LEGISLATIVE PERFORMANCE AUDIT AND OVERSIGHT COMMITTEE
One Granite Place, Room 234
Concord, New Hampshire
Friday, March 6, 2026

MEMBERS PRESENT:

Representative Gerald Griffin, Chair
Representative Keith Erf
Representative Kenneth Weyler
Representative Mary Jane Wallner
Representative Lucy Weber
Senator Timothy Lang
Senator Cindy Rosenwald
Senator Howard Pearl

GERALD GRIFFIN, State Representative, Hillsborough County, District #42: I don't have the mic on. As a little bit of background for you people, this committee has historically limited our role to the progress of performance audits and charging the future candidates for audit, and the scope of those audits. Most recently, the Committee has taken up a role as a follow-up entity ensuring that the auditor's recommendations are addressed and/or implemented.

We are, in fact, an oversight committee, and in that role we cannot ignore what is happening in the many states, including two of which directly above us. I am referring to the fraud that is being uncovered in the social service programs of those states.

We have no reason to believe that New Hampshire has that problem. We have -- uh -- there -- there are no whistle-blowers, but this Committee would be remiss if we did not ensure that there are controls in place within your departments to ensure any significant audit would be -- any significant fraud would be uncovered.

We are blessed that the structure of our state government includes an Executive Council that reviews all significant contracts. So our inquiry is going to be focused more on the implementation and performance of those contracts. So we would like you, if you could, to -- uh -- give the Committee some background on -- on what kind of controls we have in place and what we're finding, if anything. So the microphone is yours. And if you would identify yourself for the record.

LUCY WEBER, State Representative, Cheshire County, District #05: Needs to be turned on.

CHARLES BUCCA, ESQ., Director, Medicaid Fraud Control Unit, Division of Public Protection, Department of Justice: Good morning. Thank you, Mr. Chairman, and Members of the Committee. Thank you for your interest in speaking to us. We represent the New Hampshire Medicaid Fraud Control Unit.

My name is Charles Bucca. I'm the Director of the Medicaid Fraud Control Unit. With me today is Investigator Timothy Brackett. He is the Unit's Financial Investigator. And it's my understanding that the Committee had some interest in who we are and what we do, and we'd like to address that for you here today.

Um -- we work for the Attorney General's Office under the direction of General John Formella within the Criminal Justice Bureau of the Department. The Criminal Justice Bureau conducts investigations and initiates prosecutions in significant criminal cases throughout the state. Within the Criminal Justice Bureau there are a number of dedicated prosecution bureaus, such as the Homicide Unit, the Drug Unit, the Cold Case Unit, Public Integrity Unit and, of course, our unit which is the Medicaid Fraud Control Unit. And our unit investigates and prosecutes fraud by healthcare providers, who treat Medicaid beneficiaries within the State of New Hampshire.

Within our unit, when fully staffed, we have three prosecutors, including myself, the Director. We have two investigators, and we have a financial analyst investigator which, as I indicated, is Mr. Brackett, who joins me here today. In addition, we have a paralegal, and we have one

administrative assistant.

As I indicated, I'm the Director of the unit. My duties include the administrative matters associated with supervising unit members and prosecuting unit cases from their initial investigations through jury trial. We also have input and oversight with regard to any appellate issues if cases were appealed thereafter.

Very briefly about myself. I've been a prosecutor for 25 years. I've spent the majority of my career prosecuting a wide variety of different criminal offenses in Upstate New York. I came to the Attorney General's Office after completing a one-year term appointment with the U.S. Attorney's Office.

I've been prosecuting criminal offenses here in New Hampshire with the Attorney General's Office for approximately four years, the majority of which were homicides, drug offenses, and aggravated felonious sexual assaults. And recently I've been commissioned as the Director of the Medicaid Fraud Control Unit.

I'd very briefly like to ask my colleague, Investigator Brackett, to introduce himself to you, describe his background and his role in the unit. I've asked him to join us here today because he has the distinction of being the

most senior member of our unit. And by that I mean his time within the unit, not his age. So Investigator Brackett.

TIMOTHY BRACKETT, Financial Investigator, Medicaid Fraud Control Unit, Division of Public Protection, Department of Justice: Thank you. Um -- again, my name is Tim Brackett. My formal title in the unit is Financial Investigator. As part of our grant funded structure, we are required to have at least a prosecutor, an investigator, and an auditor in our unit. So, technically, I fulfill the role of auditor in my unit.

My background is I have about 34 years in law enforcement. I've got about 27 years with the New Hampshire Department of Justice in various different capacities. And I've got about 11 years in the Medicaid Fraud Control Unit. So that's my background. Thank you.

MR. BUCCA: Thank you. If I could be permitted, I would like to address the Committee with regard to our unit and some of the more details of what we do for you, so you have an understanding of that.

CHAIRMAN GRIFFIN: Please do.

MR. BUCCA: So the Medicaid Fraud Control Unit investigates and prosecutes fraud by healthcare providers who treat Medicaid beneficiaries within the State of New Hampshire.

Healthcare providers include, but are not limited to, hospitals, nursing homes, doctors, dentists, pharmacies, ambulance companies or anyone else who's paid for providing healthcare services to Medicaid beneficiaries.

The unit also investigates and prosecutes cases regarding harm to residents of healthcare facilities that's caused by abuse, neglect, or financial exploitation. The New Hampshire Medicaid Fraud Control Unit receives approximately 75 -- not approximately, but exactly 75% of its funding from the U.S. Department of Health and Human Services under a grant, and the remaining 25% is funded by the State of New Hampshire.

So with regard to what we find and what we prosecute -- uh -- those are essentially divided into three buckets; Medicaid fraud, resident abuse and neglect, and drug diversion. So I'll address each of them in that order for you.

With regard to Medicaid fraud, there are a number of different potential things that could constitute Medicaid fraud, but some of the most common that we see, that we find, that we prosecute are things like billing for services not rendered, which would mean that a provider bills Medicaid for a procedure or service that was not actually provided. Uh -- there's billing for upcoded services, and that would be where a provider would misrepresent the diagnosis or the

symptoms on patient records, and they would select a higher paying procedure code to obtain greater reimbursement than allowed under the law. There's also billing for uncovered services and that would be where a provider bills Medicaid for a service that requires the use of a licensed or certified professional, but uses unqualified staff. Uh -- drug substitution. An example of that would be where a pharmacist fills a recipient's prescription with a generic drug, but bills Medicaid at a higher cost brand name drug.

There are kickbacks that we see, kickback schemes, and that's where a provider would offer or pay a kick-back to induce someone to refer Medicaid recipients to that provider as a patient or a client. Examples of kickbacks could include cash, vacations, or other gifts that are provided.

Um -- we see supplemental charges. That would be where a provider charges the Medicaid recipient for a service which is covered by Medicaid and should be billed to Medicaid, and then the charges -- and then charge the recipient the difference between the provider's usual fee and what Medicaid would pay. And there's also the inflation of the usual and customary charges. Provider charges Medicaid more than their usual and customary charge for the same product or service billed to other insurers and the public. A provider

might inflate the cost of a procedure, or a service, or of the goods provided. So those are the sum of the general frequent things that we see with regard to Medicaid fraud.

With respect to resident abuse, neglect, and financial exploitation -- uh -- resident abuse or neglect is any action or a failure to act which causes unjustifiable harm to a healthcare facility resident. That includes physically assaulting a resident, as well as withholding necessary food, care, or medical treatment from that resident.

The unit investigates reports of abuse and neglect in any inpatient or residential healthcare setting, including hospitals, nursing homes, and assisted-living centers. Resident financial exploitation is the illegal or improper use of the funds or assets of the healthcare facility resident. It includes the misuse of personal funds held at the facility and may also include the misuse of funds by resident's designated financial agent.

Lastly, with respect to drug diversion, drug diversion from hospitals, nursing homes, and other residential facilities is an ongoing problem. Diversion would be the unauthorized possession of which would include obtaining, retaining, or administering of controlled drugs. Drug diversion can put the patient, who's supposed to be having

those drugs at risk, and it consumes valuable medical and financial resources.

Examples of this would include unauthorized administration of medications, unauthorized substitution of medications, failing to dispose of excess medication or pretending to dispose of medication using another substance like a saline. Withdrawing excess medication from the dispenser or a cart, and then failing to dispose of that medication properly. Documenting that a patient received medication when they did not. And suspected impairment on the job due to unauthorized personal consumption of medication by the staff members.

Um -- what I'd like to do next with the Committee's permission is just discuss what our process is, how long it takes, and -- um -- you know, discuss -- uh -- how referrals of cases come to us. We prepared a flowchart with regard to that. I don't know if the Committee Members all have seen it or had a chance to review it, but I'm going to ask Mr. -- or Investigator Brackett to kind of run us through that process and answer any questions that we have regarding it.

