December 20, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

/Joe Green/ for
FROM: George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in New Hampshire (A-01-10-00009)

Attached, for your information, is an advance copy of our final report on New Hampshire's compliance with the prompt pay requirements for receiving the increased Federal medical assistance percentage under the American Recovery and Reinvestment Act of 2009. We will issue this report to New Hampshire's Department of Health & Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-10-00009.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region I Room 2425
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

December 22, 2010

Report Number: A-01-10-00009

Mr. Nicholas A. Toumpas
Commissioner
New Hampshire DHHS Commissioner's Office
Brown Building
129 Pleasant Street
Concord, NH 03301

Dear Mr. Toumpas:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in New Hampshire.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Stephen Conway, Audit Manager, at (617) 565-2946 or through email at Stephen.Conway@oig.hhs.gov. Please refer to report number A-01-10-00009 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
223 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 MEDICAID PROMPT PAY REQUIREMENTS IN NEW HAMPSHIRE

Daniel R. Levinson
Inspector General

December 2010
A-01-10-00009

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. Pursuant to section 1903(a) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act will provide an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Pursuant to section 5001(f)(2)(A) of the Recovery Act, effective February 18, 2009, a State is not eligible for the increased FMAP for any claim received from a practitioner on days when the State did not comply with prompt pay requirements referenced at section 1902(a)(37)(A) of the Act. Pursuant to 42 CFR § 447.45(d), a State Medicaid agency must pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt and 99 percent of such claims within 90 days of the date of receipt.

New Hampshire Medicaid Program

New Hampshire's Department of Health & Human Services (the State agency) administers the State's Medicaid program. During calendar year 2009, New Hampshire's Recovery Act FMAP increase ranged from 6.2 percent to 11.59 percent, resulting in additional Medicaid reimbursements totaling $100,896,796. The State agency receives and processes Medicaid claims using New Hampshire's Advanced Information Management System (NHAIM).

OBJECTIVE

Our objective was to determine whether the State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

SUMMARY OF FINDING

Based on its claims information, the State agency did not identify any days of noncompliance with Recovery Act prompt pay requirements. However, we could not determine that New Hampshire fully complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act because we could not determine that the State agency always recorded

claim receipt dates as the actual days that it received paper or electronic claims from providers. As a result, we could not rely on the State agency's receipt dates from NHAIM to verify that it paid 90 percent of all clean claims from providers within 30 days of receipt and 99 percent of all clean claims within 90 days of receipt. The State agency's policies and procedures did not ensure that it always recorded a claim's receipt date as the actual day that it received the claim.

RECOMMENDATION

We recommend that the State agency implement policies and procedures to ensure that it records a claim's receipt date as the actual day that it receives the clean Medicaid claim. Specifically, we recommend that the State agency record the receipt date as the day that it receives a claim (1) by mail for paper claims or (2) at the Translator for electronic claims.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that it was in compliance with Recovery Act prompt pay requirements and described the steps that it was taking to address our recommendation. The State agency's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Pursuant to section 1903(a) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act will provide an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides these increases to help avert cuts in health care provider reimbursement rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid. For Federal fiscal year 2009, these temporary FMAP increases ranged from 6.2 to nearly 14 percentage points, depending on State unemployment rates.

Pursuant to section 5001(f)(2)(A) of the Recovery Act, effective February 18, 2009, a State is not eligible for the increased FMAP for any claim received from a practitioner on days when the State did not comply with prompt pay requirements referenced at section 1902(a)(37)(A) of the Act. Pursuant to section 5001(f)(2)(B) of the Recovery Act, effective June 1, 2009, these requirements also apply to claims submitted by hospitals and nursing facilities. In this report, we refer to these three requirements as the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

Prompt Pay Requirements

Section 1902(a)(37) of the Act and implementing regulations (42 CFR § 447.45) specify prompt pay requirements. Pursuant to 42 CFR § 447.45(d)(2), a State Medicaid agency "must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who

practice in shared health facilities, within 30 days of the date of receipt." Pursuant to 42 CFR § 447.45(d)(3), a State Medicaid agency must pay 99 percent of such claims within 90 days of the date of receipt.[1, 2]

Federal regulations define a clean claim as a claim that can be processed without obtaining additional information from the provider or a third party. It does not include claims from a provider that is under investigation for fraud or abuse or claims under review for medical necessity (42 CFR § 447.45(b)).[3] CMS's guidance defines the date of receipt as the actual date that a State receives a claim from a provider. CMS further defines a claim's payment date as either the payment check date, the date of an electronic funds transfer payment, the date that a payment is mailed, or the date on the Explanation of Benefits or denial notice for denied claims (CMS's guidance, Appendix, section B).

