Financial Audit of the Med-QUEST Division of the Department of Human Services

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 01-10
May 2001

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

THE AUDITOR
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OVERVIEW

Financial Audit of the Med-QUEST Division of the Department of Human Services

Report No. 01-10, May 2001

Summary

The Office of the Auditor and the certified public accounting firm of KPMG LLP conducted a financial audit of the Med-QUEST Division of the Department of Human Services (division) for the fiscal year July 1, 1999 to June 30, 2000. The audit examined the financial records and transactions of the division; reviewed the related systems of accounting and internal controls; and tested transactions, systems, and procedures for compliance with laws and regulations.

We found deficiencies in the financial accounting and internal control practices of the division. One deficiency included a material weakness, the worst possible type of reportable condition. In this weakness, we found a high error rate (30 percent) in the adjudication of Medicaid fee-for-service claim payments processed by the division's fiscal agent, the Hawaii Medical Service Association (HMSA). This high error rate raises serious concerns over the propriety of reported Medicaid expenditures, which amounted to about $392 million for the fiscal year. Based on our test sample, we concluded that the overpayment rate could have resulted in a potential loss of over $7 million.

We also found a pervasive non-compliance with established policies and procedures and the existence of weak internal controls that could cost the State and Hawaii's taxpayers millions of dollars. We found ineligible enrollees may be receiving medical benefits due to either non-performance or inconsistent performance of (1) required eligibility verification procedures, (2) reviews of eligibility determinations, and (3) required annual eligibility re-verifications. We previously brought these deficiencies to the attention of the division in 1996.

We also found that the division has not performed periodic risk analyses or system security reviews of the Medicaid Management Information System (MMIS) in accordance with federal regulations. In addition, the MMIS edit functions need updating.

During fiscal year ended June 30, 2000, we found approximately 1,100 QUEST applications outstanding over 45 days with an average wait period for eligibility determination of 15 to 16 weeks. Moreover, there is also a significant amount of uncollectible receivables outstanding as QUEST participants are not being disenrolled from the program on a timely basis and the collection efforts of the division are poor. The total premiums receivable at June 30, 2000, amounted to $5.6 million.

We found that the internal controls to protect the division from capitation overpayments diminished when the division transferred the responsibility of reconciling capitation payments to the health plans. There is no existing internal control procedure to verify that capitation payments are accurate. Total expenditures on capitation payments were about $225 million during the fiscal year.

The division also receives over $10 million per year in drug rebates; however, cash is not consistently deposited on a timely basis. Deposits were delayed up to 11 working days, leaving the cash susceptible to potential theft or misuse and a loss of potential interest income.

We also found that over half of the balance of the division's trust fund suspense account of $208,865 cannot be substantiated.

After six years, the division's new information system, which cost about $12 million, remains incomplete. The division will have to continue to pay HMSA (currently about $8 million annually) to process Medicaid fee-for-service claims until the division can add this function to its new system.

Finally, the division continues to pay Medicaid providers without executed provider agreements. Twenty-two provider contracts with Medicaid nursing and acute care facilities expired between July 1 and December 1, 1996.

Recommendations and Response

We recommend that the division establish a well documented and concise claims review processing system, adequately train employees responsible for claims review processing, and ensure that HMSA is notified immediately of any discrepancies identified. The division should hold HMSA accountable for any errors in its claims processing, review all claims for which the division made fee determinations, update the MMIS edit functions, and perform overall risk analyses and system security reviews of the MMIS.

The division should also reduce processing time for eligibility determinations to less than 45 days, perform annual re-verifications of eligibility, award presumptive eligibility to applicants when appropriate, disenroll ineligible enrollees in a timely manner, and implement procedures to actively pursue delinquent premium receivables or consider referring these accounts to collection agencies. The division should resolve the remaining member count discrepancies with health plans and collect all amounts due to the division. Also, the division should deposit cash receipts in a timely manner, investigate outstanding issues related to the trust fund suspense account, and maintain adequate supporting documentation for all claims.

The division should initiate a contract for the Medicaid fee-for-service claims processing system as soon as possible. The division should execute agreements with nursing and acute care facility providers and should also consider appropriate action for non-compliant facility providers.

The Department of Human Services (department) generally agrees with most of our findings and recommendations. For some of the findings the department did not respond. The department also indicated that the division has implemented or is in the process of implementing some of our recommendations.

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State Auditor
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A Report to the Governor and the Legislature of the State of Hawaii

Conducted by

The Auditor
State of Hawaii
and
KPMG LLP

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 01-10
May 2001

Foreword

This is a report of the financial audit of the Med-QUEST Division of the Department of Human Services for the fiscal year July 1, 1999 to June 30, 2000. The audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes, which requires the State Auditor to conduct postaudits of all departments, offices, and agencies of the State and its political subdivisions. The audit was conducted by the Office of the Auditor and the certified public accounting firm of KPMG LLP.

We wish to express our appreciation for the cooperation and assistance extended by officials and staff of the Med-QUEST Division.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

This is a report of our financial audit of the Med-QUEST Division of the Department of Human Services. The audit was conducted by the Office of the Auditor and the independent certified public accounting firm of KPMG LLP. The audit was conducted pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the State Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State of Hawaii (State) and its political subdivisions.

Background

The State Legislature created the Department of Social Services and Housing in 1959. In 1987, the department's name was changed to the Department of Human Services (department). Section 26-14, HRS describes the department's responsibilities:

> The department shall administer programs designed to improve the social well-being and productivity of the people of the State. Without limit to the generality of the foregoing, the department shall concern itself with problems of human behavior, adjustment, and daily living through the administration of programs of family, child and adult welfare, economic assistance, health care assistance, rehabilitation toward self-care and support, public housing, and other related programs provided by law.

In January 1994, the department's Health Care Administration Division was reorganized as the Med-QUEST Division (division). The division provides overall management of the plans, policies, regulations, and procedures of the department's medical assistance programs. These programs are designed to provide medical services to eligible individuals and families through either the Medicaid fee-for-service program or the QUEST program.

The Medicaid fee-for-service program provides medical assistance to residents who are 65 years or older, blind, or disabled who meet the existing eligibility criteria based on specified income and asset levels. Eligible Medicaid recipients may receive covered services from any qualified health care provider. The division reimburses contracted health care providers on a fee-for-service basis for services provided to Medicaid participants based on negotiated standard costs and rates. Providers submit claims to the division's fiscal agent for payment.

QUEST is an acronym that represents:

Quality care, ensuring
Universal access, encouraging
Efficient utilization,
Stabilizing costs, and
Transforming the way health care is provided.

The QUEST program is a result of the State's efforts to reform the Medicaid program. Each state is allowed to reform its Medicaid program under Section 1115 of the Social Security Act, which outlines requirements for experimental, pilot, or demonstration projects by states. It allows the U.S. Secretary of Health and Human Services to waive compliance with any requirements of certain sections of statutes, including Medicaid, for any projects that would promote the objectives of the Social Security Act.

In July 1993, the Health Care Financing Administration, the federal agency responsible for Medicaid, approved the department's Medicaid Section 1115 waiver application to provide Medicaid services to Hawaii recipients through managed care plans. This was called the QUEST program. The waiver covered the period April 1, 1994 through March 31, 1999, and has been subsequently extended through March 31, 2002. The QUEST program was implemented in August 1994 by enrolling participants in the Aid to Families with Dependent Children (presently known as Temporary Assistance to Needy Families), the General Assistance Program, and the State Health Insurance Program. Under the QUEST program, the division contracts with selected private health plans to provide medical services to QUEST participants. The division pays the health plans a monthly capitated rate. The health plans are responsible for providing the required range of comprehensive services through contracts with providers. Reimbursement methodologies between the health plans and providers may include a mix of fee-for-service and/or capitation arrangements.

Exhibit 1.1 displays the number of participants and federal and state expenditures of the Medicaid and QUEST programs for fiscal years 1999 and 2000.

Exhibit 1.1
Medicaid and QUEST Participants and Federal and State Expenditures

	Medicaid Program			QUEST Program		
		Expenditures			Expenditures	
Year	Enrollees	Federal	State	Enrollees	Federal	State
1999	33,000	$ 184,006,000	$ 186,167,000	123,000	$ 115,058,000	$ 124,111,000
2000	34,000	$ 207,435,000	$ 184,224,000	118,000	$ 116,397,000	$ 109,831,000

Funding for Medicaid and QUEST

Medicaid and QUEST are financed by state and federal funds, approximately 50 percent respectively. Federal funds are authorized and received through the Social Security Act, Title XIX of the U.S. Code. QUEST is expected to remain "budget neutral" over the three-year period from April 1, 1999 through March 31, 2002. In other words, the QUEST program would cost the state government no more than what the previous Medicaid program would have cost.

Organization

The division's administration is responsible for overall management of the division and reports to the director of human services. Under the direction of the division administrator, division administration is responsible for the plans, policies, regulations, and procedures of the medical assistance programs. Division administration is also responsible for organizing, directing, coordinating, evaluating, and maintaining an organization that will ensure accomplishment of the division's objectives. The division is organized into four offices and three branches as displayed in Exhibit 1.2.

