 indicate that prior authorizations for rental of oxygen systems is no longer required.

Recommendation:

The Department should continue to work to have rules adopted, pursuant to RSA 541-A, that address the requirements in RSA 151:9 and 9-a.

Auditee Response: Concur in part

We concur in part. We concur with the finding that the administrative rules subject to RSA 151:9 and 9-a have expired and have not been readopted. The Department is working toward adopting the expired rules and plans to adopt the rules as recommended. It is difficult to predict the date of implementation for the reasons stated below.

By way of background, DHHS initiated a significant rewrite of He-P 801, All Facility Rules. The reason for doing so was that health care providers subject to RSA 151, who offered more than one type of service and thereby required multiple licenses, were faced with conflicting requirements of the facility specific rules (He-P 802-830). The multiple licensing requirements also affected the Department in that Health Facilities Administration (HFA) had 29 different types of applications to process. Therefore, the intent of revised He-P 801 was to combine all common licensing requirements into one rule (He-P 801).

Development of the revised He-P 801 rules began in 1998 (prior to the rules expiring). Throughout the process, HFA has made every effort to fully involve the effected providers in an attempt to have a consensus on the finalized product. This also substantially extended the drafting time. He-P 801 was filed in July 2000 and heard before the Joint Legislative Committee on Administrative Rules (JLCAR) at its February 16, 2001 meeting. At the meeting, JLCAR

voted to enter a preliminary objection to the rule. The objection was based on staff annotations and public comments. In a letter dated April 2, 2001, the Department responded to JLCAR's preliminary objection. However, upon hearing testimony from the public, the Committee voted to enter a final objection to the proposed rule. Subsequently, JLCAR also voted to support the sponsorship of a joint resolution based upon the concerns of the final objection and indicated that the substance of the resolution should require the Department to differentiate between large and small residential care facilities in its regulation of them.

In August of 2002, and after many meetings with the representatives of the regulated community, a revised He-P 801 was submitted as a new rule promulgation. The proposal was heard before JLCAR on January 27, 2003. Based on Committee staff annotations and public comment, JLCAR voted to enter a preliminary objection to the proposal. Staff annotations consisted of only two minor issues, which the Department has resolved. Despite removal of the basis for preliminary objection, various types of providers testified that they should be exempt from He-P 801. Given this testimony, the fate of He-P 801 is uncertain. If He-P 801 is adopted, the Department is ready to file He-P 803, He-P 808, He-P 810, He-P 812 and He-P 816. In addition, a significant amount of work has been completed on He-P 807, He-P 809, He-P 811 and He-P 817.

With regard to the finding relative to He-W 571.06, the Department agrees that the rule should be amended and plans to amend the affected section of the rule when the rule is readopted prior to its expiration in December 2003. However, we do not agree completely with the finding and thus, concur in part.

The rule indicates that prior authorization is required for rental of durable medical equipment. The State Plan was amended to eliminate the prior authorization requirement for rental of oxygen systems. An oxygen system is made up of both equipment and supplies. Therefore, the rule does not match the state plan only for the portion of the system that is considered to be equipment (e.g., the tank and the regulator). The supply portion of the system (e.g., the contents of the tank, the mask, the hose/cannula) is provided in compliance with the rules, which do not require prior authorization for medical supplies.

Although rental of oxygen systems do not require prior authorization, rental of other oxygen equipment (e.g., oximeters, apnea monitors, CPAP machines) still requires prior authorization; this concurs with the current rule.

Observation No. 26: Authority For Incentive Fees Should Be Established

Observation:

The Department pays incentive fees to providers of some pharmaceuticals however the authority for these payments is unclear.

The Department has implemented payment of two types of incentive fees payable to pharmaceutical providers: 1) a unit dose incentive fee, and 2) an incentive fee for the drug

Clozaril (Clozapine). The incentive fees paid are $0.80 and $2.77, respectively, and reportedly are intended to support additional work performed in dispensing drugs in unit-dose packaging and monitoring the patients' use of Clozaril (Clozapine). The Department was unable to provide documentation to establish the authority for the payment of these fees.

