

DHHS Program Integrity

Presentation to HHS Oversight

Program Integrity Processes to Prevent, Detect and Remediate Fraud, Waste and Abuse at DHHS

August 28, 2026

Department of
HEALTH &
HUMAN SERVICES



Agenda

- Provider and Beneficiary Fraud, Waste, and Abuse (FWA)
  - Medicaid Provider FWA
  - Beneficiary Program FWA
- Contract Oversight
  - Standard Contract Monitoring
  - Subrecipient Monitoring
  - Enhanced Financial Compliance Unit Monitoring
- Internal Controls

Provider and Beneficiary Fraud, Waste, and Abuse

August 28, 2026

What is considered Fraud, Waste, or Abuse (FWA)?

Definitions (CMS definitions)

Fraud – Intentional act of deception or misrepresentation by a person with knowledge that the deception could result in an unauthorized benefit for themselves or another person.

Waste – (also called "overpayment") The overutilization or inappropriate use of services and resources, typically without criminal intent.

Abuse – (also called "overpayment") Provider or beneficiary practices that are inconsistent with sound fiscal, business, or medical practices, resulting in unnecessary costs to the benefit program.

- **Where the payment is qualified as waste or abuse, providers will receive training and education.**
- **Where DHHS identifies gaps that can lead to abuse, the Department will clarify rules and policy to prevent future abusive practices.**
- **SNAP Payment Error Rate (PER) determines a number of cases with overpayments or underpayments to SNAP beneficiaries as a result of error during the eligibility determination process. The PER does not represent Fraud, Waste, or Abuse.**

Parter Agencies

MEDICAID PROVIDER FWA PARTERS:

- NH MFCU (Medicaid Fraud Control Unit) which is under NH Attorney Generals Office. Engages in criminal and civil prosecutions based on their investigation. PIU & MCOs meet monthly with MFCU, prep and assist investigations, and can testify at trial.
- CMS NE UPIC (Northeastern Unified Program Integrity Contractor). This is a CMS vendor that reviews Medicare and Medicaid data to determine abnormalities. UPIC will present information to PI for investigation.
- HHS OIG will send information requests to MFCU and directly to PIU based on cases they are reviewing. DHHS will provide data and assistance as requested.
- MCO Special Investigation Units (SIU). Under contract MCOs are required to review claim data, investigate provider FWA, and refer potential fraud to MFCU.

BENEFICIARY FWA PARTERS:

- NH County Attorneys to prosecute member fraud under RSA 167:17-a. DHHS creates a comprehensive investigation report for the County Attorneys and assist with cases by gathering evidence and testifying in court proceedings.
- Local & State Law Enforcement assists with search warrants. DHHS will refer cases not under our responsibilities such as identity fraud. Local LE assist us in the field if there is a safety concern and have assisted with interviews.
- FNA (previously FNS) provides information on people with SNAP violations in other States to ensure they do not receive SNAP benefits in NH. DHHS enters NH SNAP violation into the FNA system for other States awareness.
- Other State & Federal Agencies such as SSA will participate in joint investigation if there are other grants or benefits involved with the member FWA.

DHHS Medicaid Program Integrity Unit (PIU)

Investigate Medicaid Provider Fraud, Waste, and Abuse

Referrals to State or MCOs

- Beneficiaries, provider staff, or peer providers may call with referrals for potential fraud, waste, or abuse
- Providers can self-report and self-audit

Data Analytics at State or MCOs

- Each MCO is required to run 6 algorithms for peer-to-peer groupings and other outlier identification
- Outliers result in requests for medical records
- All MCOs meet together to review findings from data and record reviews

Investigations at State or MCOs

- Per MCO contract, MCOs conduct investigations
- MCOs provide reports on ongoing and closed fraud and abuse or waste investigations and recoveries
- The State meets with MCOs monthly to discuss ongoing cases

Recoveries (Waste, Abuse)

- State or MCOs send recovery letters to providers with overpayments
- Over $1 million recoveries between State and MCO cases in SFY 2025 (Total Funds)