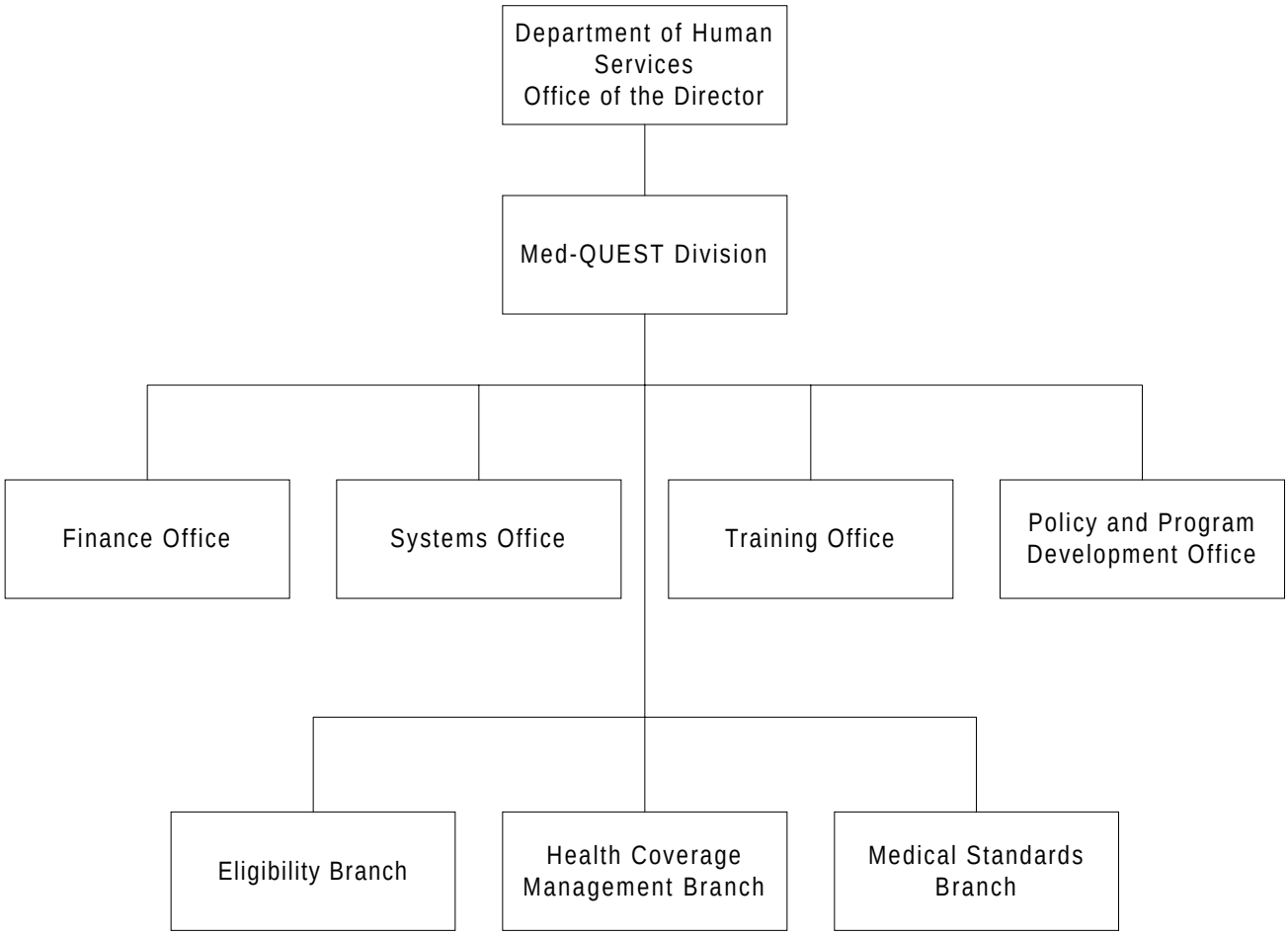
Offices

Four offices provide support services to the division administration.

The Finance Office coordinates, manages, and administers the division's fiscal and budget activities for all medical assistance programs.

The Systems Office manages, coordinates, and administers the division's information systems activities related to the medical assistance programs. In addition, this office assures that business requirements of the Medicaid program are defined, implemented, validated, and tested in the complex information systems that support the division. The Hawaii Automated Welfare Information System and the Medicaid Management Information System are the two primary systems that support the division.

Exhibit 1.2
Med-QUEST Division Organizational Chart



The Training Office manages the training function activities related to medical staff development training programs in accordance with state laws and regulations and departmental policies and procedures.

The Policy and Program Development Office is responsible for providing staff support and assistance to the division in the establishment and maintenance of short and long-term goals, objectives, and policies related to the medical assistance programs and new programs. In addition, this office coordinates with the Finance Office on the development of procurement requirements for Requests For Proposals (RFP) or Invitation For Bids (IFB) and develops evaluation criteria for the selection process.

Branches

Three branches also provide support services for the division administration.

The Eligibility Branch, which includes neighbor island sections, is responsible for implementing the statewide program for eligibility determination related to the medical assistance programs. In addition, this branch coordinates with the Finance Office on the development of procurement requirements for RFPs and IFBs and develops evaluation criteria for the selection process.

The Health Coverage Management Branch manages and carries out the QUEST program and the Children's Health Insurance program, as authorized under Title XXI of the Social Security Act, and services Medicaid providers in the fee-for-service Medicaid program.

The Medical Standards Branch develops and maintains statewide standards for care provided under the medical assistance programs.

Objectives of the Audit

1. To assess the adequacy, effectiveness, and efficiency of the systems and procedures for the financial accounting, internal control, and financial reporting of the division; to recommend improvements to such systems, procedures, and reports; and to report on the financial statements of the division.

2. To ascertain whether expenses or deductions and other disbursements have been made and all revenues or additions and other receipts have been collected and accounted for in accordance with federal and state laws, rules and regulations, and policies and procedures.

3. To make recommendations as appropriate.

Scope and Methodology

We audited the financial records and transactions and reviewed the related systems of accounting and internal controls of the division for the fiscal year July 1, 1999 to June 30, 2000. We tested financial data to provide a basis to report on the fairness of the presentation of the financial statements. We also reviewed the division's transactions, systems, and procedures for compliance with applicable laws, regulations, and contracts.

We examined the existing accounting, reporting, and internal control structure and identified deficiencies and weaknesses therein. We made

recommendations for appropriate improvements including, but not limited to, the forms and records, the management information system, and the accounting and operating procedures.

The independent auditors' opinion as to the fairness of the division's financial statements presented in Chapter 3 is that of KPMG LLP. The audit was conducted from July 2000 through November 2000 in accordance with generally accepted government auditing standards.

Chapter 2

Internal Control Deficiencies

Internal controls are steps instituted by management to ensure that objectives are met and resources are safeguarded. This chapter presents our findings and recommendations on the financial accounting and internal control practices and procedures of the Med-QUEST Division of the Department of Human Services (division).

Summary of Findings

Our findings are summarized as material weaknesses and reportable conditions. We found numerous reportable conditions involving the division's internal control over financial reporting and operations.

Reportable conditions are significant deficiencies in the design or operation of the internal control over financial reporting. In our judgment, these deficiencies could adversely affect the division's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

A material weakness is the worst possible type of reportable condition. A material weakness exists when management controls are such that misstatements in amounts that are material to the financial statements being audited may occur. Misstatements may not be detected within a timely period by employees in the normal course of performing their assigned functions.

The following matter is considered a material weakness:

1. The high error rate in the adjudication of Medicaid fee-for-service claim payments processed by Hawaii Medical Service Association raises serious concerns about the propriety of reported Medicaid expenditures, which amounted to $392 million or 60 percent of the division's total expenditures for the fiscal year ended June 30, 2000.

Other reportable conditions are summarized as follows:

2. The pervasive non-compliance with established policies and procedures and the existence of weak internal controls could cost the State and Hawaii's taxpayers millions of dollars.

3. After more than six years, the division's new information system has yet to be completed. Even when the new system is implemented, it will not fulfill all of the division's information technology requirements.

4. The division continues to pay 22 facility providers for medical services even though it has not executed provider agreements with these facilities.

Similar material weaknesses and reportable conditions were communicated to the Department of Human Services and the division in our Report No. 96-19, *Audit of the QUEST Demonstration Project*, and Report No. 98-14, *Financial Audit of the Department of Human Services*.

Significant Errors Detected in Claims Processed by Hawaii Medical Service Association

The most significant program administered by the division is the Medicaid fee-for-service program. In fiscal year ended June 30, 2000, this program accounted for approximately $392 million or 60 percent of total expenditures for the division. The Medicaid program covers those persons who meet income and asset requirements and are 65 years or older, certified as blind by the State, or determined disabled. Fee-for-service means that the program pays physicians and hospitals for each service provided to Medicaid patients. The Section 1115 waiver that allows the division to administer the QUEST program (using capitated payments) does not cover current enrollees in the Medicaid fee-for-service program.

