Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Hawaii Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Hawaii Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Hawaii Department of Human Services (DHS) Med-Quest Division (MQD). The review team also conducted a telephone interview with the director of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the MQD Financial Integrity area (within the Finance Office) that is responsible for Medicaid program integrity. This report describes 2 effective practices, 6 regulatory compliance issues, and 10 vulnerabilities in the State's program integrity operations. Three of the regulatory compliance issues are repeat findings from the 2005 CMS Medicaid Alliance for Program Safeguards (MAPS) review.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Hawaii improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Hawaii's Medicaid Program

The Hawaii Medicaid program is administered by MQD which is housed in the DHS. The MQD administers the State's Medicaid fee-for-service (FFS), QUEST and QExA managed care programs. Prior to August 1994, all beneficiaries received health care services under Medicaid FFS. In August of 1994, the Hawaii QUEST, a demonstration project, delivered medical, dental and behavioral health services for individuals eligible for Medicaid under the Aid to Families with Dependent Children and general assistance programs. These services were available to eligible individuals, families and children, and to individuals formerly covered under the State Health Insurance Program. Effective February 1, 2009, the aged, blind and disabled programs began receiving their coverage for services under the QExA managed care plans.

As of October 7, 2010, the State had 1,548 participating managed care-only providers and 6,037 providers participating in both FFS and managed care programs. In State fiscal year (SFY) 2009, the program served 235,203 beneficiaries.

Total Medicaid expenditures for the Federal fiscal year (FFY) ending September 30, 2009 totaled $1,364,448,617. The Federal medical assistance percentage (FMAP) rate for Hawaii for FFY 2009 was 55.11 percent. However, with adjustments attributable to the American Recovery and

Reinvestment Act of 2009, the State's effective FMAP was 66.13 percent for quarters one and two and 67.35 percent for quarters three and four.

Program Integrity

Within DHS' MQD, the Finance Office is the organizational component dedicated to fraud and abuse detection activities. The Finance Office is responsible for all of the financial operations of the MQD and has four staff sections that oversee different financial functions. At the time of the MIG review, MQD's Finance Office had two full-time Financial Integrity staff focusing on Medicaid program integrity with one vacant full-time investigator position. The table below presents the number of investigations, number of administrative sanctions, and overpayments identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	2	0	$6,896	$6,896
2007	7	0	$87,493	$6,216
2008	5	0	$0	$0**
2009	0	0	$552	$552

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a MFCU investigation.
** The State lost its only investigator in 2008 and remaining staff were focused on other activities.

Methodology of the Review

In advance of the onsite visit, the review team requested that Hawaii complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 14, 2010, the MIG review team visited the MQD Finance Office. The team conducted interviews with numerous MQD officials, as well as with staff from the Health Care Services Branch (HCSB) Member and Provider Relations Section. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives from managed care entities. The review team additionally conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Financial Integrity staff but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and non-emergency medical transportation. Hawaii operates a

Medicaid expansion Children's Health Insurance Program (CHIP). The expansion program operates under the same billing and provider enrollment policies as Hawaii's Title XIX Medicaid program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

Unless otherwise noted, the MQD Finance Office provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that MQD provided.

RESULTS OF THE REVIEW

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Hawaii reported its utilization of partnerships and an effective relationship with the MFCU.

Utilization of partnerships and external resources

The Financial Integrity staff is responsible for the program integrity efforts in the MQD and currently consists of two registered nurses (RNs). Despite the obvious constraints placed on such a small number of staff, they have been proactive in optimizing available partnerships and external resources. Since the inception of the Medicaid Integrity Institute (MII), the Hawaii Financial Integrity staff has attended "Investigation Data Collaboration", "Coders Boot Camp", and "Basic Investigations Training" classes. The two nurses have used the content of these trainings to develop an internal program integrity training presentation given to MQD staff. Additionally, they actively participate in the National Association for Medicaid Program Integrity, and on the MIG Region IX State Program Integrity Directors Call and the MIG Small States Call. The nurses routinely review the MII Workspace tool and consult with other program integrity director colleagues as needed. However, the MIG team identified a serious concern with the State's ineffective surveillance and utilization review (SUR) system discussed in the Regulatory Compliance Issues section of this report.

