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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Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report*.

The purpose of this review was to determine whether Hawaii's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, False Claims Act education and monitoring; managed care oversight at the state level; and program integrity activities conducted by managed care entities (MCEs).

The review team identified a number of vulnerabilities and instances of regulatory non-compliance in both the state's fee-for-service (FFS) and managed care programs, thereby creating risk to the Medicaid program. The areas of risk are related to core program integrity activities, fraud detection and investigation, provider enrollment practices, and program integrity oversight of managed care. Many of the risks stem from a chronic lack of staff assigned to program integrity functions. All the issues identified and CMS's recommendations for improvement are described in detail in this report.

CMS is concerned that some of the issues described in this review were also identified in CMS's 2010 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible.

Background

In fiscal year (FY) 2012, Hawaii's Medicaid enrollment was approximately 288,000 beneficiaries and expenditures exceeded $1.6B. The majority of Medicaid beneficiaries are enrolled in managed care programs for physical and mental health benefits, and dental benefits are provided on a FFS basis. Additionally, non-emergency medical transportation services are provided under managed care contracts for managed care enrollees but a very small number receive these services on a FFS basis.

The State Medicaid Agency, known as the Med-Quest Division (MQD), is part of Hawaii's Department of Human Services (DHS). The MQD houses a Finance Office with four divisions

that oversee different financial functions for the agency. One of these divisions is the Financial Integrity Staff (FIS), which is responsible for Medicaid program integrity in Hawaii. The MQD's Health Care Services Branch (HCSB) is responsible for activities related to provider enrollment and the managed care contracts. The limited involvement of program integrity in these service arrangements will be seen in the discussion which follows.

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/disclosures, managed care, and relationship with the MFCU. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of June 24, 2013, the CMS review team visited the MQD and conducted interviews with several MQD officials. The team reviewed Hawaii's managed care contracts to determine whether MCEs were complying with the contract provisions and other federal regulations relating to program integrity. The team also conducted in-depth interviews with representatives from four of the five MCEs and met separately with staff from the MQD's HCSB to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications and program integrity cases and reviewed other primary data to validate Hawaii's program integrity practices. In advance of the onsite review, the team conducted an interview with the Hawaii MFCU, which is located within the Criminal Justice Division of the Attorney General's Office.

Scope and Limitations of the Review

This review focused on the activities of the FIS within the MQD but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, and contract management. Hawaii operates its Children's Health Insurance Program (CHIP) as a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Hawaii's Title XIX program. The same findings and vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP expansion program. Unless otherwise noted, Hawaii 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 the MQD provided.

Medicaid Program Integrity Unit

Although the FIS has staff responsible for anti-fraud and abuse activities, the state agency lacks a distinct program integrity unit to perform a full range of program integrity functions. As a consequence, the agency lacks the management and staff resources necessary for program integrity considerations to inform policy development, provider enrollment procedures, contract procurement and monitoring, and the memorandum of understanding (MOU) which defines the agency's relationship with the MFCU. This lack of resources devoted to program integrity is reflected in many of the risks discussed below.

Program integrity positions within the FIS consist of two registered nurse reviewer positions and one investigator position. Even without a distinct program integrity unit, one of the nurse reviewers in the FIS was responsible for leading the staff but officially retired effective June 28, 2013, the last day of the onsite review. This nurse reviewer was three levels below the Medicaid Director organizationally and reported to the FIS's Third Party Liability Specialist.

Between 2007 and the time of the review, the investigator position was only filled from March to December 2012. During the long period in which the FIS's investigator position was vacant, the state agency was unable to conduct any preliminary investigations. The agency did conduct one investigation while the investigator was on board in 2012. However, due to the general lack of staffing, the agency did not have the in-house resources to identify or recoup improper payments and reported no collections from state fiscal years 2010 through 2013. Instead it referred all cases involving possible overpayments and suspected fraud to the MFCU for investigation.

We have dispensed with the usual chart listing preliminary and full investigations and overpayments that accompanies these program integrity review reports because of the absence of data to report.

Results of the Review

The CMS review team found regulatory compliance issues and vulnerabilities related to program integrity in the Hawaii Medicaid program. Several of these issues represent risks to the integrity of the state's Medicaid program. These issues fall into four areas of risk and are discussed below. To address these issues, Hawaii should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's implementation of core program integrity activities.