In 1971, the division contracted with the Hawaii Medical Service Association (HMSA) to act as its fiscal agent and to make payments to physicians and hospitals for services provided to Medicaid patients. The contract requires HMSA to review medical claims for accuracy and to pay physicians and hospitals the proper amounts due them. The division remits funds to HMSA to pay the providers. For fiscal year ended June 30, 2000, the division paid approximately $8.4 million to HMSA to process approximately 3,729,000 Medicaid fee-for-service claims.

To test the validity and propriety of Medicaid claims paid by HMSA, we selected a random sample of 50 claims amounting to $721,900 that were submitted by providers and processed and paid by HMSA during the fiscal year ended June 30, 2000. Of the 50 claims tested, we found 15 pricing and authorization errors, which is an error rate of 30 percent. The errors were comprised of five underpayments amounting to $76,800 and ten overpayments amounting to $9,600.

Providers of medical services must obtain authorization from HMSA prior to issuing certain medical goods or performing certain medical procedures. The authorization errors we found related to the submission of claims for unauthorized goods and services. The pricing and authorization errors detected included both computer and manually adjudicated medical, hospital, drug, and third party liability claims.

Errors included claims coded and priced incorrectly, incorrect approval codes submitted, and incorrect payments due to examiner error. However, we were unable to isolate those errors to any particular type of claim. The high error rate, 30 percent of the number of claims tested, the randomness of the errors, and the limited monitoring and oversight procedures of the division, raise serious concerns regarding the propriety of the reported Medicaid program expenditures and the reliability of the work of HMSA.

We also reviewed the noted errors to determine the potential financial impact on the division. Of the five underpayments noted, one was for $76,634, and the remaining four totaled $166. After extracting the underpayment of $76,634 from the total errors noted, due to its abnormality, the remaining underpayments and overpayments net to a total overpayment of $9,434, or an overpayment error rate of 2 percent. Such an error rate, when applied to the total payments made during the fiscal year ended June 30, 2000, represents a potential loss of over $7 million.

The division's review of Medicaid claims processing is weak

The division is responsible for ensuring that its claims payment standards are upheld, including the accuracy of Medicaid claims processed. The division has instituted internal control procedures such as pricing of unusual claims, surveillance and utilization reviews of providers with unusual types and levels of services, reviews of long-term care claims, and third party reviews of acute hospital claims. However, the control procedures focus on unusual and specific types of claims. The division has not developed clear guidelines for its staff to follow in reviewing the majority of Medicaid claims processed by HMSA. The division has not set guidelines for the number of claims to be tested, determination of which claims are to be tested, regularity of testing of claims, method of documentation of testing, etc. Also, there is no documentation regarding the training of claims reviewers. We note that the division has completed some reviews with relatively few errors detected. However, with a 30 percent error rate noted in our sample of 50 claims, it is difficult for us to understand why only a few errors were detected in the reviews conducted by the division. We believe that errors are likely occurring with significant frequency.

System security reviews of the Medicaid Management Information System are not performed

HMSA operates, maintains, updates, and safeguards the Medicaid Management Information System (MMIS), which processes Medicaid claims. The MMIS calculates eligible fee-for-service claims and contains system edits to ensure that payments for Medicaid claims are proper and accurate. We found that the division has not performed periodic risk analyses or system security reviews in accordance with federal regulations. The division is responsible for establishing and

maintaining a program for conducting periodic risk analyses to ensure that appropriate, cost effective safeguards are incorporated in existing systems. System security reviews should include an evaluation of physical and data security operating procedures and personnel practices. These reviews are required on a biennial basis or whenever significant changes occur. The division's last system performance review was performed in December 1995.

MMIS edit functions need updating

MMIS edit functions are programmed into the MMIS system to suspend pricing on unusual claims. For example, if a provider submits a claim for payment for more than an authorized quantity of any item, such as for ten syringes when only five were authorized, the MMIS system will suspend this claim for an examiner to review. HMSA is responsible for updating the edit functions on an "as needed basis." Some of the errors noted in our testing may have been avoided if the MMIS system edits had been updated.

Recommendations

We recommend that the division perform the following:

- Establish a well documented and concise claims review processing system, adequately train employees who will be responsible for claims review processing, and ensure that HMSA is notified immediately of any discrepancies identified;

- Hold HMSA accountable for any errors in its claims processing. The contract with HMSA states, "If an overpayment or duplicate payment is made or if adequate documentation is not maintained, and the payment is the result of either a failure of the contractor to utilize available information or a failure of the contractor to process correctly, then the contractor shall be liable for the overpayment or the duplicate payment in addition to the administrative cost, including personal services, operating expenses, and computer charges, incurred by the State in identifying such overpayment or duplicative payment";

- For all claims for which the division made fee determinations, the division should review these determinations and claim payments for propriety;

- Update the MMIS edit functions; and

- Perform overall risk analyses and system security reviews of the MMIS.

The Division Does Not Comply with Established Policies and Procedures and Internal Controls Are Weak

During our testing, we noted that the division does not comply with established policies and procedures and the existing internal controls are weak. This could cost the State and Hawaii's taxpayers millions of dollars. The division currently receives over $300 million in state appropriations and is responsible for assuring that the money is spent reasonably and properly in administering the division's programs. Based on our testing, it appears this may not be the case and that millions of dollars are being unnecessarily wasted.

Ineligible enrollees may be receiving medical benefits

The rising costs of providing medical services and the state's limited resources make it imperative that the division provide medical benefits only to eligible participants. To accomplish this goal, management has established policies and procedures for eligibility determination to ensure that only eligible persons are enrolled in the Medicaid and QUEST programs. However, during our review, we found that these policies and procedures are not consistently followed in practice. As a result, ineligible recipients may be receiving medical benefits at the expense of Hawaii's taxpayers.

Required eligibility verification procedures are not performed or documented on a consistent basis

To ensure that only eligible individuals participate in the Medicaid and QUEST programs, the division is required to obtain, verify, and certify certain information provided by applicants. Hawaii Administrative Rules require that caseworkers document verification of applicants' identification, income, and asset information against government databases of the state Department of Labor and Industrial Relations, the counties' Real Property Tax and Motor Vehicle Divisions, and the Social Security Administration. Moreover, the division requires that caseworkers certify the "Application for Medical Assistance." This certification provides evidence that applicants have been properly informed of their rights and responsibilities and of the services offered by the program.

As part of our audit, we randomly selected 25 participants to verify that standardized procedures were being followed. We found that only eight case files contained all of the required documentation and certifications. Of the remaining 17 case files, none contained documentation of income verification against other government databases, and three files did not contain documentation of identification verification or a certified "Application for Medical Assistance."

Reviews of eligibility determination are not performed on a consistent basis

The division's policies and procedures require a review of the eligibility determination by a caseworker other than the preparer. This review provides the division with additional assurance that eligibility determinations are being properly performed. Due to the high percentage of case files with missing information noted in our sample, and no evidence (such as a signature) of the performance of the reviews, it does not appear that the second reviews are being conducted. And, if second reviews are, in fact, being performed, then proper review procedures are apparently not being followed. As an additional internal control measure, supervisors are required to review between five to ten completed applications per month. Although we were informed that only about half of the supervisors performed reviews, we were unable to verify that any reviews were being completed.

Required annual eligibility re-verifications are not performed on a consistent basis

Hawaii Administrative Rules require annual re-verification of QUEST and Medicaid participant eligibility. These annual re-verifications serve as an on-going process to ensure that enrollees continue to meet eligibility requirements. We randomly selected a sample of 25 enrolled participants and found that seven participants did not have re-verification procedures performed. Of the 18 re-verifications that were performed, we found that seven case files did not have a certified "Application for Medical Assistance" and two case files did not have an "Eligibility Determination Form," which serves as a checklist to ensure that all eligibility requirements are met. Although some eligibility re-verifications are being performed, they are not being done properly or consistently.

Unacceptable delays exist in eligibility determination

We were informed that during fiscal year 2000, there were approximately 1,100 QUEST applications outstanding over 45 days and that the average waiting period was 15 to 16 weeks. Hawaii Administrative Rules and federal regulations state that, if eligibility determination for medical assistance is delayed beyond 45 days for QUEST applications, a presumption of medical eligibility shall be made on the 46th day until eligibility is determined. This rule ensures that eligible persons are not denied medical benefits because of the ineffectiveness of the government.

As of June 30, 2000, the division did not have procedures to alert caseworkers when QUEST program applications were delayed over 45 days, requiring that presumptive eligibility be awarded to applicants.

The division estimates that only 1 percent of all eligible applicants were awarded presumptive eligibility. As a result, the division was not in compliance with Hawaii Administrative Rules and federal regulations that requires awarding presumptive eligibility for all persons waiting beyond 45 days for eligibility determination.