New Hampshire Medicaid Program

New Hampshire's Department of Health & Human Services (the State agency) administers the State's Medicaid program. HP Enterprise Services (HP), the State agency's contractor, receives and processes Medicaid claims using a computerized payment and information reporting system, the New Hampshire's Advanced Information Management System (NHAIM), which is the State's Medicaid Management Information System. HP also tracks the State's daily compliance with the prompt pay requirements using the claims information recorded in NHAIM.

Providers submit Medicaid claims to the State agency by mail or electronically. The State agency estimated that 10 percent of the Medicaid claims that it received were paper claims and 90 percent were electronic claims. The State agency receives and opens mailed paper claims on all business days, except for Federal and State holidays. To create an electronic copy, the State agency generally electronically scans mailed paper claims on the day that it receives the paper claims or by noon on the following business day. The scanner marks each claim with the current date, which is used by the State agency as the claim's date of receipt.

Providers submit electronic claims using HP's Translator Services (the Translator), located in HP's offices in Florida. The Translator performs an initial process to verify that electronic claims comply with the electronic claim processing requirements of the Health Insurance Portability and Accountability Act of 1996 and the New Hampshire Medicaid program. NHAIM receives the verified claims from the Translator for adjudication and final claims processing. NHAIM records an electronic claim's date of receipt as the date that it receives the claim from the Translator.

[1] In general, a State Medicaid agency must pay all other claims within 12 months of the date of receipt.

[2] Because the Recovery Act was enacted on February 17, 2009, the first compliance date with respect to prompt pay requirements for receiving the increased FMAP under the Recovery Act for practitioner claims was February 18, 2009. Therefore, claims received 30 days before this date (on January 20, 2009) were the first claims subject to the 30-day requirement, and claims received 90 days before this date (on November 21, 2008) were the first claims subject to the 90-day requirement (CMS's State Medicaid Director letter No. 09-004 (CMS's guidance)).

[3] Throughout our report, "claims" refers to clean claims as defined pursuant to 42 CFR § 447.45(b).

During calendar year 2009, New Hampshire's Recovery Act FMAP increase ranged from 6.2 percent to 11.59 percent, resulting in additional Medicaid reimbursements totaling $100,896,796.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

Scope

Our review covered all Medicaid claims received and adjudicated by New Hampshire for the period February 18 through December 31, 2009. We did not assess the State agency's overall internal control structure. We limited our review of internal controls to those applicable to our objective, which did not require an understanding of all internal controls over the Medicaid program. We reviewed the State agency's procedures for ensuring compliance with prompt pay requirements for receiving the increased FMAP under the Recovery Act.

We performed fieldwork at the State agency's Medicaid offices in Concord, New Hampshire, from February through May 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's policies and procedures for paying Medicaid providers and for complying with prompt pay requirements and met with State agency officials to gain an understanding of those policies and procedures;
- obtained from NHAIM the population of all claims received for each day during the period November 21, 2008, through December 31, 2009;
- validated the population of claims received by selecting a judgmental sample of 10 days from the NHAIM claim data file and testing them for completeness and by selecting a judgmental sample of 30 claims and testing them for accuracy;
- verified the State agency's methodology for identifying clean Medicaid claims and calculating prompt pay percentages;
- determined, for each date of receipt as recorded in NHAIM, whether the State agency complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act by:

- determining the number of clean claims received;
- computing, for each claim, the number of days between the date of receipt and the date of payment and denial;
- determining the total number of claims paid or denied within 30 days and within 90 days;
- calculating the percentage of claims paid or denied within 30 days and within 90 days;[4] and

- discussed the results of our audit with the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our finding and conclusion based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATION

Based on its claims information, the State agency did not identify any days of noncompliance with Recovery Act prompt pay requirements. However, we could not determine that New Hampshire fully complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act because we could not determine that the State agency always recorded claim receipt dates as the actual days that it received paper or electronic claims from providers. As a result, we could not rely on the State agency's receipt dates from NHAIM to verify that it paid 90 percent of all clean claims from providers within 30 days of receipt and 99 percent of all clean claims within 90 days of receipt. The State agency's policies and procedures did not ensure that it always recorded a claim's receipt date as the actual day that it received the claim.