CHAIRMAN GRIFFIN: Please do.

JAY HENRY, Performance Audit Supervisor, Audit Division, Office of Legislative Budget Assistant: It's in your

handout. {Inaudible}.

REP. WEBER: {Inaudible.}

MR. HENRY: Yeah, it's in one of those.

ATTORNEY BUCCA: That's it on your hand right there.

REP. WEBER: {Inaudible}. I was just wondering if there was another handout.

MR. HENRY: No, it's in one of those handouts.

REP. WEBER: Okay. So it's the small --

MR. HENRY: Yeah, correct.

REP. WEBER: I {Inaudible}.

MR. BRACKETT: So, again, I'd like to thank the Honorable Chair and Members of the Committee for inviting us here. And since this is the -- the handout we're talking about, this is the first one that I'll address. And we use this as a way to basically walk you through our process of where our referrals come from, and how we work through them to an ultimate resolution.

So if you look at the flowchart that's in front of you, you'll see it will go from left to right. So we'll start at the left-hand side top. That is where the bulk of our referrals will come from. We'll work our way towards the outcomes on the right.

So if we start with the Managed Care Organizations and, again, I'll -- I'll try and explain it because I'm not sure how much understanding there is of some of the nuances within the HHS system. So I'll try and explain as I go what they are.

The Managed Care Organizations are basically private companies that are contracted by the State of New Hampshire. They help the State Medicaid Program administer the Medicaid Program itself. Each one of those Managed Care Organizations has a specific number of Medicaid clients enrolled in their plan. And they are reimbursed for each one of those Medicaid patients that is enrolled.

Each one of the Managed Care Organizations has a structure that is roughly similar to what the Department of Health and Human Services Program Integrity Unit does.

So I'll move right into the next box over and you see if you look at the chart, you can see the flowchart goes from Managed Care Organizations to HHS. HHS is really the parent organization that we're talking about. It's the Medicaid Program. And in HHS they have the Medicaid Program, but they also have the Program of Quality and Integrity. It's the Division of Program Quality and Integrity. That one includes a couple of units. For our purposes one of the

foremost is going to be the Program Integrity Unit. Program Integrity Unit is really designed to provide a means for HHS to audit their programs, to look for and detect instances of fraud, waste, and abuse within the program.

Going back to the Managed Care Organizations, because they are private entities contracted by the State, they also have that obligation. So, each one of them has what's called a Special Investigations Unit or an SIU. Each one of those SIUs is tasked with the same thing that they are supposed to look for fraud, waste and abuse within the system.

As the Medicaid Fraud Control Unit, we address provider fraud. So as these MCOs and the Program Integrity Unit at the Department of Health and Human Services uses their resources to review the Medicaid programs looking for fraud, waste, and abuse, where they identify an instance that they can categorize as a credible allegation of fraud, then they will report that to us.

Now, that tends to be the -- the more significant number of referrals that we get. We get most of our referrals from the HHS system. One way you can think of it is that we're a unit of about eight people. So if you would compare us to say, you know, Concord Police Department. Concord Police Department has a fairly robust patrol division.

And the role of a patrol division is to go out to respond to citizen requests for assistance, but also to generate material to generate activity, identify crimes that are then brought back into the police department to be investigated. With eight staff members, we don't have the same resources to do that. So, we operate within a larger structure and we're -- we're a component piece of a larger structure.

HHS is looking across the board at the Medicaid Programs in a way that we necessarily can't with our resources; but they are tasked with bringing them to us. So they're performing a function, we're performing a function, and it ends up being a fairly nice, tight, cohesive overall organization.

So, for the -- for the purposes of program integrity, like I say, they -- they do represent most of our referrals. But as we work down that list, they're somewhat in order of the percentage that we receive. So if you look at the next one down, it's labeled Qui Tams and whistleblower. So Qui Tams, if you're not familiar, are basically an instance where an individual with some degree of personal knowledge of potential fraud taking place within a company or corporation is able to retain counsel and file a civil suit against that company, based on New Hampshire's statutes, as well as other states. And they do this it becomes a Qui Tam, and they become

a relator.

So when this happens, we have the next one down you'll see is the National Association for Medicaid Fraud Control Units. The NAMFCU is kind of our parent organization at the national level. They are the -- the association of all Medicaid Fraud Control Units. And they will take a role in the Qui Tams by -- oh, so we'll take a step back in the way the Qui Tams are brought forward. It's brought forward by the relator and their legal counsel; but when it's brought forward, the named states are notified that the Qui Tam exists and that gives the named states and relevant district of the U.S. Attorney's Office a chance to join the litigation.

So what will happen is NAMFCU will receive notice that somebody has filed a Qui Tam against a particular company. Let's say it's a pharmaceutical company. Then NAMFCU will then create a team that will prosecute. It's made of prosecutors and analysts, and this team will be responsible for working with the relevant U.S. Attorney's Office, the primary U.S. Attorney's Office that will work that case. And it's usually made up of three or four different states.

We will assist those prosecutions, because these are now national scope global prosecutions. We'll assist by providing them with information, resources and assistance,

including some of our Medicaid claims numbers, so they can present damage models and then, ultimately, look at damages for settlement.

So each of one of those we will assist in the investigation. They will litigate it through, and then when there's a settlement, New Hampshire will reap the benefits of a portion of that settlement. And it will generally be based on the claims that we had as a percentage to the other states. So that's also a fairly large percentage of -- of how we get in materials.

So as we continue down, you'll also see citizens complaints. We have on our web site an e-mail address where we receive fairly frequent updates from citizens, and it could be something as simple as an individual that is going to a particular medical practice, and they just saw something that concerns them on the way that it's being billed. So they can send us either a -- an identified or an anonymous e-mail, and then we will look at that and begin our process.

So if we look at the next one down, medical provider referrals, that's generally going to be our Medicaid enrolled providers. And what we might see in an instance where a medical provider is making a referral, an example of that could be something like a home healthcare agency that receives

information or discovers through their own internal audit processes that maybe one of their home health aides is not actually performing all of the services that they're billing for. So that medical provider will bring that to our attention. By bringing it to our attention, they also help themselves by if we discover it, then we will bring action against them, as well as the provider. If they bring it to our attention, then we will focus on the individual home health aide because that provider, we felt, will have acted in good faith to bring that to our attention.

As we go down, we also get referrals from Bureau of Aging or Adult and Aging Services, formerly known as BEAS. So New Hampshire is -- obviously is a mandatory reporting state. Now, what BEAS will do is when they get a referral in or BAAS will do when they get a referral in is they will review it and they will prepare what's called a Law Enforcement Referral, a LERF. That LERF will then go out to whatever law enforcement agency they determine has jurisdiction over that location. They will also send a copy of that to our unit. So we are able to see all of the LERFs going out state-wide so that we can review them, and we are not going to be able to because it's not within our scope of authority to do something with all of them.

But some of them based on our -- our operational rules, such as being able to look at diversion, or exploitation, or abuse and neglect within a residential facility, what's called a board and care facility, if we find a LERF in there that meets that criteria, then we have the ability to either reach out to that police department and say, hey, we'll assist you on that or just do you need assistance on it. Some of them will say no. We are all set. We've got it. We've got good detectives that are able to take care of this, and we'll just let that go. If they say, no, we really could use the help, then we'll offer help or if they say we really just -- we don't know what to do with this, then we can take that investigation on and work that ourselves.

So as we continue down, Law Enforcement Referrals, that kind of gets back to the BAAS referrals that occasionally we will get a police department that maybe they got a report from a local citizen of some kind of financial exploitation or something along those lines. Or abuse and neglect of an individual in a nursing home within their facility. They can bring that to our attention and that, again, is another source of referral. We can work with them, we can let them work it, or we can take that investigation on ourselves.

Finally, we get down to federal agency referrals. We are actually -- um -- under the umbrella of the Department of Health and Human Services at the federal level, the Office of Inspector General. And occasionally we will get a referral from them, as we also get referrals in from our citizen that we send to them, where somebody has made a complaint against a -- for example, a Medicare issue. So Medicare is not something that we investigate. We investigate Medicaid fraud. Medicare is the federal side of that.

So if we get something in on our end that's related to Medicare, we will forward that on to HHS's OIG. In the same vein, if they get something that's Medicaid related, they will then forward that to us for -- for our action.

So as you look at this chart, as we move to the right, the next green box is kind of you can see all of the blue box is funneled down into the green. That's kind of the beginning of our review process.