Complaint prompts changes to the eligibility determination process

The backlog of applications prompted a complaint from the American Civil Liberties Union (ACLU) in March 2000, threatening litigation on behalf of the public for not processing applications in a timely manner. The ACLU asserted that the division was requesting unnecessary information from applicants. Confirming the ACLU complaint, we found ten instances out of a random sample of 25 applicants where unnecessary information was obtained from applicants, including copies of the applicant's social security card, copies of more than one proof of identification, and a signed letter from an applicant's mother stating that the mother did not claim the applicant as a dependent.

In response to the complaint, the division issued a memorandum in April 2000 clarifying the types of information required to be obtained from applicants, as well as the types of information that should not be requested, even though they may have been requested in the past. In addition, the division implemented a "screening" process whereby applications were reviewed for completeness and preliminary eligibility was determined.

We randomly sampled an additional 15 applications received on or after March 31, 2000 and found that six were not approved within 45 days of the application date. Of the six applicants, we found that only one applicant had received presumptive eligibility.

Significant uncollectible receivables are recorded

Under the QUEST and QUEST-Net programs, the division pays a premium (capitated payment) to various health care plans for medical services provided to program enrollees. Certain enrollees are required to reimburse the division for either 50 percent or 100 percent of the premiums, which equate to approximately $30 or $60 per person per month, respectively. The enrollee's share of the premium payment is based on asset and income levels.

The division's policies and procedures require that division personnel initiate disenrollment procedures for enrollees whose premium share payments are two months in arrears. When an enrollee's account balance becomes delinquent for two months, the division's finance office notifies the respective income maintenance worker. Income

maintenance workers are responsible for notifying enrollees that they have ten days to pay their delinquent balance or be disenrolled from the program. If payment is not received within the ten-day period, income maintenance workers then initiate procedures to disenroll these individuals from the QUEST program. Disenrolled individuals are not allowed back into the QUEST program until their delinquent balance is paid off.

At June 30, 2000, the total premiums receivable balance amounted to $5.6 million. We found that the average outstanding balance of approximately 14,000 accounts in the accounts receivable subsidiary ledger was $400.

QUEST participants are not being disenrolled from the program on a timely basis

Our random sample of ten enrollees taken from the accounts receivable subsidiary ledger revealed that outstanding premiums amounted to $22,500 or $2,250 per person and were outstanding for an average of 14 months. The division is not adhering to disenrollment policies. The maximum outstanding premiums per person should be approximately $60 to $120. Although more than one individual may be registered under an account, the outstanding premiums should not total $2,250. Outstanding premiums per person should be for two months but not 14 months. As a result, the division continues to pay premiums to health plans for individuals who were not disenrolled from the program in a timely manner.

Collection efforts are insufficient

The uncollectible premium receivable balance has continually grown since inception of the QUEST program to approximately $5.6 million. The division does not actively pursue amounts due from participants. Collection efforts to date have been limited primarily to the mailing of invoices. The division is currently in the process of working with the state Department of the Attorney General to write off the majority of the premium receivables balance at June 30, 2000.

The uncollectible balance represents an additional state subsidy for the program. The division's failure to disenroll persons in accordance with Hawaii Administrative Rules and its failure to adequately follow up on past due accounts contributes to the rising costs of the QUEST program.

Overpayments for two health plans remain outstanding

Under the QUEST program, the division pays a monthly capitation payment to each health plan for each QUEST enrollee. Enrollee information from the Hawaii Automated Welfare Information system is submitted to both the division and the health plans on a daily and

monthly basis. This information is loaded into the respective entities' databases for billing and record keeping purposes. Prior to October 1999, at the beginning of each month, the health plans submitted to the division invoices for the enrollees as of the beginning of the month, plus additions and less deletions of enrollees from the previous month. For example, September invoices would include enrollees at the beginning of September, plus any new enrollees in August less any persons leaving the program in August. The division then compared this information to its own records. This reconciliation usually resulted in numerous errors. Consequently, the division is still in the process of determining the amount of capitation overpayments outstanding from two health plans dating back to 1995.

Internal controls to protect the division from capitation overpayments have diminished

In October 1999, the division transferred the reconciliation of capitation payments to the health plans to alleviate the labor burden on its staff. Currently, the division notifies health plans of the member count based on its records and the amount of capitation payment. Health plans are responsible for reconciling capitation payment amounts and enrollment information from the division's records with their own records. Since implementation of these procedures, health plans have reported no discrepancies in enrollment information. This seems peculiar since numerous reconciling items were noted prior to October 1999. The procedures used to capture enrollment information by both the division and the health plans have not changed with the change in the billing and reconciliation procedures. Therefore, it appears that either the health plans are not reconciling enrollment information or are not notifying the division of reconciling items. In either case, the division does not have an internal control procedure, as it did previously, to verify that capitation payments are accurate. Considering that total expenditures on capitation payments in the fiscal year ended June 30, 2000 amounted to approximately $225 million, the impact to the division could be significant.

Cash is not consistently deposited on a timely basis

The division collects more than $10 million annually in drug rebates from manufacturers. These rebates, which normally exceed $100,000 per check, are received on a quarterly basis from approximately 400 drug manufacturers.

In order to verify the controls over cash receipts, we tested a random sample of 25 deposits. We found 16 instances, for a total of $1.8 million, in which cash receipts were not deposited on the day of receipt or on the subsequent working day. These deposits were delayed up to 11 working days and averaged over three working days after the day of

receipt. As a result, the deposits were susceptible to potential theft or misuse during this period and the division lost interest income.

Over half of the balance of the Med-QUEST Trust Fund Suspense Account could not be substantiated

The division pays medical expenses for Medicaid participants involved in accidents even when there is a third party liability. The third party then pays the division a settlement amount that is deposited into the Med-QUEST Trust Fund Suspense Account (trust fund). Upon resolution by the courts, the division remits payment to the respective parties (i.e., the federal government, state government, or the individual). The total balance of the trust fund amounted to $208,865 at June 30, 2000.

In fiscal year 2000, the division re-created its subsidiary ledger for the trust fund because it had lost the subsidiary ledger file in 1998 due to a computer disk drive failure, lack of back-up procedures, and lack of printed hard copies. Subsequently, the division implemented back-up procedures and now prints hard copies. During our audit, we found two items totaling $107,300, out of a sample of 15 items, which were not supported by adequate documentation for cash receipts. These two items accounted for more than half the trust fund's balance. Disputes may arise with third parties and funds may be lost upon resolution of these items.

Deficiencies have existed for over five years

Many of the weaknesses identified in this report have existed for a number of years. In 1996, the Office of the Auditor audited QUEST soon after it became a demonstration project. In Report No. 96-19 issued in December 1996, the Auditor identified a number of deficiencies. Among them were the following: 1) ineligible people may be receiving QUEST benefits due to weaknesses in the enrollment process, a lack of standardized procedures for eligibility determination, and lack of management controls, and 2) annual re-verifications of enrollee eligibility are not performed. Also, in audits performed by the division's own external auditors for fiscal years ended June 30, 1995 to June 30, 1999, numerous deficiencies were identified. Among these deficiencies were: 1) controls over cash receipts were weak, and 2) accounting procedures for the trust fund suspense account must be improved.

Recommendation

We recommend that the division enforce established policies and procedures and review existing internal controls to ensure they are sufficient. We also recommend that the division perform the following:

- Reduce processing time for eligibility determination to less than 45 days;

- Perform annual re-verifications of eligibility;
- Award presumptive eligibility to applicants when appropriate, in accordance with Hawaii Administrative Rules and federal regulations;
- Disenroll ineligible enrollees in a timely manner;
- Implement procedures to actively pursue delinquent premium receivables and consider referring these accounts to collection agencies;
- Resolve the remaining member count discrepancies with health plans and collect all amounts due to the division;
- Obtain and reconcile to the division's records the member counts from the health plans or obtain and review the reconciliation performed by the health plans;
- Deposit cash receipts daily, or at a minimum, the next working day;
- Investigate outstanding issues related to the trust fund suspense account; and
- Maintain adequate supporting documentation, especially in cases where a third party pays the division a settlement amount.

The Division's New Information System Remains Incomplete After Six Years

A fully functional information system is essential to effectively monitor and evaluate the Medicaid fee-for-service and QUEST programs. After more than six years since inception of the QUEST program and after abandonment of the QUEST Information System (QIS), on December 8, 2000 the division began operation of its new information system, the Hawaii Arizona Prepaid Management Information System Alliance (HAPA) system. The newly implemented HAPA system does not meet all of the division's information technology requirements as it does not have the ability to process Medicaid fee-for-service claims.

The QUEST Information System was abandoned after almost three years of development

The contract for the development of QIS was awarded to a consultant in December 1994. QIS was originally projected to be completed on September 30, 1997, but because of the consultant's inability to deliver the contracted system, the contract was terminated effective September 30, 1997. Both parties accepted partial responsibility for failure of the project. We previously found that the division had not provided

adequate systems staff to support the design and development of QIS despite the repeated recommendations of the Health Care Financing Administration. Additionally, the report pointed out concerns of division officials regarding management problems experienced by the consultant, changes in the consultant's staff, and communication problems between the consultant and division staff. It can be concluded by the end result that both parties contributed to the failure of the project.