Conducting Preliminary Investigations

During the last CMS review in 2010, the state was not conducting preliminary investigations. Although the state endeavored to address this issue since the last review as discussed in more detail below, it still faces significant challenges inherent in a structure which does not include a dedicated program integrity unit and has limited staffing dedicated to program integrity activities. These factors make it difficult for the FIS to be proactive in developing and conducting core program integrity functions such as data mining and analysis, audits, investigations, and administrative actions.

Given their organizational position, the FIS was not consulted on issues that could have fraud and abuse implications, such as the need for new edits in Hawaii's Medicaid Management Information System (MMIS), decisions to enroll or not enroll providers, or other general policy decisions within the agency. The review team inquired about investigative, administrative, and audit activities over the last four years. The state indicated that due to its limited staffing, during that time period it has only conducted one preliminary investigation and referred 3 cases to MFCU, all of which were based on complaints received from outside sources. In addition, the

state has not issued any administrative sanctions, identified any overpayments or collected any overpayments during that time period.

The requirement that State Medicaid agencies have the capacity to conduct preliminary investigations is found in the regulation at 42 CFR 455.14. Hawaii briefly had an investigator from the end of March 2012 to the end of December 2012. However, apart from one potential fraud case developed during this period, the state did not conduct any preliminary investigations since the time of the last review. Instead, it forwarded all cases that came to its attention directly to the MFCU, asking the MFCU to conduct the preliminary investigation and make the determination regarding a credible allegation of fraud. While the state agency does have a written policy that describes the process for conducting preliminary investigations, without the necessary staff, it is unable to fulfill this requirement. This is a repeat concern from the 2010 CMS review when the state was cited for not allocating sufficient resources to support a robust fraud and abuse detection program, including failure to conduct preliminary investigations.

Statewide Surveillance and Utilization Control Program

Hawaii is not proactively or effectively utilizing its surveillance and utilization review subsystem (SURS) to monitor claims and encounter data as required by 42 CFR 456.3. During the 2010 CMS review, the state was cited for not performing systematic analyses of FFS claims and managed care encounter data by means of an active SURS or functional equivalent. Based on recommendations from the last review, Hawaii obtained a Data Storage Warehouse in partnership with Arizona's Medicaid program in 2011. In late December 2012, Hawaii also gained access to a SURS, again through the partnership with Arizona. Although the nurse reviewers assigned to program integrity occasionally analyze provider billing patterns for unusual spikes and trends through ad hoc reports, the state does not have a dedicated data analyst position to proactively generate the kind of systematic, ongoing analyses that would be possible with an active surveillance and utilization control program.

A basic program integrity operation should include an overall statewide utilization review and control program which incorporates targeted data analyses and the frequent mining of data for aberrancies. Based on the data provided by the state, none of the referrals made to MFCU were based on SURS analysis, and the state had not yet taken advantage of the new MMIS tools to do systematic studies of over- or underutilization issues related to program integrity.

Recommendations:

- Build a distinct program integrity unit with sufficient resources commensurate with the size of Hawaii's Medicaid program to conduct the full range of program integrity functions, including the review, investigation and auditing of provider types where Medicaid dollars are most at risk.
- At a minimum, begin conducting proactive, systematic data mining activities, such as targeted analyses and frequent analysis of data for aberrancies.
- After generating self leads or when the state receives complaints of Medicaid fraud or abuse, conduct a preliminary investigation to determine whether there is sufficient basis to conduct a full investigation.

- Implement procedures to ensure that program integrity perspectives are considered in all MQD policy discussions as well as major provider enrollment decisions.

Risk Area 2: Risks were identified in fraud detection and investigation.

Suspension of Payments in Cases of Credible Allegations of Fraud

Hawaii does not document good cause exceptions to the requirement of suspending payments in cases of credible allegations of fraud, and it does not maintain adequate documentation on cases referred to the MFCU as required by 42 CFR 455.23. The state has referred three cases to the MFCU in the past four FFYs. Two of the three cases referred by the program integrity staff were from FY 2011 when the state did not have an investigator and did not conduct preliminary investigations. For this reason, the cases were sent directly to the MFCU to determine if a credible allegation of fraud existed. The state indicated to the review team that after it sent each case to the MFCU, it never received any follow up as to whether the MFCU was going to investigate the cases or if credible allegations of fraud existed.