Once we get it in, whatever the referral comes from, whatever it's nature is, we'll generally have two options. We can accept it or we can deny it. If we accept it, and you can see up at the top that we'll investigate. And let's say that our initial investigation is that it's a viable case. If it's a viable case, that we will investigate it, and

we will move towards prosecution. When we get to prosecution phase -- excuse me -- um -- we have two ways we can do that. The Medicaid Fraud Control Unit is able to prosecute both criminally and civilly. So if we have enough information that we were able to take this case criminally, criminal cases do have a higher standard. They're proof beyond a reasonable doubt, where as a civil case is preponderance of the evidence. So if we have enough evidence to show proof beyond a reasonable doubt, then we may take the case criminally. If not, if preponderance of the evidence is what we have to work with, we can still take the case civilly.

Conversely, our other option is if we investigate and we find that it's not really a viable case for any number of reasons, it's not something we can prosecute criminally or civilly, it doesn't mean the end of the case. We have other options. It becomes a non-prosecution for us; but once it's a non-prosecution, we can then refer that out to any number of entities, whether it's HHS, whether it's New Hampshire HHS, whether it's U.S. HHS, or whether it's some other entity. We can refer that back out for them to investigate.

If you look at the other side, to the deny side, it's kind of similar. We've got our non-prosecuting avenue if

we decide to deny the acceptance of that referral. And, again, looking at it, we can just see there's not enough information in there. It's just not something that we can make a case out of. We still have options and it still gets addressed. So the first is the non-prosecution side, and it gets referred out and there are other entities that can address that more appropriately.

And then, finally, we can look at a referral and if there just isn't enough information, for example, if we get a referral in from a Managed Care Organization and their referral is based on maybe their rules and regulations, most of these Managed Care Organizations are national levels, so they have multiple states that they work in, and they have rules that pertain to multiple -- excuse me, sorry -- jurisdictions. So it may be something that's not necessarily applicable to New Hampshire. We can look at that and we can say, yep, this referral that came in we're just going to deny this one. Denying it means it goes back to its source. We either send it back to HHS's Public Integrity Unit or it goes back to the MCO. It still gets investigated. It still gets reviewed. And in their review we look criminally, we look civilly, but the other option that's out there is administrative processes. We don't do the administrative process; but when I started saying that

we're part of a larger structure. The administrative processes are out there. If we can't prosecute something, it can end back at HHS, and they can go through administrative recoupment. If they look at the provider and say, yes, these do not comply with our rules, they can still issue a demand letter for repayment for those services. And if the demand isn't paid, then they can essentially garnish future reimbursement requests.

So that's the nice thing about the way we're structured is we're part of a larger structure. We can take referrals. We can take them criminally or civilly. But if it's not feasible, then we're also able to refer them to other locations where the matter is still addressed. It's never just dropped and not taken care of. There's other avenues that even if we can't prosecute it that -- that it can be taken care of. So that's basically the flowchart.

If I could just bring your attention, there was a couple other handouts that you received. Um -- one of them is kind of just a generalized flyer of who we are, what we do. It kind of explains the same thing that the Director went through. Uh -- you'll also find another one that is a summary sheet of our activity. And I won't take the time to go through that. It's -- I hope it's fairly self-explanatory. The take

away from that is this is basically about five years' worth of statistical information. And what it shows is our case settlements, resolutions, whether it's criminal convictions, civil finding, or a settlement of some type, and the amount of recoveries we brought in during that time period. And I've broken it down by our criminal cases and our civil cases. And as you can see, criminal to civil, we have pretty close to a 50/50 split on activity -- um -- the difference being the civil side, as is the nature of civil litigation, is the recoveries are quite a bit higher.

And then the last thing included in the handouts are just copies of our statutes, 167:61 (a), (b), and (c) just for reference purposes.

CHAIRMAN GRIFFIN: Thank you.

MR. BRACKETT: Thank you.

CHAIRMAN GRIFFIN: I want to ask our members if they have any questions, and I'll start with Senator Rosenwald.

CINDY ROSENWALD, State Senator, Senate District #13: I do, but Representative Weber had her hand up.

REP. WEBER: I'm perfectly happy to defer.

SEN. ROSENWALD: I thank you. I have two questions. Well, three, first one being where's Philip Bradley? Did he retire?

MR. BRACKETT: He did.

SEN. ROSENWALD: Oh, okay.

MR. BRACKETT: He did, yes.

SEN. ROSENWALD: Second one is looking at what you prosecuted over the past five years -- um -- in the civil side I see pharmaceutical manufacturer. What I don't see is Pharmacy Benefits Manager. And so because those entities have become so critical in the pharmaceutical supply chain, I'm wondering if you haven't prosecuted any or if you've lumped them in with the manufacturers.

MR. BRACKETT: If I could. We have not prosecuted any of them. As I indicated, that that's one of the things about our unit is we generally rely on some kind of referral. And a Pharmacy Benefits manufacturer type of manager type of litigation would most likely, just like the pharmaceuticals, come in as a Qui Tam. And at this point we have not received or seen any that have addressed that specific issue.

SEN. ROSENWALD: Interesting. Cuz I think there might be legislation this year that provides more transparency about that industry. But -- um -- second question is in the cases where both Medicare and Medicaid are involved in the same individual's coverage, and Medicaid pays first, would you get

involved in that or would you just say, oh, Medicare is part of this so you get advance.

MR. BRACKETT: If I could. We would -- we would take potentially a couple different tacks. There are cases that we have worked and some I can't discuss that we are working where they're joint investigations with the federal government. So if the case has both and it's relevant that there are both, we will work both.

Another example of that is the Qui Tams. Almost every Qui Tam has a component that is both Medicare and Medicaid. And that's why in those Qui Tam cases there is generally a primary U.S. Attorney's Office that is working the case on behalf of the Federal Government, and a collection of prosecutors and analysts from the states that is working at it from the state side of the house. So that the ultimate settlement involves both Medicare and Medicaid funds, and the settlement is then divvied up.

SEN. ROSENWALD: Oh, that's where I was going.

MR. BRACKETT: Necessary portion -- uh -- because the Medicaid Program as a whole also needs to be made whole. So in these cases there's also a portion where what's called the FMAP, the Federal Medical Assistance Percentage is returned to the Federal Government as part of the litigation.

And then what remains is then made available for distribution to the states and to the Federal Government based on the claims that each one of the states was able to show for quote, unquote, damages within their own jurisdiction.

SEN. ROSENWALD: Thank you. If I could just have one more question?

CHAIRMAN GRIFFIN: Yes.

SEN. ROSENWALD: So in our revenues we see Medicaid recoveries. I think of them as recoveries from the estates of deceased individuals; but would it include these recoveries as well? It's about -- um -- I think three hundred or four hundred. I mean, it's small thousand a year.

MR. BRACKETT: Yes.

SEN. ROSENWALD: Where does this money go when you recover it from -- for Medicaid?

MR. BRACKETT: If I can. It goes back to HHS. So when we do a recovery for our cases, whether it's a Qui Tam or one of its -- one of our cases, if it's a case that is just a state case, then we have it -- it prearranged with Department of Health and Human Services where we will transfer that payment to them, and it will go into two separate job codes in their organization. Those two separate job codes are to designate for them where those funds are ultimately going.

So a portion will go into a fund that they retain. That's probably some of what you see. And then the other portion will go into an account that they know that they have to send that back to the Federal Medicaid Program to make them whole as part of that FMAP. That's required.

SEN. ROSENWALD: Thank you. Thank you, Mr. Chair.

CHAIRMAN GRIFFIN: Representative Weber.

REP. WEBER: Thank you, Mr. Chairman. And thank you for taking my question. Um -- Senator Rosenwald actually covered some of the things that I was interested in, but this is fascinating. Thank you for the presentation.

Um -- one of my questions was a little bit more about the Qui Tam process. So that's where -- did I understand correctly that an individual who knows something about this starts this process and so there's one named individual. Is -- is there -- presumably they get some of the recovery is the reason for doing all of this. So there's a little skim off the top there; but they've done some leg work to get things started; is that correct?

MR. BRACKETT: Correct.

REP. WEBER: Okay.

MR. BRACKETT: They do receive. It can be

between 15 and 30% sometimes.

REP. WEBER: Okay. So they're doing really well.

MR. BRACKETT: They are.

REP. WEBER: If it's a multi-state prosecution.

MR. BRACKETT: Yes, yes, yes. These are -- these are multi-million dollar, hundred million dollars in cases.

REP. WEBER: Okay. And I assume that there is a plaintiff's bar that's dedicated to that because it would be quite lucrative if you found something that was inappropriate. You know, where you had --

MR. BRACKETT: Yes.

REP. WEBER: -- where you had the appropriate level of --

MR. BRACKETT: Yes.

REP. WEBER: -- proof available.

ATTORNEY BUCCA: That would be fair to say.

REP. WEBER: Yeah. Okay. Oh, my, I am just in the wrong profession.

ATTORNEY BUCCA: No, you're not.