Delay is costly

The delay and abandonment of QIS has been costly for the division. Since September 30, 1997, the expected completion date of the QIS project, the division has paid approximately $22 million to HMSA to process Medicaid fee-for-service claims and a consultant to accumulate utilization data. This amount could have been reduced had QIS been completed as scheduled.

The HAPA system will not fulfill all of the division's information system requirements

The HAPA system (at a cost of $12 million) does not have the ability to process Medicaid fee-for-service claims. Currently, claims submitted by medical providers under the Medicaid program are processed by HMSA. The division pays an annual fee of approximately $8 million to HMSA for processing these claims and maintaining the MMIS. As long as only the HAPA system is operational, the division will continue to incur these costs and still have only some of its system requirements met in-house.

Recommendation

We recommend that the division initiate a contract for the Medicaid fee-for-service claims processing system as soon as possible.

The Division Continues to Pay Medicaid Providers Without Executed Provider Agreements

Title 42 CFR Part 431.107 requires the division to execute a provider agreement with each provider or organization furnishing services under the Medicaid program. The agreement requires the provider to retain records, furnish information, and comply with federal regulations. Properly executed contracts are essential to ensure agreement on the type and scope of services and clearly delineate the roles and responsibilities of the division and the Medicaid providers to avoid confusion or misunderstanding. It is essential that contracts be properly executed before any services are provided. Without the benefit of a contract, there is no assurance that services being provided are those that are required. Additionally, providing services without contractually defined roles and responsibilities puts both the State and Medicaid providers in jeopardy should any legal problems arise.

We found that the division is delinquent in executing agreements with facility providers. Twenty-two provider agreements with Medicaid nursing and acute care facilities have not been executed. The division had previously executed facility contracts that expired between July 1 and December 1, 1996. On January 27, 1998, the division was notified by the state Department of the Attorney General that these facility contracts were not required. However, the division was still required to obtain provider agreements in order to be in compliance with federal regulations. The division revised its standard provider agreement to incorporate essential provisions from the facility contracts. The division planned to execute these revised agreements, "Application Agreement to Participate as a Provider of Service in the Hawaii State Medicaid Program," effective July 1, 1998. However, the division has not obtained revised provider agreements from these facilities and continues to pay them for medical services despite the lack of valid, executed agreements.

The division believes that the roles and responsibilities of both parties are delineated in previously completed and signed Medicaid provider applications which specify provider responsibilities and agreements based on Hawaii Administrative Rules. This is an unacceptable practice and should be remedied immediately. We were informed that certain facilities are reluctant to sign such agreements, which are based on federal and state guidelines, because of certain provisions in the provider agreement. Based on this information, it appears that some facilities and the division are not in agreement as to their roles and responsibilities under the Medicaid program.

Recommendation

We recommend that the division immediately execute agreements with nursing and acute care facility providers. The division should also consider appropriate action for non-compliant facility providers.

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Chapter 3

Financial Audit

This chapter presents the results of the financial audit of the Med-QUEST Division of the Department of Human Services (division), as of and for the fiscal year ended June 30, 2000. This chapter includes the independent auditors' report and the report on compliance and on internal control over financial reporting based on an audit of financial statements performed in accordance with *Government Auditing Standards* as they relate to the division. It also displays the combined financial statements of all fund types and account groups administered by the division together with explanatory notes.

Summary of Findings

KPMG LLP was unable to and did not express an opinion on the combined financial statements of the division as of and for the fiscal year ended June 30, 2000. Since KPMG LLP was unable to apply auditing procedures to satisfy themselves as to the account balances related to the Medicaid program expenditures, the scope of the firm's work was not sufficient to enable them to express an opinion on the combined financial statements. KPMG LLP noted matters involving the division's internal control over financial reporting and its operations that the firm considered to be reportable conditions, including a material weakness as defined in the report on compliance and on internal control over financial reporting based on an audit of financial statements performed in accordance with *Government Auditing Standards*. KPMG LLP also noted that the results of its tests disclosed instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Independent Auditors' Report

The Auditor
State of Hawaii:

We were engaged to audit the combined financial statements of the Med-QUEST Division of the Department of Human Services, State of Hawaii (division), as of and for the fiscal year ended June 30, 2000. These combined financial statements are the responsibility of the division's management.

As discussed in note 1 to the combined financial statements, the combined financial statements of the division are intended to present the financial position and results of operations of only that portion of the funds and account groups of the State of Hawaii that is attributable to the transactions of the division.

While performing auditing procedures on the Medicaid program expenditures amounting to $184,223,977 and $207,435,365 reported in the general and special fund, respectively, we found errors in the calculation of Medicaid claim expenditures. It was impracticable to extend our procedures sufficiently to determine the extent to which the combined financial statements as of and for the fiscal year ended June 30, 2000, may have been affected by this condition.

Since we were not able to apply auditing procedures to satisfy ourselves as to Medicaid program expenditures and the related balance sheet accounts, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on these combined financial statements.

In accordance with *Government Auditing Standards*, we have also issued our report dated November 17, 2000 on our consideration of the division's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Honolulu, Hawaii
November 17, 2000

Report on Compliance and on Internal Control Over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Auditor
State of Hawaii:

We were engaged to audit the combined financial statements of the Med-QUEST Division of the Department of Human Services, State of Hawaii (division), as of and for the fiscal year ended June 30, 2000, and have issued our report thereon dated November 17, 2000. Since we were not able to apply auditing procedures to satisfy ourselves as to Medicaid program expenditures and the related balance sheet accounts, the scope of our work was not sufficient to enable us to express, and we did not express, an opinion on the combined financial statements of the division as of and for the fiscal year ended June 30, 2000.

Compliance

As part of obtaining reasonable assurance about whether the division's combined financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grants, including applicable provisions of the Hawaii Public Procurement Code (Chapter 103D of the Hawaii Revised Statutes) and procurement rules, directives, and circulars, noncompliance

with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance that are required to be reported under *Government Auditing Standards* and which are described in Chapter 2 of this report.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the division's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the combined financial statements and not to provide assurance on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the division's ability to record, process, summarize, and report financial data consistent with the assertions of management in the combined financial statements. Reportable conditions are described in Chapter 2 of this report.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the combined financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, of the reportable conditions described above, we consider the matter relating to the internal controls over Medicaid program expenditures described in Chapter 2 of this report to be a material weakness.

This report is intended solely for the information and use of the Auditor, State of Hawaii, and the management of the Med-QUEST Division and the Department of Human Services, State of Hawaii, and is not intended to be and should not be used by anyone other than these specified parties.

Honolulu, Hawaii
November 17, 2000

Description of Combined Financial Statements

The following is a brief description of the combined financial statements audited by KPMG LLP, which are located at the end of this chapter.

Combined financial statements

Combined Balance Sheet – All Fund Types and Account Groups (Exhibit A). This statement presents the assets, liabilities, and fund balance (deficit) of all fund types and accounts groups of the division at June 30, 2000.

Combined Statement of Revenues, Expenditures and Changes in Fund Balance (Deficit) – All Governmental Fund Types (Exhibit B). This statement presents the revenues, expenditures and changes in fund balance (deficit) for all governmental fund types of the division for the fiscal year ended June 30, 2000.

Combined Statement of Revenues and Expenditures – Budget and Actual on a Budgetary Basis – General and Special Revenue Fund Types (Exhibit C). This statement compares actual revenues and expenditures of the division's general and special revenue funds on a budgetary basis to the budget adopted by the State Legislature for the fiscal year ended June 30, 2000.

Notes to Combined Financial Statements

Explanatory notes which are pertinent to an understanding of the combined financial statements and financial condition of the Med-QUEST Division of the Department of Human Services (division) are discussed in this section.

Note 1 – Financial Reporting Entity

The Hawaii State Government Reorganization Act of 1959 (Act 1, Second Special Session Laws of Hawaii 1959) created the Department of Social Services and Housing. In 1987, the name was changed to the Department of Human Services (department). The department administers programs that are designed to improve the social well-being and productivity of people of the State of Hawaii (State). The department is part of the executive branch of the state.

In January 1994, the Health Care Administration Division of the department was reorganized as the division. The division provides the overall management of the plans, policies, regulations, and procedures of the department's medical assistance programs. These programs are designed to provide medical services to eligible individuals and families through the Medicaid fee-for-service program or the managed care plan, the QUEST program.

The accompanying combined financial statements reflect the financial position and results of operations of the division. The division's combined financial statements reflect only its portion of the fund type categories and account groups. The state Comptroller maintains the central accounts for all state funds and publishes financial statements for the State annually which includes the division's financial activities.