Effective working relationship with the MFCU

Both the Financial Integrity staff and the MFCU indicated in separate interviews that their relationship has improved 100 percent over the last two years. Due to the current lack of resources, they have agreed that all complaints received by Financial Integrity staff are directly sent to the MFCU following limited preliminary investigations. The Financial Integrity staff and MFCU now meet monthly to discuss ongoing cases as well as the cases being returned to the State when the MFCU cannot make a criminal case. According to both agencies, this improved relationship allows for the MFCU to work within their three year statute of limitations to determine if fraud and abuse has occurred.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding an effective SUR system, the False Claims Act, verification of beneficiary services, disclosure of ownership and control and criminal conviction information, and reporting adverse actions taken on provider applications to the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

Hawaii does not have an effective SUR system. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 456.3 requires that the State implement a statewide surveillance and utilization control program that can safeguard against the unnecessary or inappropriate use of Medicaid services and against excess payment of Medicaid funds; assess the quality of those services; provide for the control of the utilization of all Medicaid services provided under the plan; and provide for the control of the utilization of inpatient services.

The CMS State Program Integrity Assessment (SPIA) data (at http://www.cms.gov/FraudAbuseforProfs/11_SPIA.asp#TopOfPage) indicates that Hawaii is underperforming compared to other States of similar size. For example, in FFY 2008, Hawaii reported Medicaid enrollment at 222,921 with annual program integrity expenditures of $783,400. One State with a comparable program reported Medicaid enrollment at 212,960 for the same fiscal year, and reported $2,299,268 in program integrity expenditures. Hawaii reported 13 filled program integrity full-time equivalent (FTE) positions, while the other State had 23 filled FTEs. Hawaii further reported, and the review team observed, that of the 13 FTEs reported in SPIA, only 2 were actually dedicated to program integrity activities. The remainder were assigned to various utilization review activities, but not to fraud and abuse detection or investigation. The other State identified $1,828,076 in overpayments as a result of provider audit activities while Hawaii reported $0. Another similarly sized State with Medicaid enrollment reported at 203,260 in FFY 2008, reported 15 filled program integrity FTEs and $2,810,000 in identified overpayments as a result of provider audit activities.

Hawaii contracts with the State of Arizona to use Arizona's Medicaid Management Information System (MMIS), known as the Prepaid Medical Management Information System database, for claims processing. The section of the Arizona system devoted to Hawaii data is referred to as the Hawaii Prepaid Medical Management Information System (HPMMIS). The State's surveillance and utilization control activity consists of analyzing suspect provider billing patterns (i.e., high dollar increases) and requesting infrequent ad hoc reports from Arizona, which may prompt Hawaii to notify the fiscal agent to set provider-specific prepayment review edits. The Finance Office has no systematic analysis being generated through an active surveillance and utilization review subsystem (SURS). Finance Office staff reported that the MQD has only three basic reports generated by the HPMMIS with no "formal" SURS which utilizes preset algorithms to produce reports. Consequently, the State does not have a program in place to effectively and proactively analyze medical care and service delivery data. This is demonstrated by the bulk of Hawaii's investigations being generated from complaints. The lack of a SURS was noted in the 2005 MAPS review.

Although the regulation and the State's MQD-Functional Statement dated June 30, 2009 calls for "a robust fraud and abuse program," the resources allocated to program integrity activities in the

State of Hawaii are indicative of a minimal commitment to program integrity. According to the MQD-Functional Statement, "The Financial Integrity Staff is responsible for reviewing records, claims data, eligibility files and other germane materials in accordance with State and Federal requirements in maintaining a robust fraud and abuse detection program covering potential/actual fraud and abuse by program populations and providers." The functional statement goes on to describe that "The Financial Integrity Staff coordinates and monitors fraud and abuse activities with contracted managed care organizations (MCO) and other contracted entities…, cooperates and works with Division staff and the Medicaid Fraud Control Unit…The activities performed by the staff include, but are not limited to the Surveillance and Utilization Review Subsystem (SURS) program, following up on information or complaints from citizens, etc."