REP. WEBER: And then I guess because it's obviously the biggest thing in the room -- well, let me do the

small one first. I'm interested a little bit in the durable medical equipment because I am of the age if I answer the phone it is quite often somebody who is -- wants to talk to me about my Medicare benefits, and often they think I need a knee brace. Um -- and I never go far enough with those calls to figure out whether they're going to then say they just need my bank account or credit card so that they can mail me my knee brace or whether they are going to bill inappropriately for the knee brace that I don't need. So I wondered if -- I wondered a little bit about those.

MR. BUCCA: Certainly, it could be either of these.

REP. WEBER: It could be either of those.

MR. BUCCA: If they ask you what street you grew up on or what your high school mascot was, don't answer.

REP. WEBER: Right. Got it.

MR. BUCCA: If you were looking for durable medical equipment, I wouldn't purchase it from anyone who cold called you.

REP. WEBER: No, nor would I.

MR. BRACKETT: And if I could just add, the durable medical equipment is by its definition is medical equipment that is durable enough to sustain multiple uses. But

it's also prescription required in most cases.

REP. WEBER: Uh-huh.

MR. BRACKETT: So, generally, you're going to have to have a medical provider that's going to issue you a prescription for those items.

REP. WEBER: Okay.

MR. BRACKETT: If you're getting cold calls, then it may well be that they're not entirely legitimate.

REP. WEBER: Well, no, I know they're not entirely legitimate; but my assumption is that they're probably looking to scam from me rather than scamming from somewhere where there are usually the provider, all the other stuff, you know, and they'll say you don't need to go to your doctor. But I think it would be easier just to get hold of my credit card if they were trying that one.

MR. BRACKETT: But to be honest with you, it could be both.

REP. WEBER: It could be both. Okay. Um -- and then I guess I want to know a little bit more about the pharmaceutical manufacturer ones just because it's the biggest tranche of the whole thing. And I think you said -- I'd just like to hear a little bit more about that. Obviously, some of it may be substituting generics for brand names; but -- um --

what kind of cases are in there?

MR. BRACKETT: The -- uh --

REP. WEBER: And -- and were those started locally or were they Qui Tams?

MR. BRACKETT: All of them have been Qui Tams.

REP. WEBER: Okay.

MR. BRACKETT: Those are the kind of cases that are extremely difficult to work, unless you have somebody inside. And, again, the relator, relator in a Qui Tam is somebody that has to have personal knowledge of what's taking place. So those cases are very difficult to work otherwise.

REP. WEBER: I see.

MR. BRACKETT: And they could be for any number of activities. They could be substituting pharmaceutical types. They could be generics. It really could be anything. But those -- those are almost entirely Qui Tams.

REP. WEBER: Hm-hum.

MR. BRACKETT: And it, unfortunately, New Hampshire just doesn't have the -- the resources with eight of us in the unit. So we -- we don't generally participate on those national teams. It tends to be the larger states. So we will see the complaints and the general information, but we're generally not neck deep in those type of cases --

REP. WEBER: Okay.

MR. BRACKETT: -- to see the particulars of what is taking place.

REP. WEBER: Okay. And if I may have one final one. So that brings me to the question that is the area that I actually do know something about -- um -- which is the area of elderly exploitation. And I'm wondering where in this that falls. I mean, it might be the personal care attendant, home health agency ones, or possibly the assisted-living or nursing facility. Is that where those kinds of cases would fall, because that is an easy target, and I think it's a way infinitely more widespread than anything we ever document.

MR. BRACKETT: Absolutely. Our office also has the benefit of having an elder abuse and exploitation unit that is specifically tasked with that. Um --

REP. WEBER: So those figures would not show up here.

MR. BRACKETT: Absolutely.

REP. WEBER: Okay. Gotcha.

MR. BRACKETT: What we have basically worked out between the Medicaid Fraud Control Unit and the Elder Abuse Unit is we tend to focus on those cases that are in a residential facility. A quote, unquote, board and care, which

is generally a facility that has two or more unrelated individuals that are receiving care for activities of daily living.

So in that circumstance, exploitation, abuse and neglect, we will tend to focus on those. Almost any other situation those are handled by our Elder Abuse Unit.

REP. WEBER: Okay. Thank you very much. Appreciate it. Thank you, Mr. Chairman.

CHAIRMAN GRIFFIN: Are there any other questions? I have -- I have a question. Um -- you recovered over five years, you recovered the best part of $4 million, if I'm looking at the figures correctly. How much of that does the State get to keep?

MR. BRACKETT: And it -- I guess that's kind of a loaded question. It depends on what part of the state. But, for the most part, what we're seeing here is the -- the raw numbers as they come in from the litigation itself. So because we're talking Medicaid, we're talking roughly a 50% Federal Medical Assistance Percentage. So about half of that would go back to the Federal Government to make the Medicaid Program whole, and the bulk of the rest of it usually ends up going back to Department of Health and Human Services. Our -- our unit, our agency, keeps very little of it.

CHAIRMAN GRIFFIN: And one final question. Are there any -- are there any statistics that show where New Hampshire stands on a national basis as far as Medicare fraud and fraud stands, or do you have any gut feelings?

MR. BRACKETT: Charges or just general statistics on the level of fraud?

CHAIRMAN GRIFFIN: Yeah, the -- how -- where does New Hampshire stand in terms of the level of fraud in Medicare versus other states? Are there any statistics on that or do you have any gut feel on it?

MR. BRACKETT: To be honest with you, I don't know of any statistics that would categorize that.

CHAIRMAN GRIFFIN: Okay. If there's no other -- Representative Weber.

REP. WEBER: If I may? One of your questions raised another question for me. So the numbers we have here, are these numbers what the State of New Hampshire actually received or are they the numbers before that we have returned the federal match to the federal authorities?

MR. BRACKETT: These numbers are the raw numbers that we received as part of the settlement.

REP. WEBER: Okay.

MR. BRACKETT: So they represent what our unit

brought back in these cases.

REP. WEBER: Okay.

MR. BRACKETT: Not necessarily what the State retains.

REP. WEBER: Okay. So the State retains some portion less than the numbers that we have here.

MR. BRACKETT: Correct.

REP. WEBER: What were the costs of running your unit for the last five years?

MR. BRACKETT: I don't have that information off the top of my head.

REP. WEBER: Okay. Well, I just -- I was interested. Thank you so much.

KEITH ERF, State Representative, Hillsborough County, District #28: Mr. Chair.

CHAIRMAN GRIFFIN: Yes.

REP. ERF: Can I ask a question?

CHAIRMAN GRIFFIN: Yes.

REP. ERF: So just to put things in perspective, are we in the same league as Minnesota in terms of our fraud?

MR. BUCCA: No.

MR. BRACKETT: I would have to say no as well.

REP. ERF: Okay. So -- so there is a difference

between --

MR. BRACKETT: Yes.

REP. ERF: Would you argue -- well, would you guess that we're one of the better states as far as Medicaid fraud being low?

MR. BRACKETT: From a personal standpoint, I would argue that New Hampshire is one of the better states. Um -- but as far as empirically statistically, I believe so, but I can't ground that in any kind of actual factual information.

REP. ERF: Okay. Thank you.

CHAIRMAN GRIFFIN: Well, we thank you both. I'm sorry. Senator Lang.

TIMOTHY LANG, State Senator, Senate District #02: Nope, that's okay. I'm just going to tackle -- I just want to make sure I'm clear on the revenue side. Considering I'm the Chair of Ways and Means, I want to know where the revenue goes.

So $5.2 million over the last five years was the gross take between the civil and criminal cases. Of that you say roughly 50% goes back to the Feds. So the State ends up holding onto approximately $2.6 million over the five years, which works out to be about 500k per year, is what the -- is what the State ends up with. Is that rough math work?

MR. BRACKETT: Rough math, yes. The other thing to consider in this process is, again, these are settlement numbers. Settlements are not always lump sum payments. A Qui Tam, for example, may have a payment schedule over five to ten years. Um -- even some of our local cases may have extended payment plans where the court has found that the individual just does not have the financial means to payoff the obligations. So they're paying off, say, $50 a month for however long.

SEN. LANG: I understand master settlement agreements and other things.

MR. BRACKETT: Yes.

SEN. LANG: And I get that. One more follow-up.

CHAIRMAN GRIFFIN: Yes.

SEN. LANG: And so it looks in total over the last five years we've had 60 cases, roughly about twelve cases a year. Does that work about right?

MR. BRACKETT: Correct, ballpark.

SEN. LANG: Thank you.

CHAIRMAN GRIFFIN: We thank you both for coming. Your -- your presentation has been very enlightening for us, and we appreciate you coming in and sharing it with us.

MR. BUCCA: Thank you. Thank you for allowing

us the opportunity to be heard.

CHAIRMAN GRIFFIN: How about Health and Human Services, are you guys set? {Inaudible}. Would you please identify yourselves for the record?