The third case was referred to the MFCU in 2012 when the state did have an investigator on staff. The case contained a well-documented preliminary investigation in which the investigator determined that a credible allegation of fraud existed and referred the case to the MFCU on 7/10/12. After this date, there is no documentation in the case file. The state told CMS that the MFCU verbally requested that the state exercise good cause not to suspend payments on the case. However, there was no documentation in the case file indicating such a request, and at the time of the review, the state had not received an update from the MFCU on the status of the case, despite several state requests for information. This leaves the state in a vulnerable position as it continues to pay referred providers in the absence of any guidance from the MFCU.

The MOU between the MQD and the MFCU does not address timelines for the latter to respond to the state agency. However, in section III, Terms (2), the MOU mentions that the MFCU "shall promptly advise the MQD in writing as to the resolution of all cases referred by the MQD to MFCU." The sample case files reviewed by the team contained no indication that the MFCU had replied in writing either to written MQD referrals or following informal verbal communications that it may have provided the MQD. The MFCU reported that its ability to advise the state in writing on any matter—whether accepting a case, transmitting requests to the state to exercise good cause not to suspend payments, or replying to quarterly certification requests—was limited by the state's Sunshine Law. In addition, the MOU did not address which component was responsible for reporting criminal convictions to HHS-OIG. It also did not contain language on the payment suspension requirements in 42 CFR 455.23 or the CMS fraud referral performance standards.[1]

[1] The currently applicable fraud referral performance standards were issued by CMS on September 30, 2008 and can be found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf.

Recommendations:

- Develop and implement policies and procedures to meet the full requirements of 42 CFR 455.23 concerning documentation in cases with a credible allegation of fraud resulting in a suspension of payments to providers or a good cause exception not to suspend upon MFCU referral.
- Amend the MOU with the MFCU to include the following: (1) required time frames for MFCU responses on the status of cases referred by the state agency; (2) the payment suspension requirements as reflected in 42 CFR 455.23 that took effect on March 25, 2011, (3) the CMS fraud referral performance standards; and (4) the reporting of criminal convictions to HHS-OIG.

Risk Area 3: Risks were identified in the state's provider enrollment practices.

Capturing Ownership and Control Disclosures at Enrollment

During the 2010 CMS review, the state was cited for not collecting ownership and control disclosures from its fiscal agent. Since then, this has been corrected and the fiscal agent has provided the required disclosures. However, the regulatory requirements at 42 CFR 455.104 underwent substantial changes effective March 25, 2011, and Hawaii's provider enrollment forms did not fully address these changes.

The Hawaii FFS provider enrollment form (DHS 1139) is used to enroll all provider types except the fiscal agent and MCEs. The form does not collect the date of birth and Social Security Number (SSN) for persons with ownership and control interests in disclosing entities and the primary business address, every business location, and applicable P.O. Box numbers for corporations as described at 455.104(b)(1)(i) and (b)(1)(ii), respectively. In addition, the form does not collect the address, date of birth, and SSN for managing employees of the disclosing entities in accordance with 455.104(b)(4).

Hawaii has two managed care programs that are administered under separate contracts: Med-Quest (Quest) and QUEST Expanded Access (QExA). The state utilizes a form called "Disclosure Statement (CMS Required)" to obtain ownership and control disclosures from the MCEs for both programs. This form appropriately requests the name and address of each person with an ownership or controlling interest in the disclosing entity. It requires disclosing entities to identify persons with ownership and control interests who also have ownership or controlling interests in any subcontractor or other disclosing entity and asks about familial relationships. However, the form does not capture the enhanced address information from corporate entities as required by 42 CFR 455.104(b)(1)(i). In addition, it does not solicit the date of birth and SSN of persons with an ownership or control interest and does not collect information on managing employees of the MCE.

Enrollment and Screening of Providers

At the time of the review, the state did not require all ordering or referring physicians to be enrolled as participating providers in accordance with 42 CFR 455.410. The HCSB

Administrator indicated that the agency is in the process of implementing this requirement as part of an approved State Plan amendment with an effective date of October 1, 2013.