Note 2 – Significant Accounting Policies

Basis of Presentation

The financial transactions of the division are recorded in individual funds and account groups which are reported by type in the combined financial statements and are described in the following sections. Each fund and account group is considered a separate accounting entity. The operations of each fund are accounted for with a separate set of self-balancing accounts that comprise its assets, liabilities, fund balance (deficit), revenues, and expenditures. Account groups are used to establish accounting control and accountability for the division's general fixed assets and general long-term debt. Account groups are not funds as they do not reflect available financial resources and related liabilities. Financial resources are allocated to and are accounted for in individual funds based upon the purposes for which they are to be spent and the means by which spending activities are controlled.

Governmental Fund Types

General Fund – The general fund is the general operating fund of the division. It is used to account for all financial activities except those required to be accounted for in another fund. The annual operating budget, as authorized by the State Legislature, provides the basic framework within which the resources and obligations of the general fund are accounted.

Special Revenue Funds – Special revenue funds are used to account for the proceeds of specific revenue sources (other than expendable trusts) that are restricted to expenditures for specified purposes.

Fiduciary Fund Type

Trust Fund – The trust fund is used to account for amounts held, collected, and disbursed by the division in a trustee capacity.

Account Groups

General Fixed Assets Account Group – General fixed assets acquired for use by the division in the conduct of its general governmental operations are accounted for in the general fixed assets account group at cost or estimated fair market value at date of donation. Accumulated depreciation is not recorded in the general fixed assets account group.

General Long-Term Debt Account Group – The obligation for the long-term portion of accrued vested vacation is recorded in the general long-term debt account group.

Basis of Accounting

The accounting and financial reporting treatment applied to a fund is determined by its measurement focus. All governmental funds are accounted for using a current financial resources measurement focus. With this measurement focus, only current assets and current liabilities are generally included on the combined balance sheet. Operating statements of these funds present increases (i.e., revenues and other financing sources) and decreases (i.e., expenditures and other financing uses) in net current assets.

The division uses the modified accrual basis of accounting for the general and special revenue funds. Under the modified accrual basis of accounting, revenues and related current assets are recognized in the accounting period when they become both measurable and available to finance operations of the fiscal year or liquidate liabilities existing at fiscal year-end. Measurable means that the amount of the transaction can be determined. Available means that the amount is collected in the current fiscal year or soon enough after fiscal year-end to liquidate liabilities existing at the end of the fiscal year. Revenues susceptible to accrual include federal grants and funds appropriated by the State Legislature and allotted by the Governor. Expenditures are generally recorded when the related fund liabilities are incurred.

Use of Estimates

The preparation of combined financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenditures during the reporting period. Actual results could differ from those estimates.

Appropriations

Appropriations represent the authorizations granted by the State Legislature that permit a state agency, within established fiscal and budgetary controls, to incur obligations and to make expenditures. Appropriations are allotted quarterly. The allotted appropriations lapse if not expended by or encumbered at the end of the fiscal year.

Encumbrances

Encumbrance accounting, under which purchase orders, contracts, and other commitments for the expenditure of monies are recorded in order to reserve that portion of the applicable appropriation, is employed as an extension of formal budgetary integration in the governmental fund types. Encumbrances outstanding at fiscal year-end are reported as reservations of fund balances since they do not constitute expenditures or liabilities.

Accumulated Vacation and Sick Leave

Employees' vested annual vacation and sick leave are recorded as expenditures when actually taken. The employees of the division are entitled to receive cash payment for accumulated vacation leave upon termination. The liability for such accumulated vacation leave pay and related payroll taxes is not reflected in the governmental funds, but is reflected in the general long-term debt account group. Sick leave is not convertible to pay upon termination of employment and is recorded as an expenditure when taken.

Cash

Cash reported in the combined balance sheet primarily represents cash in the State Treasury.

Receivables

Receivables in the general and special revenue funds consist primarily of amounts due from health plans under the QUEST program and QUEST participants. The amounts reported as net receivables were established based on management's estimate of amounts collectible.

Due from Federal Government

Due from federal government consists of that portion of awarded revenues for which cash has not yet been received.

Property and Equipment

Property and equipment reported in the general fixed assets account group are recorded at cost. Those assets were acquired or constructed for general governmental purposes and were reported as expenditures in the funds that financed the assets at acquisition. No depreciation is provided on those assets.

Due to Individuals

Due to individuals consists of assets held by the division in a trustee capacity.

Accrued Medical Assistance Payable

Accrued medical assistance payable represents the division's estimate of the Medicaid fee-for-service claims that have been incurred but not reported.

Grants

Federal reimbursement-type grants are recorded as intergovernmental receivables and revenues when the related expenditures are incurred.

Risk Management

The division is exposed to various risks of loss related to torts; theft of, damage to, or destruction of assets; errors or omissions; natural disasters; and injuries to employees. A liability for a claim for a risk of loss is established if information indicates that it is probable that a liability has been incurred at the date of the combined financial statements and the amount of the loss is reasonably estimable.

Total Columns on the Combined Financial Statements

The total columns are captioned Memorandum Only to indicate that they are presented only to facilitate financial analysis. Data in those columns do not present financial position or results of operations in conformity with GAAP. Neither is such data comparable to a consolidation. Interfund eliminations have not been made in the aggregation of this data.

Note 3 – Budgeting and Budgetary Control

Revenue estimates are provided to the State Legislature at the time of budget consideration and are revised and updated periodically during the fiscal year. Amounts reflected as budgeted revenues in the combined statement of revenues and expenditures – budget and actual on a budgetary basis – general and special revenue fund types are those estimates as compiled by the division. Budgeted expenditures are derived primarily from acts of the State Legislature and from other authorizations contained in other specific appropriation acts in various Session Laws of Hawaii.

To the extent not expended or encumbered, general fund appropriations generally lapse at the end of the fiscal year for which the appropriations

were made. The State Legislature specifies the lapse date and any other particular conditions relating to terminating the authorization for other appropriations.

Summarization of the budgets adopted by the State Legislature for the "budgetary" general and special revenue funds is presented in the combined statement of revenues and expenditures – budget and actual on a budgetary basis – general and special revenue fund types. For purposes of budgeting, the division's budgetary fund structure and accounting principles differ from those utilized to present the combined financial statements in conformity with GAAP. The division's annual budget is prepared on the modified accrual basis of accounting with several differences, principally related to (1) the encumbrance of purchase order and contract obligations, (2) special revenue fund program grant accruals and deferrals, and (3) unbudgeted revenues and expenditures. These differences represent a departure from GAAP. The following schedule reconciles the budgetary amounts to the amounts presented in accordance with GAAP for the fiscal year ended June 30, 2000:

	General	Special Revenue
Excess of revenues over expenditures – actual on a budgetary basis	$ 2,655,867	$ 12,301,290
Reserved for encumbrances at fiscal year-end	96,392	1,559,148
Expenditures for liquidation of prior fiscal year encumbrances	(2,934,038)	(7,843,535)
Net change in accrued medical assistance payable	(2,000,000)	(2,000,000)
Accruals related to federal reimbursements for program expenditures	6,304,482	(6,304,482)
Net change in other receivables	(54,500)	1,500
Excess (deficiency) of revenues over expenditures – GAAP basis	$ 4,068,203	$ (2,286,079)

Note 4 – Cash

Cash consisted of the following as of June 30, 2000:

Cash in State Treasury	$ 9,755,289
Cash on hand	250
	$ 9,755,539

The State maintains a cash pool that is available for all funds. Each fund type's portion of this pool (reported as cash in State Treasury) is displayed on the combined balance sheet as "Cash." Those funds are pooled with funds from other state departments and agencies and deposited in approved financial institutions by the state Department of Budget and Finance. Deposits not covered by federal deposit insurance are fully collateralized by government securities held in the name of the State by third party custodians.

Note 5 – Receivables

Receivables of the division, net of an allowance for doubtful accounts, consisted of the following at June 30, 2000:

	General	Special revenue
Health plans under the QUEST program	$ 14,327,127	$ 14,327,127
QUEST premiums	5,555,554	—
Other	1,552,500	1,552,500
	21,435,181	15,879,627
Less allowance for doubtful accounts:		
QUEST premiums	5,511,554	—
Other	1,475,000	1,475,000
	6,986,554	1,475,000
Net receivables	$ 14,448,627	$ 14,404,627

Note 6 – Equipment, Furniture, and Fixtures

The changes in the division's general fixed assets, which consist of equipment, furniture, and fixtures, were as follows:

Balance at July 1, 1999	$ 1,281,246
Additions	192,769
Deductions	(41,779)
Balance at June 30, 2000	$ 1,432,236

Note 7 – General Long-Term Debt

The general long-term debt account group of the division is used to account for the long-term portion of the obligation for accrued vested vacations. The obligation for accrued employee benefits payable by the division changed during the fiscal year ended June 30, 2000, as follows:

Balance at July 1, 1999	$	1,038,031
Net increase		267,785
Balance at June 30, 2000	$	1,305,816

Note 8 – Non-Imposed Employee Fringe Benefits

Payroll fringe benefit costs of the division's employees funded by state appropriations (general fund) are assumed by the State and are not charged to the division's operating funds. These costs, totaling $860,967 for the fiscal year ended June 30, 2000, have been reported as revenues and expenditures of the division's general fund.