Prosecution at MFCU

- Medicaid Fraud Control Unit (MFCU) at DOJ investigates and prosecutes
- 58 open cases during SFY 2025
- Closed 19 cases – 10 with either a criminal conviction, civil prosecution, or referral to federal agency

Beneficiary FWA

Special Investigations Unit (7 investigators, 3 claims staff)

- Investigate referrals of potential beneficiary fraud or unintentional overpayments resulting from agency or client error.
- Investigate referrals from Bureau of Family Assistance for potential fraud at the point of application or redetermination (Front-End Detections).
- Once investigated, claims for overpayment amount are established and overpayments are recouped, either via agreement with the client or after AAU hearing.
- Investigated 30 trafficking allegations in CY 2025, very difficult to prove; 2 found guilty.

Referrals to Law Enforcement:

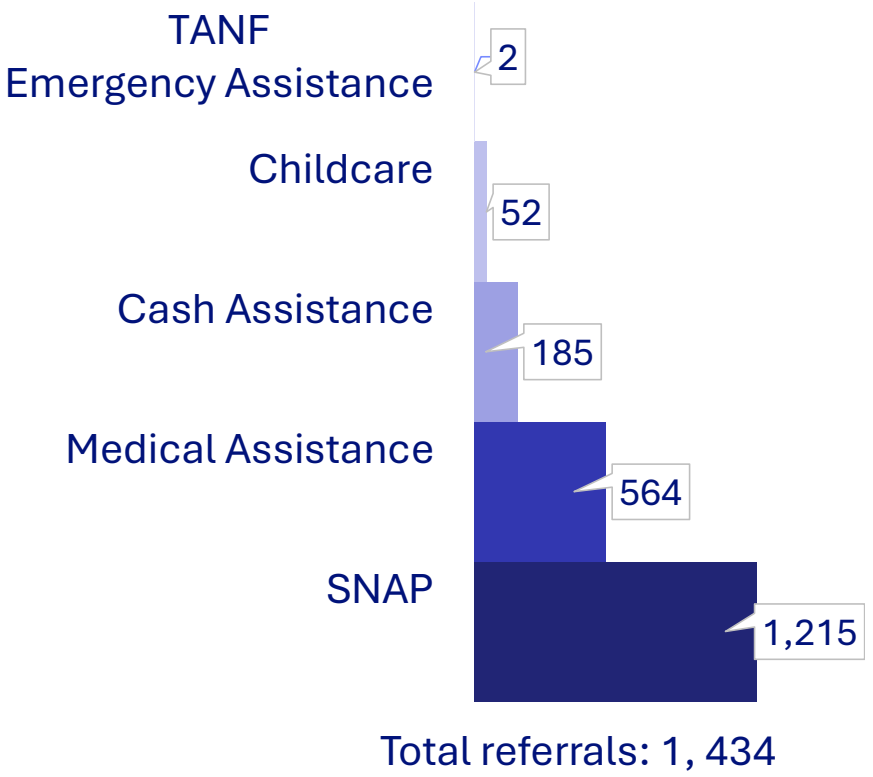
- Referred 8 cases to County Prosecutors in SFY 2025 (SNAP, TANF, Medical Assistance and Childcare Assistance).
- Referrals related to theft of benefits, such as identity fraud, are referred to law enforcement.

Beneficiary FWA

In SFY 2025, SIU:

- received 1,447 referrals; of 1,215 SNAP referrals, 279 were overissuance due to error, 364 resulted in fraud investigations
- disqualified 111 individuals from the SNAP program and 27 from TANF

- Established claims of $710,000 SNAP, $207,000 Cash, $35,000 Childcare in overpayments
- Convicted 3 individuals of Welfare Fraud totaling an additional $200,000 in SNAP, Medicaid, and Childcare overpayments
- Next Steps:
  - New analysis of reports for Out-Of-State EBT card use is under development*
  - Receipt of federal award for system enhancements. New process will reduce manual data entry and error correction, resulting in more reliable analysis and reporting of benefit recovery and fraud trends, including data per employee.