Verification of Provider Licenses

The state does not have a method to verify the validity of out-of-state provider licenses as required by the regulation at 42 CFR 455.412. Providers are required to submit a copy of a valid license at the time of enrollment. However, state staff indicated that they have no way of validating out-of-state provider licenses or confirming that there are no restrictions.

Termination or Denial of Enrollment

At the time of the review, the state was not uploading or downloading data on provider terminations from CMS's provider terminations database, which state agencies use to identify providers who have been terminated by Medicare or another state's Medicaid or CHIP program as required by 42 CFR 455.416. During interviews, the HCSB Administrator was uncertain whether Hawaii had obtained access to the database. Without such access, the state has no means of determining if providers terminated by Medicare or another state's Medicaid or CHIP program are improperly enrolled in the Hawaii Medicaid program.

Conducting Site Visits

At the time of the review, the state had not conducted pre or post-enrollment site visits of moderate or high risk providers to verify that information submitted to the state is accurate in accordance with the requirements at 42 CFR 455.432.

Exclusion Searches

The 2010 CMS review found that the state agency did not check persons with ownership and control interests, officers and managing employees for exclusion upon enrollment and did not retain complete information on such persons in the Hawaii Prepaid Medical Management Information System (HPMMIS) or in another database.

The current review found that the DHS 1139 enrollment form used to enroll all FFS providers did not collect complete address information, SSNs and dates of birth for persons with ownership and control interests and managing employees. This would make it difficult for the state to validate the name if a match is found. Moreover, the information which the state did obtain was still not stored in the HPMMIS or in another searchable database to make these checks possible. This means that the state cannot run all the appropriate affiliated parties against the federal databases that must be checked at the time of provider enrollment and reenrollment including the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM)[2], the Social Security Administration Death Master File,

[2] In July 2012, the EPLS was migrated into the new System for Award Management (SAM).

and the National Plan and the Provider Enumeration System (NPPES). It also cannot perform proper searches of LEIE or EPLS on a monthly basis.

In its review guide responses, the state agency indicated that it requires FFS providers to screen their employees annually for exclusions. This does not comport with the exclusion checking guidance issued by CMS in State Medicaid Director Letter #09-001, dated January 16, 2009, which recommends monthly screenings of all employees and subcontractors. This vulnerability was also found in the 2010 review.

The current review also found that Hawaii was still not performing complete exclusion checks on persons with ownership and control interests in the MCEs as well as agents and managing employees at the time of contract procurement or on an ongoing monthly basis. It also did not retain the information needed in the HPMMIS or in another searchable database to support these database searches.

Screening Levels for Medicaid Providers

The HCSB is not classifying providers by risk and as a result is not applying the screening criteria required by 42 CFR 455.450 for each risk classification. At the time of the review, HCSB had not yet designated individual providers and specific provider types at the level of limited, moderate, or high risk to the program; and risk-appropriate screenings were not being performed on initial applications, requests for new practice locations, and re-enrollment or revalidation applications.

Medicaid Provider Application Fees

The HCSB enrollment staff indicated that it had not begun collecting application fees prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation at 42 CFR 455.460.

Recommendations:

- Revise enrollment and disclosure forms and contracts used for FFS providers and MCEs to ensure the collection of complete and accurate disclosure information.
- Ensure that names of any person with an ownership or control interest or who is an agent or managing employee of the provider and MCE is stored in the current HPMMIS or searchable database and checked against the LEIE, EPLS, Social Security Administration Death Master File and NPPES upon enrollment and reenrollment, and against the LEIE and EPLS on a monthly basis.
- Develop and implement policies and procedures to address the requirements of 42 CFR 455 Subpart E for enrolling ordering and referring providers, verifying provider licenses, identifying providers terminated by other federal and state health programs, conducting site visits, assigning screening levels, and collecting application fees.

Risk Area 4: Risks were identified related to the state's oversight of managed care.

Program Integrity Oversight in Managed Care

The state does not enforce and the MCEs do not comply with a series of contract requirements on fraud and abuse reporting and data analysis. The state's Request for Proposals (RFP), which has been incorporated into the managed care contract by reference, contains specific MCE reporting requirements on program integrity activities and data analysis (in Section 51.570.1). These include mandated:

- quarterly summaries of fraud and abuse referrals;
- summaries of fraud and abuse training, monitoring and profiling activities; and
- trend analyses of utilization, claims monitoring and claims processing activities.