Note 9 – Changes in Assets and Liabilities of the Trust Fund

The trust fund is purely custodial (assets equal liabilities) and thus does not involve the measurement of results of operations. The changes in assets and liabilities of the trust fund for the fiscal year ended June 30, 2000, were as follows:

	Balance July 1, 1999	Additions	Deductions	Balance June 30, 2000
Assets – cash held in trust	$ 756,272	$ 29,994	$ 577,401	$ 208,865
Liabilities – due to individuals	$ 756,272	$ 29,994	$ 577,401	$ 208,865

Note 10 – Lease Commitments

The division leases office facilities on a long-term basis. Those office leases expire on various dates through 2005. Certain leases include renewal and escalation clauses. Future minimum lease rentals under noncancelable operating leases with terms of one year or more at June 30, 2000, are as follows:

Fiscal year ending June 30,		
2001	$	149,000
2002		150,000
2003		152,000
2004		161,000
2005		147,000
	$	759,000

Total rent expense for the division for the fiscal year ended June 30, 2000 amounted to approximately $128,300.

Note 11 – Fund Balance Deficits

The division's general and special revenue funds had unreserved fund deficits at June 30, 2000, aggregating to $35,508,591 and $567,514, respectively. Those deficits resulted primarily from expenditures being recorded on the accrual basis when incurred, and revenues being recognized only when the funds are measurable and available.

Note 12 – Retirement Benefits

Employees' Retirement System

All eligible employees of the division are required by the Hawaii Revised Statutes (HRS) Chapter 88 to become members of the Employees' Retirement System of the State of Hawaii (ERS), a cost-sharing multiple-employer public employee retirement plan. The ERS provides retirement benefits as well as death and disability benefits. All contributions, benefits, and eligibility requirements are established by HRS Chapter 88 and can be amended by legislative action. The ERS issues a publicly available financial report that includes financial statements and required supplementary information. The report may be obtained by writing to the ERS at City Financial Tower, 201 Merchant Street, Suite 1400, Honolulu, Hawaii, 96813.

Prior to June 30, 1984, the plan consisted of only a contributory option. In 1984, legislation was enacted to add a new noncontributory option for members of the ERS who are also covered under Social Security. Persons employed in positions not covered by Social Security are precluded from the noncontributory option. The noncontributory option provides for reduced benefits and covers most eligible employees hired after June 30, 1984. Employees hired before that date were allowed to continue under the noncontributory option or to elect the new non-contributory option and receive a refund of employee contributions. All benefits vest after five and ten years of credited service for the contributory and noncontributory options, respectively. Both options provide a monthly retirement allowance based on the employee's age, years of credited service, and average final compensation (AFC). The AFC is the average salary earned during the five highest paid years of service, including the vacation payment, if the employee became a member prior to January 1, 1971. The AFC for members hired on or after that date is based on the three highest paid years of service, excluding the vacation payment.

Most covered employees of the contributory option are required to contribute 7.8 percent of their salary. The division is required to contribute to both options at an actuarially determined rate.

Measurement of assets and actuarial valuations are made for the entire ERS and are not separately computed for individual participating employers such as the division. The contribution rate as of June 30, 2000 was approximately 5.8 percent of annual covered payroll as determined by the state Department of Budget and Finance. Contributions by the division for the fiscal years ended June 30, 2000, 1999, and 1998 were approximately $311,000, $369,600, and $847,300, respectively, which were equal to the required contributions for each fiscal year.

Post-Retirement Health Care and Life Insurance Benefits

In addition to providing pension benefits, the State provides certain health care and life insurance benefits to all employees who retire from the division on or after attaining age 62 with at least 10 years of service or age 55 with at least 30 years of service under the noncontributory option and age 55 with at least 5 years of service under the contributory option. Retirees credited with at least ten years of service, excluding sick leave credit, qualify for free medical insurance premiums; however, retirees with less than ten years must assume a portion of the monthly premiums. All disability retirees who retired after June 30, 1984, with less than ten years of service also qualify for free medical insurance premiums. Free life insurance coverage for retirees and dental coverage for dependents under age 19 are also available. Retirees covered by the medical portion of Medicare are eligible to receive a reimbursement of the basic medical coverage premiums. Contributions are based upon negotiated collective bargaining agreements, and are funded by the State as accrued. The division's general fund share of the expense for post-retirement health care and life insurance benefits for the fiscal year ended June 30, 2000 has not been separately computed and is not reflected in the division's combined financial statements. The division's special revenue fund share of the post-retirement health care and life insurance benefits expense for the fiscal year ended June 30, 2000 was approximately $323,000, and is included in the division's special revenue funds' expenditures.

Note 13 – Commitments and Contingencies

Accumulated Sick Leave

Employees earn sick leave credits at the rate of one and three-quarters working days for each month of service without limit. Sick leave can be taken only in the event of illness and is not convertible to pay upon termination of employment. However, an employee who retires or leaves government service in good standing with 60 days or more of unused sick leave is entitled to additional service credit in the ERS. Accumulated sick leave as of June 30, 2000 amounted to approximately $3,070,700.

Deferred Compensation Plan

The State offers its employees a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The plan, available to all state employees, permits employees to defer a portion of their salary until future years. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency.

All plan assets are held in a trust fund to protect them from claims of general creditors and from diversion to any uses other than paying benefits to participants and beneficiaries. The division has no responsibility for loss due to the investment or failure of investment of funds and assets in the plan, but does have the duty of due care that would be required of an ordinary prudent investor. Therefore, in accordance with Governmental Accounting Standards Board Statement No. 32, *Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans*, deferred compensation plan assets are not reported in the accompanying combined financial statements.

Medicaid Program

The division reimburses providers of medical services provided to Medicaid recipients under a Prospective Payment System (PPS). Under PPS, standard costs and rates are negotiated between the division and the State's Medicaid providers in advance. PPS allows providers to file for standard cost and rate adjustments up to five years subsequent to the rendering of those services. The amount of future adjustments, if any, to be made for services provided through June 30, 2000 cannot be determined at this time. Any adjustments would be funded from future appropriations.

In December 1994, the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) informed the division of a possible disallowance associated with the State's nursing facility tax program. Under this program, nursing facilities are assessed a 6 percent tax on all nursing facility income, and an income tax credit is provided to private pay patients. The nursing facility tax program was ended as of July 1, 1997.

The HCFA is contending that the income tax credit associated with this nursing facility tax violates Section 1903 (w)(4)(A) of the Social Security Act and 42 CFR Part 433.68(f), which specifies that a hold harmless provision exists when the state imposing the tax provides for a payment to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or the difference between the amount of the tax and the amount of payment under the state plan.

The division has contested the possible disallowance of approximately $18,000,000 as of June 30, 2000. As of November 17, 2000, the contingency remains pending and the final outcome cannot be determined at this time.

The division is also subject to liabilities arising from charges for medical services provided to Medicaid recipients.

QUEST Program

In July 1993, the HCFA approved the Hawaii Health QUEST Demonstration Project under the authority of Section 1115 of the Social Security Act. The Medicaid waiver project was approved for the period April 1, 1994 through March 31, 1999 and has been subsequently extended through March 31, 2002. Special terms and conditions of the waiver limit the federal share of program costs over the five-year demonstration period and extension to Medicaid expenditures that the federal government would have incurred for certain groups under the former Medicaid program (referred to as the federal limit). Any program costs that exceed the federal limit will be borne by the division.

While the ultimate liability, if any, in the disposition of this matter is presently difficult to estimate, it is management's belief that the outcome is not likely to have a material adverse effect on the division's financial position. Accordingly, no provision for any liability that might result has been made in the accompanying combined financial statements.

Note 14 – Risk Management

The division is exposed to various risks of loss related to torts; theft of, damage to, or destruction of assets; errors or omissions; and workers' compensation. The State generally retains the first $250,000 per occurrence of property losses and the first $2 million with respect to general liability claims. Losses in excess of those retention amounts are insured with commercial insurance carriers. The limit per occurrence for property losses is $300 million ($50 million for earthquake and flood) and the annual aggregate for general liability losses per occurrence is $50 million. The State also has an insurance policy to cover medical malpractice risk in the amount of $40 million per occurrence with no annual aggregate limit. The State is generally self-insured for workers' compensation and automobile claims. The estimated reserve for losses and loss adjustment costs includes the accumulation of estimates for losses and claims reported prior to fiscal year-end, estimates (based on projections of historical developments) of claims incurred but not reported, and estimates of costs for investigating and adjusting all incurred and unadjusted claims. Amounts reported are subject to the impact of future changes in economic and social conditions. The State

believes that, given the inherent variability in any such estimates, the reserves are within a reasonable and acceptable range of adequacy. Reserves are continually monitored and reviewed, and as settlements are made and reserves adjusted, the differences are reported in current operations. A liability for a claim is established if information indicates that it is probable that a liability has been incurred at the date of the combined financial statements and the amount of the loss is reasonably estimable.