MEREDITH TELUS, Director, Division of Program Quality and Integrity, Department of Health and Human Services: Good morning. My name is Meredith Telus. I'm the Director of the Division of Program Quality and Integrity for the Department of Health and Human Services.

NATHAN WHITE, Chief Financial Officer, Department of Health and Human Services: And Nathan White, Chief Financial Officer with the Department of Health and Human Services. Good morning.

CHAIRMAN GRIFFIN: Good morning. Thank you. I think I hit -- hit on some of this before. But we're pretty -- pretty much focused on the -- on the outside contracts and how you -- how you keep a finger on them and control over them. It appears that in other states that's where most of the fraud has been happening, and we want to ensure that we have sufficient control over the -- uh -- I guess we call them the contractors. So the microphone is yours, feel free.

MR. WHITE: Great. Thank you for the opportunity to present. Um -- so this morning Meredith and I,

we're going to be covering various functions at the Department relative to contract management oversight and some of our procedures as well that we utilize on a regular basis.

So if you turn to Page 2, you'll see the agenda. There is no page number. I apologize. But if you do turn to the second page, you'll see the agenda there. And so Meredith and I are going to start with some of the basics around contract management. And then I'm going to be discussing some of the fiscal management, and then Meredith is going to be moving into some of the programs specific reviews that correspond quite nicely with your prior presenters. Her team works directly with that team as well.

So if you move forward past the next contract management slide to the slide that is entitled Contracts Are Critical to DHHS' Ability to Serve Clients. I think the statement itself is quite important. I just wanted to take a moment to highlight that.

So HHS has many different types of contracts and Meredith is going to cover what those agreement types look like. But we -- we have -- we think of this in almost like two different ways. One is where we have contractors that are providing services directly to citizens in New Hampshire to the community. And -- and those you'll see there in the first box.

Our area agencies, our Community Mental Health Centers, Meals on Wheels Programs, these are all critical programs that we rely on our contractors to provide directly on behalf. And I'm going to use the word subrecipient when I'm talking about those providers. And subrecipient is an important term. It's under Federal Uniform Guidance. There's specific federal requirements and actions that you have to take with enhanced oversight. And the reason for that is because we don't necessarily, we wouldn't know unless we checked whether those services were being provided with fidelity and effectively. And I think about the next box there, those are the services provided directly to HHS. And when I say contractors, I'm thinking about these. These are our contractors.

So these are the folks that provide maintenance for some of the very sophisticated technology and tools that we have at our Public Health Lab, most of which I cannot pronounce. They also provide services to our 24/7 facilities. So podiatry services at Glencliff Home. There might be fire extinguisher services at New Hampshire Hospital, kitchen, whatever it may be, as well as our IT and data systems for our NewHeight Systems, our MMIS, and otherwise.

If you turn to the next page, one of the core principles when it comes to good contract management is you

have to have a good contract. And to have a good contract, you need to make sure that you have a very strong system that incorporates key business requirements and keeps the process itself fair, and competitive, and objective, at a reasonable price and at an effective price.

This slide here, this just highlights some of the key principles that HHS adheres to when we're setting up our -- when we're setting up our procurements, which happen in advance of entering into our contracts. And we always make sure that we ensure a fair, competitive process, so that there is no ability for any external party to influence what ends up being an RFP and, ultimately, what ends up being in a contract. Because then it would favor them, and it would introduce a level of risk that we're talking about here as far as the ability to -- um -- manipulate the -- the contract or the payment terms.

Um -- key to that as well is -- is integrity of the bidding process. We make sure that anybody that is on our team is qualified. They have no conflicts of interest. We do make -- occasionally we do have external parties participate in our scoring teams under rare circumstances. Under those circumstances they also have to sign certain disclosure documents. And, ultimately, we're seeking that we get the

highest quality service for the lowest price, and there's a balance between those things. And we use different solicitation tools. And I won't go into all the details of an RFP, versus an RFA, versus an RFQ or an RFI. Suffice to say there is a team that is designated at HHS that continually looks at this.

If you turn to the next page, I provided something similar to this Committee probably two years ago on the centralized procurement team that HHS has that puts the contracts together. This is just a quick reminder document. About seven or eight years ago, HHS set-off on a very intensive effort to modernize its centralized procurement functions. The Legislature since then provided subsequent positions to support that effort. Um -- and there has been much improvement in that area where we took it from a paper-based process to a digital-based process that now we can forecast every procurement. We have dashboards that we use internally. I can tell you where any solicitation is in process, how many parties are involved, who's involved through a few clicks of a button.

It's been a tremendous amount of work. I can't speak enough to the positive work that Robert Moore, the Director there, has done with his team and continues to do everyday. And the reason that I'm highlighting this again is

because a contract doesn't just happen overnight. And what is in a contract is very important, because if you don't have teeth in a contract, you cannot hold somebody accountable, both when you're managing it and if something goes sideways.

So moving on. I'm going -- I'm going to hand this next slide over to Meredith, and this has to do with some of the road map initiatives and the overall improvements that we have been making to the larger contract life cycle. I was only referring to the procurement stage; but there's many other phases of the process. And, again, we're starting at a high level, and we will get closer to the questions that I believe you'd like to get into today. Go ahead, Meredith.

MS. TELUS: Thank you, Nathan. So yeah, as Nathan was noting, the former slides that we were referring to really have to do with the procurement process because if the procurement isn't -- isn't standardized and isn't done appropriately, then we can't do the contract management appropriately.

So -- um -- as part of a road map initiative, we've developed a contract life cycle management policy. This is the first time we've had an extensive policy within the Department that really outlines everybody's roles and responsibilities as part of the contracting process. And it's

split up into phases of contracting.

So phase one actually starts with planning before the procurement even takes place. And in the planning phase that's where leadership and -- within the program and finance need to come together and say strategically what is the procurement that we need in order to accomplish our goals and meet our statutory obligations.

So there's a planning phase that's outlined in this policy. Then there's the procurement phase as we were just referring to. Then there's the active contract management phase, which is where we really get into the meat of a contract that's been executed, approved by G&C, and now we actually need to manage this contract to our expectations.

And then finally, there's a closeout phase. And so each of these is well-developed in this policy to tell everyone in the Department what their role is and what the expectations is for their part of the process.

And on the next slide, which looks like this -- yeah. Oh, everyone's on the right slide. Okay. Great. Contract management. The contract quality management.

So we do have within the Division of Program Quality and Integrity in our -- um -- Bureau of Program Quality, we have a unit that is actually dedicated to contracts

quality management. And there's two to three people in that unit. We just had a vacancy, so we have two people now, that are dedicated to working with individual program areas on their contracts to help them manage those contracts better. And they're developing standardized tools that everyone can use across the Department for contract management.

So what you'll see here in this bulleted list are specific tools that have been developed that we can sit with an individual contract manager and say, "Here's what you're going to need to use to help manage this contract better and work directly with your contractor."

So some of these are, like, tracking deliverables, developing outcome metrics, which is very tricky to get outcome metrics that are appropriate. Outcome reporting and trend analysis, communication logs, issue logs, issue escalation process, so that when something is not getting resolved with your contractor, you have -- you know what to do next, who are you going to, and how are you going to resolve this problem, and it doesn't just sit. Um -- and then contract evaluations that we do at a midpoint and an end point to determine was that contract successful in meeting the Department's goals.

And on the next slide, which looks like this,

this -- this slide is really, just to point out to the Committee, that there are many different kinds of agreements that we have with people who provide services for the Department. So we're referring to contractors and that is we have 800 contracts a year, something like that. Eight hundred to a thousand contracts a year. We have many, many contracts every year. But there's within that a number of different agreement types. And, also, there are providers. And the right-hand side of this slide is just pointing out that the Department also has providers with whom we may or may not have a signed agreement. And those are still people who may be receiving dollars from the Department. So child care providers, Medicaid providers, we may not have a signed contract that has been, you know, put to bid and negotiated and then -- and then signed by both parties.

For a Medicaid provider, we have a standard provider participating agreement. They sign that agreement or they don't sign it, but there's no negotiation. It's, you know, if you've chosen to become a New Hampshire Medicaid provider to receive Medicaid money, you will abide by the administrative rules, and the terms of this provider participating agreement. So I just put it in a slightly different category than a standard contract.

MR. WHITE: And now we're going to move forward to fiscal management. So with all of our contracts -- um -- again, it depends on the nature of the contract, what service we're buying or paying for -- um -- that helps drive the question of how are we paying them. And many of our contracts are cost reimbursement. And with cost reimbursement, we don't pay a dollar until you can show us that you've actually incurred that expense. And that is a very low-risk model for payment.