* There is no national database of recipients of SNAP services in multiple states. DHHS is hoping to manually analyze transaction to identify individuals that have potentially moved out of New Hampshire.

SNAP Disqualification

If we find a beneficiary has an Intentional Program Violation (IPV, a determination of fraud), there are different terms of the disqualification. See NH RSA 167:17-d; 7 CFR 273.16(b)

- 1st SNAP IPV is 1 year disqualification.
- 2nd SNAP IPV is 2 years disqualification.
- 3rd SNAP IPV is permanent.
- 10 years for two receiving benefits in 2 states.

Beneficiaries are not removed from the SNAP program for not paying a claim (per federal law).

Claims can be recouped from a percentage of benefits.

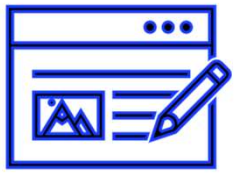
If the client is not open SNAP, and there is non-payment on claim, the State engages the Treasury Offset Program for IRS tax returns.

Childcare Provider & Beneficiary Audits



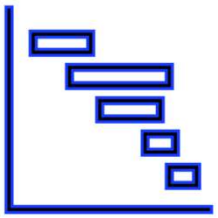
Provider Reviews

- Monthly sample of providers to evaluate compliance with attendance, required signatures, and other records



Provider Review Results SFY 2025

- 28 Providers reviewed
- 19 providers with findings
- 16 providers with overpayments
- $18,600 recouped to date



Childcare Subsidy Audits

- Federally required eligibility audit conducted every 3 years; evaluate eligibility and payment amounts
- Initial FFY 2025 review just completed– 276 sampled cases*
- We conduct "interim" reviews in the intervening years to continue monitoring improvements

* Identified 37% cases in error; total improper payments identified was 4%

Contract Oversight

August 28, 2026

Contract Fiscal Management

Standard Contract Monitoring

- HHS staff actively monitor contracts to ensure outcomes, deliverables, outputs, reporting, and allowability.
- Payments require adequate and sufficient documentation/evidence of work performed/delivered.