FEDERAL GUIDANCE

CMS's guidance, Appendix, section H, states that the State agency's procedures for designating the receipt date must be followed consistently by the State agency and should not result in more than a single business day difference between the designated date and the actual calendar day of receipt.

CMS recognizes that State agencies often use fiscal intermediaries (FI) for processing Medicaid claims. However, pursuant to CMS's guidance, Appendix, section J.3, the use of FIs or a similar administrative or operational process does not relieve State agencies from complying with the prompt pay requirements, nor does it relax them. The date that the FI or the State agency

[4] For each receipt date, we calculated these percentages by dividing the number of claims paid or denied within the specified period by the total claims received on that date.

receives the claims should be considered the date of receipt by the State agency when determining compliance with the prompt pay requirements.

INACCURATE CLAIM RECEIPT DATES

Paper Claims

The State agency did not record a claim's receipt date by noon of the following business day when the mailroom staff could not electronically scan and date a high volume of claims in a single day. Furthermore, the State agency performed additional work before electronically scanning and recording the receipt date for claims under the following circumstances:

- claims were submitted for services performed more than 1 year earlier and the State agency's policy required such claims to be approved internally before adjudication,

- claims were submitted that required the State agency to perform a manual review because the beneficiaries had additional insurance, and

- claims were submitted to adjust previously paid claims.

The State agency did not always follow its usual procedures for scanning and recording a paper claim's receipt date within 1 business day of receiving it.

Electronic Claims

The State agency did not record in NHAIM the date that New Hampshire received valid electronic claim files at the Translator. Instead, the State agency recorded the date that NHAIM received the claims from the Translator for final processing as the receipt date. The State agency said that NHAIM receives claims from the Translator within 1 business day. However, we were unable to verify this based on the information that the State agency provided. In addition, we were aware of one instance in which NHAIM experienced a system failure from February 16 through February 19, 2009, and did not receive electronic claims from the Translator. When NHAIM was restored, the State agency processed the backlog of claims over several days, dating electronic claims as NHAIM received them. The State agency did not record the original receipt date for electronic claims during the system failure.

CONCLUSION

The State agency's policies and procedures did not ensure that it always recorded a claim's receipt date as the actual day that it received some paper claims and all electronic claims at the Translator. As a result, we could not rely on the State agency's receipt dates from NHAIM to verify that it paid 90 percent of all clean claims within 30 days of receipt and 99 percent of all clean claims within 90 days of receipt.

RECOMMENDATION

We recommend that the State agency implement policies and procedures to ensure that it records a claim's receipt date as the actual day that it receives the clean Medicaid claim. Specifically, we recommend that the State agency record the receipt date as the day that it receives a claim (1) by mail for paper claims or (2) at the Translator for electronic claims.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that it was in compliance with Recovery Act prompt pay requirements and described the steps that it was taking to address our recommendation. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857

603-271-4688 FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

NICHOLAS A. TOUMPAS
COMMISSIONER

October 22, 2010

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services, Office of Inspector General
Office of Audit Services, Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: Review of the American Recovery and Reinvestment Act of 2009 Medicaid Prompt Pay Requirements in New Hampshire Report Number: A-01-10-00009

Dear Mr. Armstrong:

The New Hampshire Department of Health and Human Services responds to the draft report of the above-referenced audit, which you forwarded on August 25, 2010.

The draft report Summary of Finding states "*Based on its claims information, the State agency did not identify any days of noncompliance with Recovery Act prompt pay requirements. However, we could not determine that New Hampshire fully complied with the prompt pay requirements for receiving the increased FMAP under the Recovery Act because we could not determine that the State agency always recorded claim receipt dates as the actual days that it received paper or electronic claims from providers. As a result, we could not rely on the State's agency receipt dates from NHAIM to verify that it paid 90 percent of all clean claims from providers within 90 days. The State agency's policies and procedures did not ensure that it always recorded a claim's receipt date as the actual day that it received the claim*".

The Recommendation states, "*that the State agency implement policies and procedures to ensure that it records a claim's receipt date as the actual date that it receives the clean Medicaid claim. Specifically, we recommend that the State agency record the receipt date as the day that it receives a claim 1) by mail for paper claims or 2) at the translator for electronic claim*".