In SFY 2009 Hawaii had three authorized FTE positions, one of which was to be an investigator. The investigator FTE had been vacant since June 2008. As a result, all three FTEs were filled with RNs, none of whom had investigatory experience. For SFY 2010, the Financial Integrity staff consists of two authorized FTEs, both filled by RNs, and one vacant investigator position. As the two RNs do not have investigatory expertise, they essentially review the three basic reports generated from HPMMIS and receive complaints from other DHS divisions, MCOs and the general public. Because the State lacks an experienced investigator, the MFCU and Financial Integrity staff have agreed that all complaints are referred to the MFCU which conducts most of the investigatory work.

Financial Integrity staff complete as much of a preliminary investigation as they are capable of conducting without an in-house SURS: collecting more details from a complainant, obtaining billing information, and checking licensure status of a provider. After collecting this information, the case is referred to the MFCU for additional investigation. If the MFCU chooses not to pursue a criminal case, the MFCU returns the complaint to the Financial Integrity staff. The State reported to the review team that there is an approximate two year backlog of returned complaints due to the State's limited staffing.

The HCSB administers and monitors contracted MCOs. It also manages member and provider relations, including FFS, and monitors and manages compliance with applicable contracts, rules, regulations and laws impacting MCO contracts. Interviews with Financial Integrity staff revealed that the majority of communication with HCSB staff consists of referrals that HCSB may make regarding questionable provider behavior. The Financial Integrity staff reported limited interaction with HCSB as they are not proactively involved in collaborating with other program areas on policy making in regards to provider enrollment and provider education.

Recommendations: Implement a SUR system that ensures the safeguards outlined in 42 CFR § 456.3. Allocate resources that support a robust fraud and abuse detection program which allows for compliance with the Federal requirement for preliminary investigations by the Medicaid agency prior to referral to the MFCU.

The State has not complied with the State Plan requirement to review providers' policies and employee handbooks pertaining to the False Claims Act.
Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

Hawaii does have a State plan amendment for false claims education in place. However, the State indicated that at the time of the onsite review it had not begun reviewing providers' policies and employee handbooks.

Furthermore, the State's current contracts with the QUEST managed care health plans do not require the plans to comply with this statute. The contracts do not ensure that providers and contractors who receive or make payments of at least $5 million annually have established written policies for all employees (including management) about the False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules required by the Act. Hawaii did provide evidence that the current Request for Proposal (RFP) requires this in the QExA plans.

***Recommendations*:** Modify and implement policies and procedures to review all entities in accordance with the statute. Involve Financial Integrity staff in the policy development process.

The State does not verify with beneficiaries whether services billed by providers were received.
The regulation at 42 CFR §455.20(a) requires that the State agency have a method for verifying with beneficiaries whether services billed by providers were received. The MQD does not perform any verification of billed services for Medicaid beneficiaries.

Recommendation: Develop and implement policies and procedures for verifying with beneficiaries whether billed services were received.

The State does not capture all required ownership, control, and relationship information from its fiscal agent. (Uncorrected Repeat Finding)
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the

disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Hawaii has two fiscal agents, one of which contracts for dental, transplant and catastrophic services. The RFP for this fiscal agent did not request 42 CFR § 455.104 disclosure information and the State did not collect the information in any other format. This is a repeat finding from the 2005 MAPS review.

NOTE: The CMS team reviewed the fiscal agent contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

***Recommendation*:** Collect required ownership and control disclosures in accordance with 42 CFR § 455.104. Collect and maintain the disclosure from the fiscal agent.

The State does not collect criminal conviction information from its fiscal agent. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS-OIG whenever such disclosures are made.

The RFP for the dental, transplants and catastrophic services fiscal agent did not request 42 CFR § 455.106 disclosure information. The MQD has not collected the required health care-related criminal conviction information from this fiscal agent. This is a repeat finding from the 2005 MAPS review.

Recommendations: Collect required criminal conviction disclosures in accordance with 42 CFR § 455.106. Refer that information to HHS-OIG within the timeframe specified by the regulation.

The State does not report to HHS-OIG adverse actions taken on provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Hawaii has no regulation or program integrity policy requiring that HHS-OIG is notified of any adverse action, including a termination, which MQD takes on a provider's application to the FFS Medicaid program. The State has not reported adverse actions to HHS-OIG as required.