Um -- generally speaking, we do not utilize advance payments. We do occasionally, but under fairly rare circumstances. I think the opioid abatement contract that recently went to G&C probably six months ago is one of the few instances in which we make an advanced payment, but it was to another governmental organization. And because of that, that helps lower our overall level of risk. That does create, and I will openly admit, that does create a process though where you can see delays in payments, because we are taking a lower risk approach to that. And our teams work diligently with our providers and our contractors to show them what is the type of supporting documentation that we need to see in order to pay you.

We do have other models of payment where we may

pay on a deliverable or a specific outcome. I think IT projects where you know you're getting the service, you've seen that they've built the system, you've tested it, that's more of a deliverable-based model that we look at.

We also have some rate-based. And if you look at some of our residential provider contracts, we ask them, we say show us all your financials, show us what your operating costs are. Based on those operating costs, we will pay you X amount of dollars per child, per bed, per day. And, again, there's supporting documentation that goes along with that. But, either way, we don't make payment, generally speaking, unless we have the supporting documentation that ensures that that service, that deliverable, has been achieved. And that does, again, that does create friction. I have gotten calls from Senators saying, "Hey, I've talked to so and so. How come you haven't paid them?" And I said, "Well, because they haven't given me this. And I'm not comfortable having my team make that payment until we can assure that we're getting what we need." Um -- and that's just part of that balance between making sure that we do a good job, and with -- with the integrity of the funds and acting as a fiduciary, a responsible fiduciary, and making sure that we can also get the services out the door and ensure that the providers in the community can

continue to operate. And that's a tricky balance that -- that we navigate everyday.

Um -- we have -- we have -- so on the box there, subrecipient monitoring policy, this is the policy that we utilize for our subrecipients. Again, our subrecipients are generally those providers that are providing services on behalf of the Department; our Community Mental Health Centers, our Regional Public Networks. Those are generally considered to be subrecipients, and we have a specific policy. That rule comes from the Federal Government, but we apply it to our general funds. We do not take a lower standard approach with our general funds. We take the exact same approach to ensure that we have proper oversight, and that -- that is attached to this presentation.

Um -- we also -- uh -- we do have a Financial Compliance Unit that assists many of the individuals across the Department that are managing these contracts on a daily basis and they will provide when we -- when we see a problem, when something doesn't feel right, we will send that team on-site with the other folks, and they have expertise in auditing and they assist with -- uh -- complicated and sophisticated field audits, getting financials, looking at file reviews to ensure that the services are delivered. That's sort of one, and that

team reports to Meredith, and that's a very important tool -- uh -- and -- and resource that we have that, again, we use where we see higher risk activities. Um -- so that's -- that's a high-level overview of that.

On the next slide, I just want to highlight the enhanced subrecipient risk assessment process.

So going back to what I was talking about at the beginning, before we enter into a contract, if we're -- if we're going to have a subrecipient, we conduct a risk assessment. And there's two major components to that risk assessment. We get their audited financial statements, and we have a tool that we use that looks at various factors, such as liquidity or cash on hand, and then we assign a score. And then we also look at their operations. Did they recently have a change in leadership? Do they have prior audit findings? Did they change their accounting system recently? Have they gone through some major reconstruction? Those are all risks that we see; but then we also ask the question have you done this program before, which would certainly lower some of those risks.

And based on what we see in that risk assessment, we actually incorporate those components of risk into the contract itself. It might be in the payment terms.

It might be in scope of service. We might be enhancing the number of times we meet with them. We might be requiring more reporting. It just depends on the nature and the circumstance -- um -- and that really helps manage that risk on a regular and ongoing basis. Again, that's why the -- like it's so important that you do an RFP or an RFA correctly because that serves as the foundation of the contract, which serves as the foundation for mitigating risk and proper oversight. So I will move that over to Meredith for program oversight.

MS. TELUS: So in this section, I just wanted to -- um -- take a moment to go over some of the specific -- areas of specific program oversight that I heard come up in the Committee last time you met. Um -- so just have a chance to address some of those.

So within the Division of Program Quality and Integrity in our Bureau of Program Integrity, we have Special Investigations Unit, and they are actually responsible for investigating beneficiary fraud, instances of beneficiary fraud. Um -- so the cases they do are primarily SNAP, but they do all cases of beneficiary fraud.

And on the right-hand side -- yes, right-hand side you'll see this -- uh -- chart here that just shows -- um

-- referrals to this unit in a year. So this is actually, and I apologize, this is not labeled, this is actually Calendar Year 2025.

Um -- so the majority of the referrals that we get related to beneficiary fraud and referrals come in from all over. They can be friends, family members, neighbors. Um -- they're often the -- um -- Human Service Specialists that work within our District Offices can make referrals to our unit. And of the referrals that we get, the majority are SNAP cases. You'll note that the numbers here do not add up to 1,434, and that's because a single case can include multiple benefit types. So they overlap within the case.

Um -- we're federally required to investigate any referrals for SNAP fraud, and so that we train the District Offices to make those referrals to us. Um -- but we also investigate TANF, child care, Medicaid, and other program fraud. And so just to highlight, in State Fiscal Year 2025, this unit had 364 investigations. So, the chart, again, is on a calendar year; but the number of referrals we get is pretty steady year to year. So over a thousand referrals for SNAP. Of those, 364, once we looked at them, were actually worthy of an investigation. Of the ones we investigated, 92 resulted in what we would refer to as an intentional program violation. So

where the person actually, we felt, was -- um -- fraudulent in representing something. And 111 household members were disqualified as a result of that. And we had $611,000 worth of claims established just on -- on those cases.

So -- um -- the number of -- of referrals, I just want to point out that, you know, for SNAP in particular, so 1200 referrals, they may or may not result in an investigation. But if there is any instance of client error or agency error in making a determination of eligibility, we will still establish a claim against the case and recoup the funds. I just want to point that out.

On the next slide is the discussion of Medicaid Program Integrity, and this is where we investigate the provider fraud, waste, and abuse.

So something I just want to highlight. Our partners are not still here, but -- um -- in many states — when I started I was somewhat surprised to find out — many states work very siloed from their MFCUs. So the MFCUs and the DOJs are doing their thing prosecuting Medicaid fraud, and the Program Integrity Unit within a Department of Health and Human Services or Division, however it works out in other states, are doing their thing investigating, and recovering overpayments administratively, but they are not collaborative. And, in

fact, in many states, they have a reputation of being acrimonious.

We have an incredibly collaborative relationship with our MFCU. We meet with them monthly at a minimum. They're involved in our conversations with the MCOs. We'll have co-meetings where we are meeting with our managed care plans and the MFCUs with us in those conversations. So we have a very, very close relationship. And -- and I just find it -- um -- unfortunate, somewhat funny and unfortunate that other states aren't as lucky as we are to have this very close relationship.

Um -- so as -- as was discussed with the MFCU a little earlier though, the process really is that the referrals come to the state or to our managed care plans. And they can come from beneficiaries who were receiving services -- um -- from staff at a provider, peer providers, anyone can call with a referral for potential fraud, waste, or abuse. Providers can self-report that they had an issue and sometimes providers self-audit. Sometimes we direct them to self-audit. Sometimes they just do self-audit, and then they'll call us and let us know that they misbilled something.

We also do data analytics. We do it and we require our managed care plans to do data analytics to find

outliers, peer outliers within a group based on billing. Um -- either of those -- either referral or data analytics will result in investigations. And so we investigate initially or our managed care plans investigate, and those can result in something that looks like what we'll call waste or abuse where someone did something they shouldn't have, and it resulted in overpayment. Or it can result in what we think of as fraud, which means there was intent, intent to defraud. And whenever there is, we think, intent to defraud that results in a referral to MFCU, we don't handle fraud ourselves. It has to go to the MFCU.

And if it is not a fraud case, it will result in recoveries. So we will do a recovery or our managed care plans will do the recovery. And last year that was amounted to about a million dollars worth of recoveries. That's total funds. Or it can result in prosecution at MFCU. And as they discussed with you that can be civil, it can be criminal, and there were 58 open cases last year. Nineteen were closed -- um -- ten of which had a criminal conviction or civil prosecution or a referral to a federal agency.

And then on the last slide -- um -- child care provider and beneficiary audits. So provider reviews, this is not federally required, but it's something that we do, because

we think that it's prudent. We do a monthly sample of child care providers to evaluate compliance with attendance and signatures and documentation and records. In State Fiscal Year 25 we reviewed 28 providers. Nineteen of those resulted in findings. Um -- sixteen we found overpayments and we recouped $18,000.

We also do child care subsidy audits on the beneficiary side. This is federally required to be done every three years. We're currently in the middle of one of those. But we do also choose to do reviews in the intervening two years. That's not federally required, but we just -- we don't want to wait every three years to do these reviews. So we're kind of doing them constantly. And when we do these reviews, either on the provider side or the beneficiary side, we then turnaround and work very closely with our Bureau of Family Assistance to make sure that they are looking at their processes in internal controls. So that we're identifying what are the most commonly made mistakes. Is it something that's happening within the system, is it something that's happening because of human error, and how can we mitigate those so that they don't reoccur.