While the MCEs have been submitting the quarterly reports on referrals, these have mainly been blank, with no activities reported. For the most part, none of the other mandated summaries or analyses of training, monitoring and utilization have been forthcoming. The state does not have staff to monitor mandated MCE reporting and hold the plans accountable.

Hawaii also reported that it did not have policies and procedures in place to monitor plan compliance with the core managed care program integrity requirements at 42 CFR 438.608 and 438.610. Although language on these requirements can likewise be found in the Quest and QExA contracts, the state lacked the personnel to review MCE compliance plans and verify that debarred individuals were not in positions of authority and leadership in MCEs. The RFP included a chart that listed departmental responsibilities for the managed care program. However, it did not make clear which state agency component would be responsible for monitoring MCE compliance with the contract's program integrity provisions. The state's limited resources hinder the performance of effective managed care program oversight even where appropriate contract requirements exist.

In addition to the inadequate monitoring of compliance with baseline managed care regulations and contract requirements on data analysis and case reporting, the team noted other compliance monitoring issues relating to the verification of network provider billings as well as network provider disclosures and screenings. These risks are discussed individually below.

Verifying Beneficiary Receipt of Services

During the 2010 CMS review, MQD did not contractually require the MCEs to verify the receipt of services with beneficiaries. Also, MQD did not independently verify the receipt of services by direct contact with managed care enrollees.

Hawaii's managed care contract now requires the health plans, as a part of their internal controls and policies and procedures, to verify that services were actually provided using random sampling of all members. However, two of the four health plans were not doing this. One of the two plans had been sending Explanations of Medical Benefits through June 2012 but discontinued the process when members mistook the verifications for bills. This plan said it was

in the process of implementing a random sample selection process to verify services. The other plan had no record of doing any verification.

Capturing Ownership and Control Disclosures at Enrollment

At the time of the 2010 CMS review, none of the three MCEs interviewed were collecting the information on ownership and control from their network providers and subcontractors that would otherwise be required from FFS providers under 42 CFR 455.104. Since then, Hawaii has amended its managed care contracts (at section 40.400) to require the collection of full ownership and control disclosures as set forth in 42 CFR 455 Subpart B upon the execution of provider agreements. The current review found that one of the four MCEs was still not collecting the ownership and control information specified at 42 CFR 455.104 within Subpart B. Its provider credentialing form did not solicit any of the information points covered by the regulation.

Requesting Business Transaction Information

The 2010 CMS review found that neither the state's contract with the MCEs nor the MCE provider agreements required network providers to disclose the same business transaction information upon request that FFS providers must furnish under the regulation at 42 CFR 455.105. The current review found that while the managed care RFP had adopted this requirement, two of the four plans were still not requiring the disclosure of business transaction information on request in their provider agreements. One of these plans provided the team with a copy of a revised provider agreement incorporating the 455.105-related language. However, the agreement was not scheduled to take effect until July 2013.

Capturing Criminal History Disclosures at Enrollment

Section 40.400 of Hawaii's managed care RFP and the "scope of work" provisions in the contract require MCEs to report criminal conviction information disclosed by providers as well as the denial of provider applications pursuant to 42 CFR 455.106. However, three of the four health plans interviewed were not soliciting complete criminal conviction information from its network providers. One MCE's application form did ask for criminal conviction information for managing employees. However, it did not specifically ask for the same information regarding agents or persons with ownership or controlling interests in the provider. In addition, two of the MCE applications did not collect health care related criminal conviction information going back to the inception of the Medicaid, Medicare, or Title XX programs.

Exclusion Searches

Hawaii issued a memorandum on May 14, 2013 to the Quest and QExA managed care plans describing changes to the state's MCE contracts which incorporated the new database search requirements. The amended contract language applied to network providers and affiliated parties as well as MCE ownership, management and agents in both the Quest and the QExA programs. However, while the contract amendment for the QExA plans had an effective date of May 1, 2013, the new requirements were not in effect at the time of the onsite review for the Quest program. Rather, their scheduled effective date was July 1, 2013.

Two of the four MCEs interviewed were not checking network providers against the Social Security Administration's Death Master File at the time of enrollment. One of these MCEs was also not checking all names disclosed on the application against the LEIE and EPLS. Additionally, one of the four MCEs did not check its organizational directors or persons with ownership or control interests per 455.436(a) upon enrollment and reenrollment on an ongoing monthly basis.