Recommendation: Develop and implement policies and procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

Vulnerabilities

The review team identified 10 vulnerabilities in Hawaii's program integrity practices. These related to not following the CMS minimum criteria for referrals to the MFCU, inadequate written policies and procedures, capture of managing employee information on provider enrollment forms, and incomplete exclusion searches. Additional issues include collection of disclosure information from MCO network providers, notification to HHS-OIG of local convictions and adverse actions, initiation of provider exclusions, and MCOs not verifying the receipt of services provided to Medicaid beneficiaries.

Not following the minimum criteria for referrals to the MFCU set forth in CMS guidance.
A MFCU referral must contain the minimum criteria set forth in the "Performance Standard for Referrals of Suspected Fraud From a Single State Agency to a Medicaid Fraud Control Unit" guidance released by CMS in September 2008, in conjunction with the "Best Practices For Medicaid Program Integrity Units' Interactions With Medicaid Fraud Control Units" document, also released in September 2008.

Hawaii's current policy is to refer all complaints to the MFCU with only limited MQD investigation because of an extended multiple year vacancy in its one investigator position. This has affected the quality of additional information which should be contained in the MFCU referral including inconsistent inclusion of billing information related to the complaint and not including a calculation of the dollar amount of potential fraud. During the review team's sampling it was noted that the referrals to the MFCU were missing the amount paid to the provider in past three years or during the period of alleged misconduct.

Recommendation: Revise and implement policies and procedures regarding referrals to the MFCU. Refer to the minimum criteria as set forth in the CMS performance standard document for guidance.

Not having adequate written program integrity policies and procedures.
Under the regulation at 42 CFR § 455.13, the State Medicaid agency must have methods and criteria for identifying and investigating suspected fraud cases. The regulations prescribe

additional requirements for the effective functioning of the States' Medicaid program integrity operations. The State has inadequate written policies and procedures for program integrity functions. The shortage of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or provider enrollment staff.

Hawaii has very few existing policies and those policies have not been revised since 1991. The State also lacks policies for program integrity-related issues. For example, MQD has no written policy to notify the Secretary of ownership and control disclosures made by providers not subject to periodic survey and certification. In addition, Financial Integrity staff stated that the notification to HHS-OIG of denied enrollment, suspensions or terminations in the FFS Medicaid program has not been part of their process and there is no policy or procedure for such notification.

The State reported to the review team that its policies were originally written in 1991, prior to the introduction of managed care into the Hawaii Medicaid program. Consequently, there are no policies and procedures for State program integrity oversight of MCOs. The absence of written managed care policies and procedures leaves the State vulnerable to inconsistent operations and unable to provide necessary oversight of MCOs.

Recommendation: Develop and implement policies and procedures for all program integrity activities.

Not capturing managing employee information on provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." One of the State's MCOs does not request managing employee information on its credentialing application. Thus, the MCO would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads within its network.

Recommendation: Modify credentialing packages to require disclosure of managing employee information.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Repeat Vulnerability)
The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. Even if the State were compliant with the requirements in the regulations, the State is neither collecting nor maintaining complete information on owners, officers, and managing employees in the MMIS,

therefore the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (the MED).

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the Excluded Parties List System (EPLS) on a monthly basis.

The MQD has a system in which FFS providers are checked against the LEIE for exclusions upon enrollment and thereafter are checked against the MED for exclusions on a regular basis as updates are received electronically. However, MQD is not checking owners, officers and managing employees for exclusion upon enrollment and is not retaining complete information on owners, officers, and managing employees in the HPMMIS or in another database. This is a repeat vulnerability from the 2005 MAPS review. Furthermore, this approach toward exclusion checking in the FFS program does not comport with the guidance issued by CMS in the two SMDLs regarding screening for excluded individuals and entities.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities. Require contractors to search the LEIE on a monthly basis for excluded employees and subcontractors.

Not collecting disclosure of ownership and control information from MCO network providers. Hawaii's managed care contract does not require MCOs to collect the full range of ownership and control disclosures that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. None of the three MCOs interviewed collect the information on ownership and control from their network providers and subcontractors.