And that is the end of our presentation. Um -- we do have a couple of other attachments here. I just want to

point out, I think during the discussion last month -- um -- Mr. Chair, you had asked for an org chart so that you can understand kind of how we're organized and how we do some of this work. And so we've included an org chart that covers the Department. You'll see within this under operations, the Division of Program Quality and Integrity, and Program Quality and Program Integrity are two of the Bureaus under there. Most of what is covered in the -- in the latter part of this presentation is within the Division of Program Quality and Integrity. Contracts, contract management, and our grants administrator are within the Division of Finance, just to cover that.

CHAIRMAN GRIFFIN: Well, thank -- thank you very much. The presentation was very informative and complete. Uh -- we lost a couple of our members to another Committee that's taking votes at this point. But I know one of our members last -- last time raised an issue about SNAP. And he had some statistics at the time. And he noted that there were a lot of single males on SNAP, and he wondered why that came about, that there was such a large number of single males on SNAP. Would you address that?

MR. WHITE: Um -- I -- I think we need to see the -- the -- the data to better understand that conclusion.

Um -- I think in terms of the -- of the question that was asked earlier and some of the concerns around the fraud question. So if you look at about three slides back, the 111 household members that were disqualified, so annually we see about 75,000 participants. So that's about a .0014 percent rate. So I -- I think as far as the broader question of is there rampant fraud or abuse happening -- um -- I think a prudent person would conclude .0014 percent is pretty low comparatively to see what we have seen in the news and other realms. So I -- I -- I -- I can follow-up with Representative Erf on that question to understand the data that he's looking at and --

CHAIRMAN GRIFFIN: I think it was Representative Weyler.

MR. WHITE: Representative Weyler. Sure, I can follow-up with him.

SEN. ROSENWALD: Thank you.

CHAIRMAN GRIFFIN: Senator Rosenwald.

SEN. ROSENWALD: So, Nathan, where does the money go, the one million --

MR. WHITE: Yes.

SEN. ROSENWALD: -- that -- um -- in recoveries; for example, in the previous fiscal year? Does that -- is that the line that we see on the daily revenues that says Medicaid

recoveries?

MS. TELUS: The -- if it is a fee-for-service recovery, that would come back to the Department. If it's a managed care recovery, they retain the monies, and they recover the money in one of two ways. Either it's a recovery in claims. So they're recouping it from future claims to that provider. They're reducing their claims to that provider by whatever amount is owed or it's coming back in a check to the MCOs, a separate financial transaction. We make sure that our actuary for Medicaid is aware of both of those amounts. If it's in the claims, they'll automatically see it. If it comes back as a check, we make sure that the actuary gets reports of all of those transactions from each of the MCOs, and then that amount is used to reduce the Medicaid rate that we're paying out to the MCO.

So the MCO portion does not come back to the Department. It's used to reduce the rates in the first instance that are going out the door; but the fee-for-service portion is coming back to the Department.

MR. WHITE: Yes. And -- and -- and so in -- in -- in the daily revenues and the discussion with -- with Senator Lang earlier -- um -- with the unrestricted revenues, so this year I think overall we're looking at currently

projecting about just shy of $3 million in total. So what's coming back, the fee-for-service, so year-to-date through January from the AG's Office Fraud Unit, we saw about $38,000 in total.

Um -- most of the revenue that we do receive is from the estate recoveries, the Medicaid estate recoveries team. And, again, that's really hard to predict because we could have a really big windfall because a couple of large cases were settled. It doesn't necessarily happen in a linear fashion. So we don't have control over most of that.

MS. TELUS: And I'll just add, so the portion from the AG's Office is just the fraud portion. There's other waste and abuse that we're getting through fee-for-service that's just an overpayment that we recoup administratively.

Similarly, though, these are smaller numbers because our fee-for-service population is very small proportion of the overall program.

SEN. ROSENWALD: Ten percent of Medicaid --

MS. TELUS: Right.

SEN. ROSENWALD: -- is fee-for-service. I have a couple other questions.

CHAIRMAN GRIFFIN: Senator Rosenwald.

SEN. ROSENWALD: Thank you. Um -- so -- um --

this -- this is a very small error rate or fraud rate in SNAP; and, yet, we were over the threshold for getting stuck with higher administrative costs. Is that because of Department error --

MS. TELUS: Yes.

SEN. ROSENWALD: -- rather than fraud?

MS. TELUS: That's a -- that's a great question. That's exactly right. So, this is related to referrals that have come in where someone suspects some kind of fraud. And that's where all of these numbers are coming from. We have to get a referral into the SIU in order to know whether or not someone may be committing fraud. And that is totally separate from the error rate, which is determined by a different unit.

MR. WHITE: And -- and, again, the error rate is -- is not fraud and should never be considered as such. It -- it could be as simple as someone making a phone call and reporting what their income was, and then missing a digit or reporting the wrong thing. And so an error rate can be both overpayments or underpayments and primarily due to administrative errors that can happen during manual processes.

Um -- the Department is in the process of upgrading the system to try to minimize and automate some manual processing to deal with that. The team that does that

is -- is seeing higher vacancy rates, which certainly doesn't help. But we have been very intentionally looking at what the processes are that exist, how to correct and control for those to improve them because to your point, Senator Rosenwald, as a result of the changes in HR1, beginning in -- um -- well, actually, beginning in next State Fiscal Year, we will start to see some impacts from those changes. And then in State Fiscal Year 28, we will see three-quarters of impact. So that if we fall below a certain percentage, the State may be on the hook for millions of dollars if our error rate exceeds that percentage. And there's very few states in the country today that are below the federal threshold that was established.

SEN. ROSENWALD: I'm sure that was done on purpose. If I could, one more?

CHAIRMAN GRIFFIN: Please.

SEN. ROSENWALD: Um -- the Rural Health Transformation Grant that -- um -- were not competitively bid went to the Executive Council, got tabled this week. Um -- some of the grantees are state. I guess I'd call the University System an agency. I don't know, a state -- part of the State. But some of them are private, like the Community Mental Health Association -- um -- and the Foundation for Healthy Communities. They're getting millions of dollars of

grants and they're subgranting. What is the process for the Department to make sure that they're doing all of the outcome measurement and integrity and how are you checking up on these subgrantees?

MR. WHITE: So the Governor's Office Go-North is receiving $202 million of the funds. HHS is acting as the pass-through. So our Department will not be directly actively managing those. We will be supporting strategically subject matter expertise; but Go-North will be ensuring that those sub -- sub awards have teeth in them.

Um -- I -- I know that if you looked at the contracts themselves, there are provisions within them that require that the -- any recipient come back through Go-North before they make an award to make sure that the process was followed. I know that those contracts also included specific procurement language to make sure that the integrity of the system and the spirit of the competitive bidding process was upheld. And -- um -- as -- as you probably heard, the councilors raised some of the same concerns, and I believe the Go-North Office and team will be having conversations over the next two weeks.

SEN. ROSENWALD: So David Schwan (Phonetic spelling), he's going to do all of this himself?

MR. WHITE: Donna Lee Lozeau is the Director. Whitney Hammond has also the been assigned to that team and they're building the Go-North team as -- as we speak.

SEN. ROSENWALD: Thank you.

MS TELUS: If I can --

SEN. ROSENWALD: It's a lot of work.

MS. TELUS: -- just add. During the development of the submission for the Rural Health Transformation Grant, we worked very extensively on output and outcome measures that would be anticipated and that was part of a requirement of the grant. So they a have a basis with which to work. I'm not saying the measures we picked rather rapidly during the submission are going to be the final ones that they use, but -- um -- ultimately over time, but -- but they do have a lot of work has been done to consider what will be measured during the course of the grant lifetime.

SEN. ROSENWALD: Thank you.

CHAIRMAN GRIFFIN: From -- from what we see in the news media, it appears that a lot of the fraud that's coming to light is -- is in the daycare area. Have you stepped up our -- our reviews of that area?

MS. TELUS: That was in the last slide of the presentation. That is -- those are the provider reviews and

beneficiary reviews that I'm referring to there. Those areas are not federally required, and we started doing those a couple years ago, because we decided it was just prudent.

CHAIRMAN GRIFFIN: But have you stepped them up recently in the light of what's going on?

MS. TELUS: Increased them? We're at capacity for how much we can do for both of these. So -- um -- at this time. But we rotate. So it's a sample. So we rotate across the state so that we make sure we hit all of the providers eventually.

CHAIRMAN GRIFFIN: Okay.

MS. TELUS: And, also, I will mention, too, sorry, it is also risk-based. So we're taking providers and beneficiary instances where something pops out in the data to make them look somewhat risky in the first instance.