RSA 126-A:3, V, states in part "[t]he commissioner may waive the application of RSA 126-A:3, III if the commissioner determines such action is necessary to ensure the availability of prescription and other pharmaceutical services to persons served by the Department or to avert serious economic hardship in the provision of prescriptions and other pharmaceutical services. The commissioner **shall** [emphasis added] adopt rules under RSA 541-A relative to a waiver of the application." RSA 126-A:3, III establishes the prohibition against billing at more than the usual and customary charge as defined in that paragraph.

It does not appear that the commissioner has adopted rules under RSA 541-A relative to a waiver of the application of RSA 126-A:3, III. The Department's payment of the incentive fees appears to be a result of a verbal agreement to the fees. Without a written waiver it cannot be established that the commissioner formally granted a waiver from RSA 126-A:3, III.

Recommendation:

The Department should determine whether the Department's current practice of paying an incentive fee for unit-dose packaging and for the drug Clozaril (Clozapine) is appropriate. If payment of the incentive fees is determined to be appropriate, the Department should evidence that determination through a written waiver as provided for in RSA 126-A:3, V.

Auditee Response: Concur in part

The Department has determined that the payment of the unit dose credit is appropriate as evidenced by administrative rule (He-W 570.14(b)).

We concur that the Department should request a formal waiver to the usual and customary reimbursement to demonstrate that this incentive fee was designed to maintain appropriate medication access for institutionalized recipients. A written waiver will be prepared by June 30, 2003.

Auditor's Report On Management Issues

To The Fiscal Committee Of The General Court:

We have audited the accompanying Statement of Revenues and Expenditures of the Medicaid Program, a federal/State program primarily administered by The State of New Hampshire Department of Health and Human Services, for the year ended June 30, 2002 and have issued our report thereon dated February 19, 2003, which was qualified with respect to the lack of presentation of the financial position of the Medicaid program in the General Fund.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statement is free of material misstatement.

In planning and performing our audit of the financial statement of the Medicaid program for the year ended June 30, 2002, we noted an issue related to the operation of the program that merits management consideration but does not meet the definition of a reportable condition as defined by the American Institute of Certified Public Accountants, and was not an issue of noncompliance with laws, rules, regulations, or contracts.

The issue that we believe is worthy of management consideration but does not meet the criteria of a reportable condition or noncompliance is included in Observation No. 27 of this report.

This auditor's report on management issues is intended solely for the information and use of the management of the Department of Health and Human Services and the Fiscal Committee of the General Court and is not intended to be and should not be used by anyone other than these specified parties.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

February 19, 2003

Management Issues Comments

Observation No. 27: Additional Support In The Surveillance Utilization Review Unit Should Be Considered

Observation:

Limited staff size in the Department's Surveillance Utilization Review (SURS) Unit results in an inability for the SURS to review all Medicaid cases with indications of possible fraud that come to the attention of the SURS.

According to federal regulations, including Title 42 Code of Federal Regulations section 455.14, if the Medicaid agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. In the Department, the SURS performs this function.

The current structure of the SURS includes three employees; a medical consultant II, a program specialist II, and a quality control reviewer. During fiscal year 2002 there were over 14,000 providers enrolled in the Medicaid program, approximately 84,000 eligible Medicaid recipients, and over 4.9 million Medicaid eligible claims filed (including pharmacy claims).

A typical on-site review by SURS staff consists of two employees traveling to a provider's facility to review records, etc. Considering the size of the Medicaid program both in terms of dollars expended and the number of claims submitted, a SURS staff of three does not appear sufficient to provide thorough post-payment review of provider claims or services received by clients. During fiscal year 2002, the SURS Unit was able to review 27 recipient cases and 24 provider cases.