Exhibit A

MED-QUEST DIVISION
DEPARTMENT OF HUMAN SERVICES
STATE OF HAWAII

Combined Balance Sheet – All Fund Types and Account Groups

June 30, 2000

	Governmental Fund Types		Fiduciary Fund Type	Account Groups		Totals (Memorandum Only)
Assets	**General**	**Special Revenue**	**Trust**	**General Fixed Assets**	**General Long-Term Debt**	
Cash (notes 4 and 9)	$	$ 5,950,030	$	$	$	9,755,539
Receivables, net (note 5)		14,404,627				28,853,254
Due from general fund		8,020,166				8,020,166
Due from federal government		15,239,700		—		15,239,700
Equipment, furniture, and fixtures (note 6)		—		,432,236		1,432,236
Amounts to be provided for retirement of general long-term debt					1,305,816	1,305,816
Total assets	$ 18,045,271	$ 43,614,523	$ 208,865	$ 1,432,236	$	
Liabilities, Fund Balance (Deficit) and Other Credit						
Liabilities:						
Vouchers payable	$ 1,833,003	$ 4,544,610	$ —	$ —	$ —	$ 6,377,613
Accrued wages and employee benefits payable (note 7)	297,090	1,078,279	—	—	1,305,816	2,681,185
Due to individuals (note 9)	—	—	208,865	—	—	208,865
Due to special revenue fund	8,020,166	—	—	—	—	8,020,166
Due to State of Hawaii	6,307,211	—	—	—	—	6,307,211
Accrued medical assistance payable	37,000,000	37,000,000	—	—	—	74,000,000
Total liabilities						
Fund balance (deficit) and other credit:						
Investment in general fixed assets				1,432,236		,432,236
Fund balance (deficit):						
Reserved for encumbrances	96,392	,559,148	—	—	—	1,655,540
Unreserved (note 11)	(35,508,591)	(567,514)	—	—	—	(36,076,105)
Total fund balance (deficit) and other credit	(35,412,199)					(32,988,329)
Total liabilities, fund balance (deficit) and other credit	$ 18,045,271	$ 43,614,523	$ 208,865	$ 1,432,236	$ 1,305,816	$ 64,606,711

See independent auditors' report and accompanying notes to combined financial statements.

Exhibit B

MED-QUEST DIVISION
DEPARTMENT OF HUMAN SERVICES
STATE OF HAWAII

Combined Statement of Revenues, Expenditures, and Changes in Fund Balance (Deficit)
– All Governmental Fund Types

Fiscal Year Ended June 30, 2000

	Governmental Fund Types		Totals (Memorandum Only)
	General	Special Revenue	
Revenues:			
State allotted appropriations	$ 303,695,595	$ —	$ 303,695,595
Intergovernmental	—	341,473,773	341,473,773
Other (note 8)	860,967	4,753,688	5,614,655
	304,556,562		
Expenditures (notes 8, 10, 12, and 13):			
Assured standard of living:			
Medicaid program	184,223,977	207,435,365	391,659,342
QUEST program	109,831,263	116,396,979	226,228,242
Overall program support for social services	6,433,119	24,681,196	31,114,315
Excess (deficiency) of revenues over expenditures			
Other changes in fund balance (deficit) – lapsed appropriations			
Deficiency of revenues over expenditures and other changes in fund balance (deficit)	(6,384,034)	(2,286,079)	(8,670,113)
Fund balance (deficit) at July 1, 1999	(29,028,165)	3,277,713	(25,750,452)
Fund balance (deficit) at June 30, 2000 (note 11)	$ (35,412,199)	$	$ (34,420,565)

See independent auditors' report and accompanying notes to the combined financial statements.

Exhibit C

MED-QUEST DIVISION
DEPARTMENT OF HUMAN SERVICES
STATE OF HAWAII

Combined Statement of Revenues and Expenditures – Budget and Actual on a Budgetary Basis –
General and Special Revenue Fund Types

Fiscal Year Ended June 30, 2000

	General Fund			Special Revenue Funds			Totals (Memorandum Only)		
	Budget	Actual	Variance Favorable (Unfavorable)	Budget	Actual	Variance Favorable (Unfavorable)	Budget	Actual	Variance Favorable (Unfavorable)
Revenues:									
State allocated appropriations	303,695,595	$ 303,695,595	$ —	$ —	$ —	$ —	$ 303,695,595	$ 303,695,595	$ —
Intergovernmental	—	—	—	333,804,833	341,473,773	7,668,940	333,804,833	341,473,773	7,668,940
Other	—	—	—	7,411,460	4,753,688	(2,657,772)	7,411,460	4,753,688	(2,657,772)
	303,695,595	303,695,595	—	341,216,293	346,227,461	5,011,168	644,911,888	649,923,056	5,011,168
Expenditures:									
Medicaid program	185,793,798	184,726,699	1,067,099	207,446,435	203,603,299	3,843,136	393,240,233	388,329,998	4,910,235
QUEST program	110,847,258	110,728,751	118,507	122,397,347	121,564,262	833,085	233,244,605	232,293,013	951,592
Overall program support for social services	7,054,539	5,584,278	1,470,261	11,372,511	8,758,610	2,613,901	18,427,050	14,342,888	4,084,162
	303,695,595	301,039,728	2,655,867	341,216,293	333,926,171	7,290,122	644,911,888	634,965,899	9,945,989
Excess of revenues over expenditures	$ —	$ 2,655,867	$ 2,655,867	$ —	$ 12,301,290	$ 12,301,290	$ —	$ 14,957,157	$ 14,957,157

See independent auditors' report and accompanying notes to the combined financial statements.

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Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Human Services (department) on May 3, 2001. A copy of the transmittal letter to the department is included as Attachment 1. The response of the department is included as Attachment 2.

The department generally agrees with our findings and notes that the Med-QUEST division (division) has begun to address some of the findings and recommendations. We commend the department for the division's efforts to address the findings and for already beginning to implement some of the recommendations. For some of our findings, the department did not respond but noted that the division is continuing efforts to resolve these findings.

The department notes that the division is working with its fiscal agent, the Hawaii Medical Service Association (HMSA), to "correct shortcomings in the processing of medical assistance claims." The division is planning on implementing two initiatives to reduce the claims processing errors. First, the division plans to establish and implement a Medicaid fee schedule and second, the division plans to incorporate the fee-for-service claims processing function (currently handled by HMSA) into its Hawaii Arizona Prepaid Medical Management Information System Alliance system. Once this is implemented, the division will have a consolidated information system that will handle both the QUEST managed care and the fee-for-service programs.

The department also states that the division has streamlined its application processing system to be more timely, and has recently cleared its backlog of eligibility determinations. The department notes that the division has reissued directives and had refresher sessions for its field staff to reinforce adherence to eligibility policies. In the exceptions when application processing is delayed beyond established timeframes and the delay is not caused by the applicant, the department reports that medical coverage is provided until the applicant is deemed ineligible.

ATTACHMENT

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

May 3, 2001

COPY

The Honorable Susan M. Chandler
Director
Department of Human Services
Queen Liliuokalani Building
1390 Miller Street
Honolulu, Hawaii 96813

Dear Dr. Chandler:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Financial Audit of the Med-QUEST Division of the Department of Human Services*. We ask that you telephone us by Monday, May 3, 2001, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Monday, May 14, 2001.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR

SUSAN M. CHANDLER, M.S.W., Ph.D.
DIRECTOR

PATRICIA MURAKAMI
ACTING DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P.O. Box 339
Honolulu, Hawaii 96809-0339

May 14, 2001

The Honorable Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street
Honolulu, Hawaii 96813-2917

Dear Ms. Higa

Thank you for the opportunity to comment on your draft report, *Financial Audit of the Med-QUEST Division of the Department of Human Services*. We have addressed some of your findings and recommendations, and are continuing our efforts to resolve the others.

The Med-QUEST Division (division) has worked with the current Fiscal Agent to immediately correct shortcomings in the processing of medical assistance claims. For the long term, the division will implement two initiatives that will significantly curtail claims processing errors. First, as authorized by the 2000 Legislative session, the fee-for-service Medicaid Program will establish and implement a Medicaid fee schedule that will promote greater efficiency and accuracy. Second, the fee-for-service claims processing function will be incorporated into our Hawaii Arizona Prepaid Medical Management Information System Alliance (HAPA) system. When implemented, the division will have one consolidated information system for both the QUEST managed care and fee-for-service programs.

The Med-QUEST Division has also streamlined its processing of applications to become more timely. In fact, the division just recently cleared its backlog of eligibility determinations. The division has reinforced adherence to eligibility policies with re-issuance of directives and refresher sessions for field level staff. In the few exceptions when application processing is delayed beyond the established timeframe and the delay is not caused by the applicant, medical coverage is provided until the applicant is deemed ineligible.

Again, thank you for the opportunity to comment on your report. The department values your analyses, and will consider your recommendations in our continuing efforts to improve our administration of the medical assistance programs.

Sincerely,

Susan M. Chandler
Director