NOTE: The CMS team reviewed the managed care contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with

ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Modify the managed care contracts to require the full range of disclosures at 42 CFR § 455.104.

Not requiring the disclosure of business transaction information from MCO network providers.

Neither the State's contract with the MCOs nor the MCO provider agreements require network providers to disclose the required business transaction information on request that is stipulated at 42 CFR § 455.105. Three of the MCO network provider agreements or credentialing applications reviewed by the team did not contain language requiring providers to supply the same business transaction disclosures upon request that are required of FFS providers. There is also no provision requiring the transmission of the requested disclosures within the 35-day time frame specified for FFS providers.

Recommendation: Modify MCO contracts and network provider agreements and credentialing applications to require timely disclosure, upon request, of the required business transaction information.

Not notifying HHS-OIG of local convictions.

Under the regulation at 42 CFR § 1002.230, the State Medicaid agency must provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice, when an individual has been convicted of a criminal offense related to the delivery of health care items or services under the Medicaid program. If the State agency was involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after conviction, and if the State agency was not involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after learning about the conviction.

The MQD does not have a policy and procedure to inform HHS-OIG of local convictions related to crimes in the Medicaid program, and indicated it relies on the MFCU to do this. The MIG team reviewed the Memorandum of Understanding between the State Medicaid agency and the MFCU and found no clause addressing the MFCU's responsibility to inform HHS-OIG of such convictions. During an interview, State Financial Integrity staff indicated that MQD does not always know if the MFCU has notified HHS-OIG.

Recommendation: Develop and implement policies and procedures to inform HHS-OIG of local convictions related to crimes in the Medicaid program.

Not initiating provider exclusions.
Although Hawaii Administrative Rule §17-1736-23 allows MQD to terminate a provider permanently or indefinitely and to suspend or exclude a provider in accordance with the permissive exclusion authority conveyed by the Federal regulation at 42 CFR § 1002.210, MQD is not using this exclusionary authority and does not have policies and procedures to implement this regulation.

The State only exercises its exclusion authority when other authorities, such as the HHS-OIG, have already sanctioned providers. Only when such notification is received from an outside authority, and the provider is found in Hawaii's Medicaid program, does MQD issue a letter terminating the provider from the program.

Recommendation: Develop and implement policies and procedures to initiate State provider exclusions.

Not verifying receipt of services provided to beneficiaries in the managed care program.
Med-QUEST does not contractually require the MCOs to verify that services were received as billed. One out of three MCOs does not send EOMBs nor does the MCO have another mechanism to verify receipt of services. Hawaii's Med-QUEST does not independently verify the receipt of Medicaid managed care services.

Recommendation: Modify contracts with MCOs to require verification of beneficiary receipt of services.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The State does not require its MCOs to inform them when the MCOs have denied enrollment or credentialing of a provider due to program integrity concerns. Therefore, the State is unable to report these actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

***Recommendations*:** Require MCOs to notify the State when taking adverse action against a provider's participation in the program, including when it denies credentialing for fraud-related concerns. Develop and implement policies and procedures to report all adverse actions to HHS-OIG.

CONCLUSION

The State of Hawaii applies two effective practices that demonstrate program strength and the State's commitment to program integrity. These practices include:

- utilization of partnerships and external resources, and
- the cooperative relationship with the MFCU.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition 10 areas of vulnerability were identified. The CMS encourages Hawaii to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Hawaii to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Hawaii will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Hawaii has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Hawaii on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

NEIL ABERCROMBIE
GOVERNOR

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November 8, 2011

Mr. Robb Miller, Director
Division of Field Operations
Medicaid Integrity Group
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Dear Mr. Miller:

Enclosed you will find the corrective action plan (CAP) from the State of Hawaii Med-Quest Division (MQD). This CAP is in response to the Program Integrity Review done by your staff in June 2010 and the final report which was received on September 21, 2011.

We appreciate your comments and the opportunity to work with your program integrity review team. The MQD is actively working towards compliance.

If you have any questions concerning our CAP, please contact Suzanne Noland, R.N. at (808) 692-8055 or snoland@medicaid.dhs.state.hi.us.

Sincerely,

for Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

Enclosure