During fiscal year 2002, the SURS collected $700,000 of Medicaid recoveries based on current and prior year SURS review activities.

The SURS also employs a contractor to review inpatient hospital claims. The efforts of the contractor resulted in an additional $700,000 of recoveries from inpatient hospitals.

Recommendation:

The Department should consider additional resources for the SURS Unit to improve the Department's ability to detect and resolve Medicaid frauds and other mis-utilization of Medicaid services.

Auditee Response: Concur

The Department concurs with this audit observation and recommendation. The SURS positions cover their own cost and then substantially contribute additional revenue ($250,000) to the

Department. Vacancies and hiring freezes however, compromise the ability to fulfill this responsibility.

The Department's 2004/2005 budget request included four additional SUR's positions as part of a cost management initiative.

Independent Auditor's Report

To The Fiscal Committee Of The General Court:

We have audited the accompanying Statement of Revenues and Expenditures of the Medicaid Program, a federal/State program primarily administered by The State of New Hampshire Department of Health and Human Services, for the year ended June 30, 2002. This financial statement is the responsibility of the Department of Health and Human Services. Our responsibility is to express an opinion on this financial statement based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statement is free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statement. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As more fully discussed in Note 1, the financial statement referred to above is not intended to present the financial position of the Medicaid program in the General Fund.

In our opinion, except for the matter discussed in the third paragraph, the financial statement referred to above presents fairly, in all material respects, certain financial activity of the Medicaid program for the year ended June 30, 2002, in conformity with accounting principles generally accepted in the United States of America.

Our audit was conducted for the purpose of forming an opinion on the financial statement referred to in the first paragraph. The accompanying schedule on page 55 is presented for the purpose of additional analysis and is not a required part of the financial statement of the Medicaid program. Such information has been subjected to the auditing procedures applied in our audit of the financial statement referred to in the first paragraph and, in our opinion, is fairly presented in all material respects in relation to the financial statement taken as a whole.

In accordance with *Government Auditing Standards*, we have also issued a report dated February 19, 2003 on our consideration of the Department's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and rules, regulations, and contracts. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

February 19, 2003

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

STATEMENT OF REVENUES AND EXPENDITURES
FOR THE YEAR ENDED JUNE 30, 2002

Revenues	
Federal Revenues	
Medical Assistance	$ 454,134,534
Administration	33,377,206
Total Federal Revenues	487,511,740
Local Revenues	66,012,831
Total Revenues	**$ 553,524,571**
Expenditures	
Nursing Facilities	$ 193,931,146
Disproportionate Share	181,453,768
Home-Care Based Services	146,765,421
Clinic	102,000,535
Drugs (Net of Rebate)	70,927,509
Administration	56,183,374
Outpatient Hospital	40,801,813
Inpatient Hospital	37,417,393
Physicians And Other Practitioners	31,082,257
Managed Care Premiums	16,622,973
Targeted Case Management	12,655,184
Rural Health Clinics	6,829,241
Home Health Services	5,505,411
Dental	4,543,893
Other Care	70,224,249
Other Expenditures (Adjustments)	(13,991,559)
Total Expenditures	**$ 962,952,608**
Excess (Deficiency) Of Revenues Over (Under) Expenditures	**$ (409,428,037)**

The accompanying notes are an integral part of this financial statement.

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

NOTES TO THE FINANCIAL STATEMENT
FOR THE YEAR ENDED JUNE 30, 2002

NOTE 1 -- SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statement of the Medicaid program has been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) and as prescribed by the Governmental Accounting Standards Board (GASB), which is the primary standard-setting body for establishing governmental accounting and financial reporting principles.