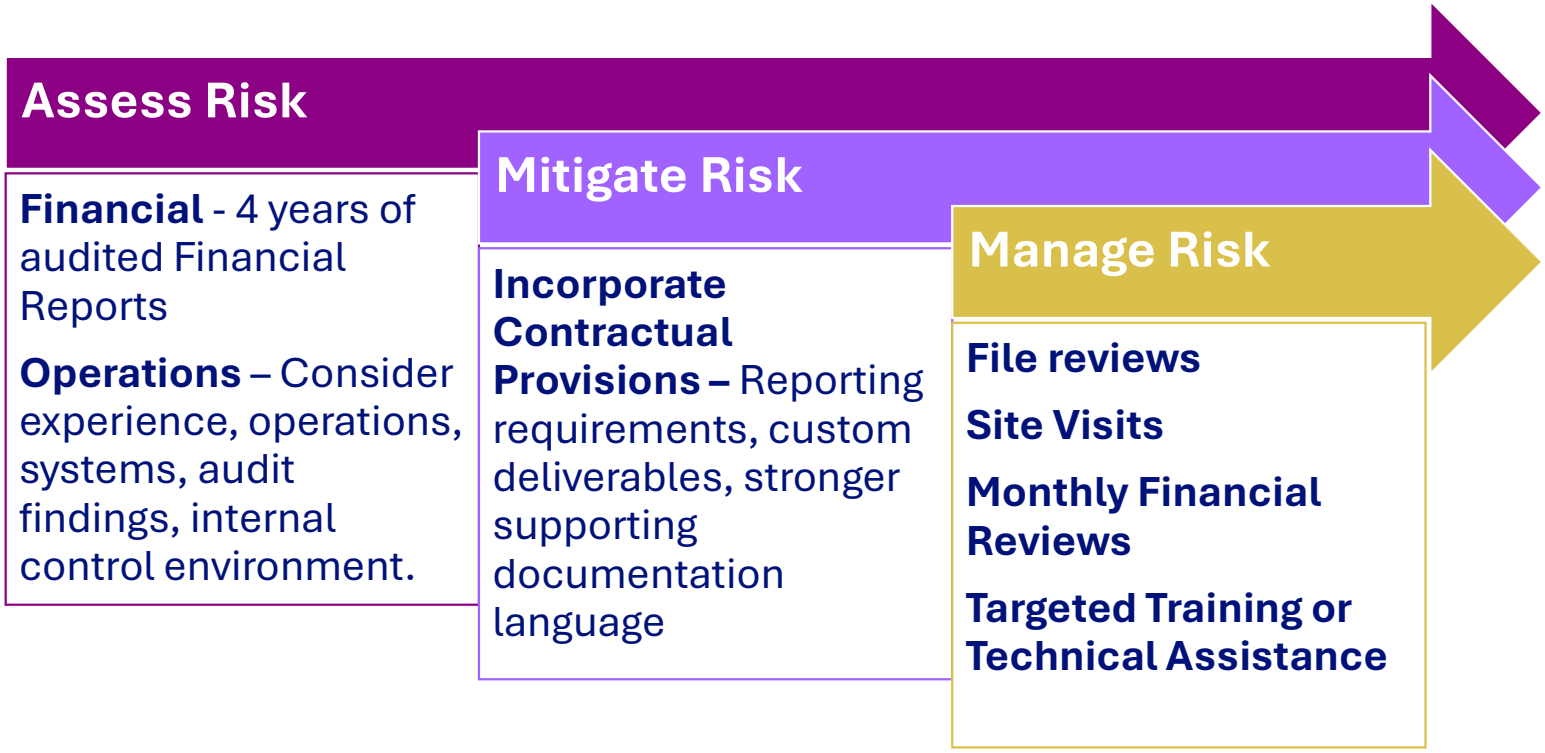
Subrecipient Monitoring

- Establishes processes for assigning programmatic and financial risk for each contract
- Contracts provisions are modified based on risk
- Most cost-reimbursement contracts require complete invoice back-up documentation monthly

Financial Compliance Unit Contract Oversight

- Works with Grants Administrator to provide training on how to review invoices and back-up documentation
- Performs Desk or Field Audits of Sub-recipients as necessary
- Reviews contractor financial audits
- Coordinates the KPMG Single Audit and corrective actions

Enhanced Subrecipient Risk Management



Services are delivered effectively

Funds are used appropriately

Targeted Outcomes are Achieved efficiently

Internal Controls

August 28, 2026

Internal Fraud Mitigation Tools

- DHHS *Prevention of Fraudulent and Unethical Conduct* Policy
- Mandatory, Department-wide Ethics Training
  - Required every 2-3 years
  - Includes training on the Prevention of Fraudulent and Unethical Conduct Policy
- Ombudsman – takes internal and external referrals

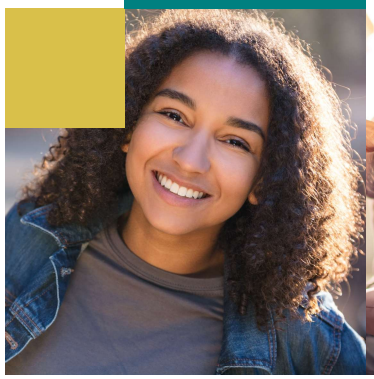


Thank you.