CHAIRMAN GRIFFIN: Thank you. Representative Weber.

REP. WEBER: Thank you, Mr. Chairman. Thank you for taking my question. So, just because I'm not on any of the financial committees -- uh -- when we go back to these, which are really useful, really helpful -- um -- am I right in thinking that the $611,000 in claims are ones that are recovered -- are claims rather from recipients rather than and

the over a million on the next page is providers?

MS. TELUS: Correct.

REP. WEBER: Okay. And so in the first place -- page in the 611, that's claims established, but that's not necessarily the amount recovered; is that correct?

MS. TELUS: Correct. Uh -- for SNAP, we are -- we participate in the Treasury Offset Program however, so we can recoup from tax returns. And so we are relatively successful in our recovery on those claims.

REP. WEBER: Okay.

MR. WHITE: And -- and just to provide sort of a broader picture of what that -- what that number's coming out of. I think in 2024 there's about $154 million of SNAP benefit payments. So when you're looking at the 611, it's out of the hundred roughly, depending on the year, of course, roughly $154 million. And side note, that $154 million of direct benefits historically has never touched our budget. It does not go through the State's Budget. That will change in the next biennium if the State has to contribute to that benefit though.

REP. WEBER: If I may?

CHAIRMAN GRIFFIN: Follow-up.

REP. WEBER: So just on a philosophical basis, I was thinking about this. It was a little clearer with the

Medicaid Recovery Unit because the whole department is so enormous and does so many different things. Um -- it's hard for me just looking at it from a long distance away to say, gee, we're losing money hand over fist on the Medicaid Recovery Unit. I assume that the value in the unit, is that because of the over -- and also of your unit, is that because of the oversight they provide, they have also deterred an enormous amount of both error and -- and -- um -- actual outright misdeeds?

MS. TELUS: So, until relatively recently, I don't think we had a criminal conviction on a Medicaid provider. And about five years ago, maybe a little bit more, the MFCU had been very stable in their staffing and really developed a lot of expertise, and they started getting criminal convictions on a relatively regular basis. And now you'll see press releases from the DOJ that we also repost on our web sites, so that people know that you can go to jail --

REP. WEBER: Right.

MS. TELUS: -- for defrauding the Medicaid Program.

REP. WEBER: Right. I have to assume that, quite aside from whatever you recover with respect to that, that does have a deterrent effect on somebody who's paying

attention.

MS. TELUS: Exactly. And the amount for fraud is irrelevant. It's not -- it's not based on a number. You can defraud the program for $30,000, you have still defrauded the program. So, yeah, it -- it -- it, you know, some cases are large, some cases are not large in dollar amount.

REP. WEBER: Right.

MS. TELUS: But it really comes down to intent for fraud.

REP. WEBER: Okay. Thank you.

CHAIRMAN GRIFFIN: Well, again, we thank you very much for taking the time to appear before us and informing us about the controls that are in place. And, hopefully, New Hampshire will not experience what some of our neighbors have experienced. So thank you for your good work.

MR. WHITE: Thank you.

MS. TELUS: Thank you for your time. Thank you.

CHAIRMAN GRIFFIN: So the Committee -- the Committee has an agenda here that I think most of the items can wait till next month; is that true? Is there anything on here that we need to deal with today? We've lost some of our members to other --

SEN. ROSENWALD: {Inaudible}.

CHAIRMAN GRIFFIN: Uh --

SEN. ROSENWALD: {Inaudible}.

CHAIRMAN GRIFFIN: Yeah. We can't take any votes because we've lost --

MR. HENRY: Right now you have four. You can do stuff now but.

SEN. ROSENWALD: Okay.

REP. WEBER: {Inaudible}.

MR. HENRY: It has been, yeah. {Inaudible}.

CHAIRMAN GRIFFIN: Well, what -- what is on this agenda that we need to do today?

{Inaudible}.

CHAIRMAN GRIFFIN: Yeah.

CHRISTINE YOUNG, Director, Audit Division, Office of Legislative Budget Assistant: {Inaudible} working on special {Inaudible}.

CHAIRMAN GRIFFIN: Okay.

MS. YOUNG: And last meeting we had a discussion about Special Education costs.

CHAIRMAN GRIFFIN: Yeah.

MS. YOUNG: And they're here and here to have a discussion on that if members would like to do that.

SEN. ROSENWALD: Does that require votes?

CHAIRMAN GRIFFIN: Uh --

SEN. ROSENWALD: That doesn't require votes.

CHAIRMAN GRIFFIN: That's not going to require votes, right?

MS. YOUNG: No.

CHAIRMAN GRIFFIN: I don't think we want to be voting on anything.

REP. WEBER: I don't want to be voting on anything, but I also am concerned that -- I know that that particular area was very much of concern to a number of our members that are not here any longer. And with apologies to the {Inaudible}, I think it would be better served with all of our members {Inaudible}.

HOWARD PEARL, State Senator, Senate District #17: I agree.

CHAIRMAN GRIFFIN: That's pretty much the consensus. So I think that's the consensus and as Chair my apologies. I was -- I was unaware of the detail there. Uh -- so I think what we'll do is set a date for the next meeting and we'll move these agenda items.

SEN. ROSENWALD: Medicaid fraud is just so interesting.

CHAIRMAN GRIFFIN: Yeah. And if -- if your

auditors are available next time, we'll put them right up front. How's that? {Inaudible}. Okay. I think we're looking at the first Friday of April, which is the 3rd, I guess.

SEN. PEARL: It's Good Friday. I don't know if that changes things.

SEN. ROSENWALD: {Inaudible}.

REP. WEBER: {Inaudible}. That doesn't mean that people can't be here, so.

CHAIRMAN GRIFFIN: Up north?

REP. WEBER: Yeah.

CHAIRMAN GRIFFIN: How about the 11th? I mean, the 10th.

SEN. PEARL: That's open my calendar.

REP. WEBER: I'm more open on the 10th.

CHAIRMAN GRIFFIN: Okay. We'll make it the 10th, I think. And nine o'clock again? Seems to work. And -- uh -- oh, there's one other thing I want to talk about. When -- when we had the open items in -- uh -- the Liquor and -- uh -- the various licensing bureaus -- uh -- a number of them promised to come back to us or promised they -- they'd update us at the six month mark, and I think we're there. So maybe -- maybe Mr. Henry can reach out to them and see where they stand. I think it was the Parole Board, Liquor.

MR. HENRY: Yeah. Do you want just information from them or do you want them back here in front of you?

CHAIRMAN GRIFFIN: I think we could have them back here, yeah.

MR. HENRY: Yeah, we did submit -- we have the list.

CHAIRMAN GRIFFIN: Yeah.

MR. HENRY: Yeah, that we gave you.

CHAIRMAN GRIFFIN: Right.

MR. HENRY: And we started to track. They're supposed to report every six months.

CHAIRMAN GRIFFIN: Right.

MR. HENRY: Um -- from the date of their report when they -- they received the report.

CHAIRMAN GRIFFIN: Right.

MR. HENRY: And -- but they're not all on a schedule because you brought them in on, you know, at different times.

CHAIRMAN GRIFFIN: Right.

MR. HENRY: So they're a little bit, you know, mixed up, I guess you'd say. So we -- do you want us -- do you want us to decide which ones?

CHAIRMAN GRIFFIN: Uh -- yeah. I mean, I'm

thinking the Parole Board. Is that still open? Right?

MR. HENRY: Yep.

CHAIRMAN GRIFFIN: And Liquor, that's still open. And -- um -- what else do you show as still open?

MR. HENRY: Well, you can go to the very back of --

CHAIRMAN GRIFFIN: Yeah.

MR. HENRY: -- of this handout. That the -- if you go to the back I call it a B because there's two -- two lists here. But the one that's listed as B, the top four we know are late because it's been over six months since they reported to Transparent-New Hampshire. And Senator Lang wanted to follow-up with the Mental Health Workforce, the Dental Examiners, and the Human Rights Commission. He just wanted me to contact them to see if they could, you know, if they're -- if they have a follow-up yet.

CHAIRMAN GRIFFIN: Right. So can you do that first?

MR. HENRY: Yep.

CHAIRMAN GRIFFIN: And, if necessary, I'll line them to come in.

MR. HENRY: Yep.

CHAIRMAN GRIFFIN: Okay. I guess that's it for

the day, and I'll make a motion to adjourn.

SEN. PEARL: So move.

CHAIRMAN GRIFFIN: All in favor aye? Cindy, you yell aye.

(Committee adjourned.)

C E R T I F I C A T E

I, Cecelia A. Trask, a Licensed Court Reporter in the State of New Hampshire, do hereby certify that the foregoing transcript is a true and accurate record of the official YouTube recording. I was not physically present and have transcribed said video to the best of my ability, skill, knowledge and belief.

Cecelia A. Trask, RPR, RMR
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