Reporting Adverse Actions Taken Against Providers

The 2010 CMS review cited the state agency for not requiring the MCEs to inform the agency when the MCEs denied enrollment or credentialing of a provider for program integrity reasons. The contract in effect during the current review required the MCEs to report provider application denials or terminations of providers found to be on the exclusion list or otherwise linked to fraud-related concerns *(QExA section 40.210 p. 75)*. The state also discussed reportable application denials and terminations in its memorandum of May 14, 2013 outlining contract amendments for the Quest and QExA managed care plans. Despite the state's efforts at policy clarification, however, the team found that MCE reporting remained generally inconsistent and incomplete.

For example, one MCE said it reported actions taken to terminate a provider contract and disenroll current providers but not incidents where it denied providers or subcontractors access to the network or decredentialed existing network providers. A second MCE said it reported adverse actions, debarments and suspensions in accordance with federal or state law. However, it did not report the denial of enrollments or credentialing or the refusal to subcontract with providers for cause. A third MCE indicated that it had reported enrollment denials to FIS prior to October 2012 but ceased reporting them afterwards when it discontinued a report that was also used for other purposes. FIS staff said they had requested that this plan's Provider Suspension and Termination Report be reinstated.

The lack of consistency in the reporting of adverse actions prevents the state in turn from reporting some actions to HHS-OIG that would be reportable in the FFS Medicaid program under 42 CFR 1002.3. It also potentially limits the ability of Hawaii Medicaid to prevent problem providers from enrolling in other plans that may not be aware of their prior history.

Recommendations:

- Develop and implement policies and procedures for monitoring MCE compliance with all contractual requirements, including those related to fraud reporting and data analysis as well as the network provider enrollment and disclosure, reporting, screening and service verification requirements cited above. Ensure that internal policies and procedures specify the staff or position titles responsible for ongoing monitoring activities. Ensure that sufficient state agency or contracted staff is available for ongoing monitoring activities.
- Ensure that the federal database search requirements in the Hawaii Quest contract go into effect on a timely basis and are applied to network providers as well as any person with an ownership or control interest in the MCE, or who is an agent or managing employee of the MCE.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Hawaii to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in RISS for information provided by other states including best practices and managed care contracts.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities to address the areas of insufficiency in Risk Area 1.
- Identify other states with state agency-MFCU MOUs that address issues not currently discussed in the Hawaii MOU, such as payment suspensions, timelines for MFCU responses to state agency referrals, and fraud referral performance standards to address the issues outlined in Risk Area 2. The MIG staff can assist Hawaii in identifying other states with appropriate MOU prototypes.
- Consult CMS guidance on payment suspensions including the March 25, 2011 Informational Bulletin located at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer Hawaii to states that are further along in this process to address the areas of non-compliance identified is Risk Area 2.
- Access the annual program integrity review summary reports on the CMS's website. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Hawaii review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate to address the issues outlined in Risk Area 3.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, such as those related to program integrity in managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues to address the issues outlined in Risk Area 4.
- Engage with CMS to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse through the Medi-Medi program and through collaborative audits.

Summary

The instances of non-compliance with federal regulations identified in this report are of concern and should be addressed immediately. CMS is also concerned about uncorrected, repeat risks that remain from the time of the agency's last comprehensive program integrity review.

We will require the state to provide a corrective action plan (CAP) for each of the areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the State Medicaid Agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with Hawaii to build an effective and strengthened program integrity function.

Official Response from Hawaii
August 2014

Neil Aberromie
Governor

Patricia McManaman
Director

Barbara A. Yamashita
Depty Director

State of Hawaii
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August 13, 2014

Mr. Peter Leonis
Medicaid Integrity Group
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Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601

Dear Mr. Leonis

Enclosed you will find the corrective action plan (CAP) from the State of Hawaii Med-QUEST Division (MQD). The CAP is in response to the Program Integrity Review done by your staff in June 2013 and the final report which was recivered June 11, 2014.

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

If you have any questions conering our CAP, please contact Shelley Siegman, R.N., at (808) 692-7962.

Sincerely,

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

Enclosures