Contact us:
Ann Landry
Nathan White
Meredith Telus

August 28, 2026

Department of
HEALTH &
HUMAN SERVICES





Appendix

Federal Medicaid PI Landscape
NH Medicaid Activities
External Audit Remediation
More Information on SNAP PER

August 28, 2026

Federal Landscape on Medicaid Provider Program Integrity

- Since May HHS OIG has de-certified/conditionally certified or suspended 10 state MFCUs and only certified 1 state.
- New Hampshire MFCU recertification scheduled 10/1
- The CMS Unified Program Integrity Contractor (UPIC) conducting an audit of MCO overpayment cases and fraud referrals (results at the end of 2027)
- Roundtable with NE state Medicaid agencies, MFCUs, and CMS in Boston, September 10. Listening sessions and 1:1 office hours with CMS staff
- Increased congressional oversight including Oversight and Investigations subcommittee hearing on *State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies*
- House Energy and Commerce Committee sent letters to 11 states requesting information and documents on the actions each state is taking to strengthen Program Integrity; CMS sent letters to 4 additional states (NH has not received any letters)
- CMS initiated deferrals of Medicaid payment of $320 million to MN and $1.3 billion to CA
- On February 25, 2026, CMS issued an RFI for the "Comprehensive Regulations to Uncover Suspicious Healthcare" (CRUSH) initiative for assistance to strengthen program integrity efforts across CMS programs

NH Medicaid Provider Program Integrity Activities

Current Areas under State/MCO review:

- ABA providers:
  - Requested CMS Moratorium on additional out-of-state providers
  - Review of telehealth services
  - Review of Prior Auth process
  - “Deep Dive” review of sampled medical recorded at 9 high-risk providers initialed July 1
- HCBS review of whole-person and family-based self-directed care
- Non-emergency medical transportation (Friends and Family particular area of focus)
- OTPs (current focus on potential Stark Law referrals)

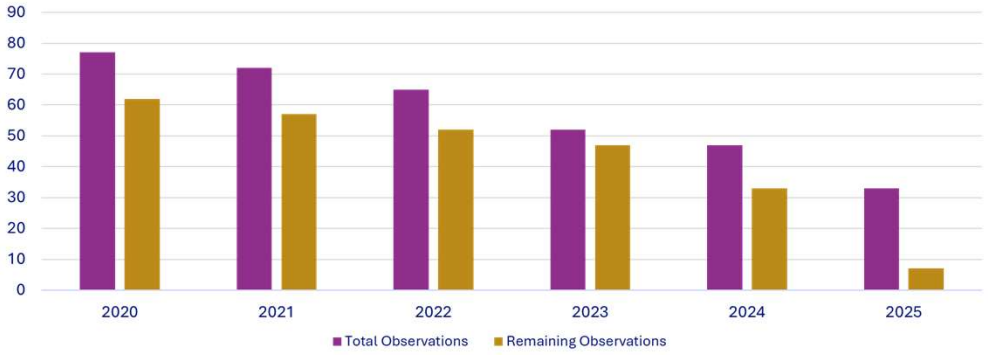
Provider Revalidation Project

- DHHS is participating in the CMS-directed provider revalidation project, which includes:
- Revalidating nearly 4,000 group providers before June 4, 2028
- Complete screening of new owner/managers
- Site visits for high and moderate risk providers

External Audit Remediation and Follow-Up

- Dedicated program to address LBA Audit findings, including posting to Transparent NH
- Dedicated program to reduce Single Audit findings
  - 2018 audit included 50 prior year findings and 21 current findings
  - 2025 audit included 7 prior year and 3 current year findings. 7 of the 10 are the same finding, which will be remediated this fall and not present in the 2027 audit.
- Other Federal Audits
  - Created a database to maintain federal audit findings and follow-up
  - Working to mitigate recent audit findings from ACF, Office of Child Care
  - Manage the CMS Payment Error Rate Measurement (PERM) audit of eligibility and claims

Reduction in Outstanding LBA Audit Findings



More Information on the SNAP Payment Error Rate (PER)

The SNAP PER focuses specifically on payment accuracy for sampled SNAP cases reviewed through the federal Quality Control (QC) system.

PER Measures	PER Does Not Measure
Overpayments	Fraud rates
Underpayments	Application denials
Agency-caused errors	Timeliness performance
Client-caused errors	Documentation/notice issues
Technical eligibility and benefit calculation issues	Customer service quality