New Hampshire was one of the first states in our region to take the necessary steps to begin the daily monitoring of the prompt pay provision. We also are one of the first states to be audited.

New Hampshire believes it is in compliance with the prompt pay requirements. New Hampshire has consistently reached far above the threshold for prompt payment compliancy rate, i.e., 97.10% and above for 30 days and 99.9% and above for all clean claims within 90 days of receipt. To the extent that OIG's recommendation is for New Hampshire to implement such policies and procedures, New Hampshire is currently addressing the issue in a prudent and responsible manner. We understand and will comply with the auditor's recommendation regarding documenting compliance with the prompt pay provision.

New Hampshire's MMIS claims processing is currently maintained within its legacy system. To date, New Hampshire has utilized a total of 875 hours of modification costs in order to comply with the ARRA Prompt Pay requirements as well as numerous hours of State staff time. These resources were used to study current payment timeline in greater detail, to assess options for reducing claims that suspend, and to develop detailed reporting procedures.

New Hampshire has taken steps to address the recommendation contained in the report. In the case of those claims that require a manual review to assure the required third party liability (TPL) information is included, the manual review for TPL is equally important to both the State and CMS from a cost avoidance perspective. Those claims are now being scanned prior to manual review to allow input directly into the system and are then suspending for manual review. Additionally, with the implementation of the new Optical Character Recognition (OCR) solution in early November 2010, the receipt date will be set at the time the claims are scanned. This will enable New Hampshire to set a receipt date for any days when all paper claims received are not scanned on the day of receipt.

In the case of the issue identified with electronic claims where currently the receipt date is assigned at the time of the load from the translator to NHAIM rather than at the translator, the State maintains, that claims are currently received from the translator within 1 business day meeting prompt pay requirements. The only exception to that has been the 5 days the translator was down due to a firmware issue February 16, 2009 thru February 20, 2009 and 4 days due to the Rhode Island floods March 30, 2009 thru April 2, 2009. New Hampshire is pursuing an estimate of necessary MMIS system changes, level of effort, time-line for completion and cost for modifying the legacy MMIS to modify the record of the receipt date as recommended. After receiving the modification cost, time, and resource estimates, the State will consult with CMS in making a determination whether implementing a change to the legacy system, for a brief period of time, for the purpose of better documenting prompt pay requirements in accordance with the prompt payment audit recommendation now takes priority over avoiding the additional expenditure of 90% federal matching funds that will require a system change in the legacy system and a duplicate system change in the new MMIS that has a go live date of October 1, 2011. The new MMIS allows for the implementation of a solution that will satisfy the audit recommendation far superior than that which can be built into the legacy system. We believe that it would be a wasteful elevation of form over substance to make system changes in the legacy system but we believe it is prudent to consider the overall costs to the Medicaid program particularly from a federal perspective given the enhanced 90% federal match. This is especially true when New Hampshire is currently meeting prompt pay requirements because the receipts date from the translator within 1 business day.

To further demonstrate our commitment to implementing a corrective action plan to address the audit finding, we would like to share with you how the solution will be realized in the new MMIS. Specifically in the new MMIS, paper claims will reflect the actual date of receipt of the claim in the mailroom. The julian calendar date for all claims scanned into the system through the OCR process will be set to the actual receipt date.

All electronic claims received by the translator will be assigned a Transmission Identification number and the date and time that the file was received will be stored. Every claim transaction created within the MMIS will be able to be tied back to the individual transaction within a transaction set

processed through the electronic claims gateway using the unique transmission ID that is assigned to the batch transmission with the date and time the transmission was received.

Again, New Hampshire is in compliance with the prompt pay requirements. We have consistently performed far above the threshold for prompt payment compliancy rate i.e. 97.10% and above for 30 days and 99.9% and above for all clean claims within 90 days of receipt. However, we are taking certain additional steps in response to the audit recommendations. New Hampshire reserves the right to supplement this response in the event OIG modifies its preliminary findings and recommendations.

We appreciate the opportunity to comment on the audit. Please do not hesitate to contact me if you have any questions.

Sincerely,

/Nicholas A. Toumpas/

Nicholas A.Toumpas
Commissioner

Cc:
Richard McGreal, CMS Region 1 Associate Regional Administrator
Kathleen A. Dunn, NH Medicaid Director
Marilee Nihan, NH Medicaid Finance Director
Diane Delisle, MMIS, DHHS