A. Financial Reporting Entity

The Medicaid program is a federal/State program administered primarily by the Department of Health and Human Services, a department of the primary government of the State of New Hampshire. The accompanying financial statement reports the Medicaid program of the State of New Hampshire. The financial activity of the Medicaid program is accounted for and reported in the General Fund in the State of New Hampshire's Comprehensive Annual Financial Report (CAFR). Assets, liabilities, and fund balances are reported by fund in the Governmental Fund Financial Statements and by governmental-activity in the Government-wide Financial Statements for the State as a whole in the CAFR. The Medicaid program as a program of a department of the primary government, accounts for only a portion of the General Fund and those assets, liabilities, and fund balances as reported in the CAFR that are attributable to the Medicaid program cannot be determined. Accordingly, the accompanying financial statement is not intended to show the financial position of the Medicaid program in the General Fund and the changes in these fund balances are not reported on the accompanying financial statement.

B. Basis Of Presentation - Fund Accounting

A fund is a separate accounting entity with a self-balancing set of accounts. Fund accounting is designed to report financial position and the results of operations, to demonstrate legal compliance, and to aid financial management by segregating transactions related to certain government functions or activities.

Governmental Fund Types

General Fund

The General Fund is the State's primary operating fund and accounts for all financial transactions not accounted for in any other fund.

C. Measurement Focus And Basis Of Accounting

All governmental funds are accounted for using the current financial resources measurement focus and reported on the modified accrual basis of accounting. Revenues are recognized as soon as they are both measurable and available. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period. For this purpose, the State generally considers non-grant revenues to be available if they are collected within 60 days of the end of the current fiscal period. Grant revenues that the State earns by incurring obligations are recognized in the same period as when the obligations are recognized.

Expenditures generally are recorded when a liability is incurred, as under accrual accounting. However, expenditures related to debt service, compensated absences and claims and judgments are recorded only when payment is due.

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
(Cash Basis)
FOR THE YEAR ENDED JUNE 30, 2002

MEDICAID CLUSTER 93.778, 93.777 AND 93.775
Federal Grantor: Department of Health and Human Services

Catalog Number	Program Title	Expenditures
93.775	State Medicaid Fraud Control Units	$ 455,817
93.777	State Survey and Certification of Health Care Providers and Suppliers	1,117,065
93.778	Medical Assistance Program	540,549,023
	Total Expenditures of Federal Awards	$ 542,121,905

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APPENDIX

CURRENT STATUS OF PRIOR AUDIT FINDINGS

The following is a summary, as of February 19, 2003, of the status of the observations related to the Medicaid program contained in the State of New Hampshire Single Audit and Management Letter reports for the year ended June 30, 2001. A copy of these prior reports can be obtained from the Office of Legislative Budget Assistant, Audit Division, 107 North Main Street, State House Room 102, Concord, NH 03301-4906.

		Status
Single Audit Comments		
FY-2001	Automated Data Processing System Security Reviews Not Performed *(see current year observation No. 3)*	○ ○ ○
FY-2001	Health And Safety Standards For Health Care Facilities	● ○ ○
FY-2001	Expired Administrative Rules *(see current year observation No 25)*	○ ○ ○
FY-2001	Incomplete Provider Files *(see current year observation No. 19)*	○ ○ ○
FY-2000	Expired Administrative Rules *(see current year observation No 25)*	○ ○ ○
FY-1999	Incomplete Documentation To Determine Recipient Eligibility *(see current year observation No 20)*	● ● ●
FY-1999	Expired Administrative Rules *(see current year observation No. 25)*	○ ○ ○
Management Letter Comments		
FY-2001	Health Insurance Portability And Accountability Act Of 1996	● ○ ○
FY-2001	Automation Of The MMIS And Bridges Liability Calculation *(see current year observation No. 6)*	● ○ ○
FY-2001	County Accounts Receivable	● ● ●
FY-2001	Medicaid Management Information System *(see current year observation No. 3)*	○ ○ ○
FY-2001	Disproportionate Share *(see current year observation No. 8)*	○ ○ ○

Status Key

Fully Resolved	●	●	●
Substantially Resolved	●	●	○
Partially Resolved	●	○	○
Unresolved	○	○	○

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