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# Audit of the Department of Human Services' Med-QUEST Division and Its Medicaid Program

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawai'i

Report No. 14-02  
January 2014



**THE AUDITOR**  
STATE OF HAWAI'I

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## Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawai'i 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.
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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.
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**In FY2015,  
Med-QUEST Division  
health care payment  
appropriations alone  
accounted for nearly  
15 percent of State  
spending.**

Recommendations

Response

Prior Audits

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Report No. 14-02, January 2014

## *Med-QUEST reporting and inattention to fraud impede legislative efforts to contain costs*

### **Data provided by division does not fulfill legislative needs**

While Hawai'i's Medicaid program is financed with a combination of state and federal funds, we found that the Med-QUEST Division concentrates its reporting around meeting federal measures and requirements, which focus on quality of health care services delivered, and not State concerns, which are largely related to costs. With State contributions to the Medicaid program nearly doubling over the past five years, legislators are understandably concerned about the relevance and usefulness of the information it currently receives from the division. Absent adequate and appropriate information; however, the Legislature is unable to make informed decisions about and enact legislation to implement any cost containment measures relating to the Medicaid program.

### **State's Medicaid program costs compare favorably to peer states and national averages**

After analyzing data from the Med-QUEST Division and other government and private sources, we found that Hawai'i's Medicaid costs compare favorably to other states and the national average. Although Hawai'i has a higher Medicaid enrollment as a percentage of its population compared to other states, its Medicaid costs are below the national average and the division has been relatively successful in controlling spending per enrollee and stabilizing program costs. In addition, while Hawai'i has some flexibility in containing these costs, we found that these options are becoming more limited. Requirements associated with the Compacts of Free Association agreements and Affordable Care Act to be implemented in 2014, prevent the division from making certain adjustments to benefits and eligibility.

### **State is exposed to tens of millions of dollars in losses due to fraud, waste, and abuse**

We also found that division management has neglected to commit sufficient resources to its efforts to curb fraud, waste, and abuse. As a result, Hawai'i's detection and enforcement activities lag far behind national averages, exposing the State to tens of millions of dollars in losses annually. For instance, in 2011, the Centers for Medicare and Medicaid Services projected that improper payments from the Hawai'i Medicaid and Children's Health Insurance programs totaled \$66.9 million. Since additional federal regulation will limit cost containment options for the State, the division needs to be more proactive in containing the costs that it can control by establishing and implementing an effective and efficient fraud, waste, and abuse detection program.

### **Agency response**

The department generally agreed with our conclusions and recommendations and said it has already undertaken actions to address several of our recommendations. It agreed Hawai'i's Medicaid program fares well compared to peer states and the rest of the nation, and that it has managed to control costs on a per-enrollee basis even while enrollment has increased. The department also said it is committed to eliminating all fraud, waste, and abuse, and that it has made substantial improvements in program integrity. And it stated that implementation of its new eligibility system, KOLEA, will reduce eligibility errors. The department identified four efforts it plans to pursue this legislative session to improve support for additional program integrity efforts. Although the department contends that our fraud, waste, and abuse finding was primarily based on outdated documentation, we note the department provided that documentation as the most current available.

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Submitted by

**THE AUDITOR**  
STATE OF HAWAI'I

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## Foreword

This is a report on the audit of the Department of Human Services, Med-QUEST Division and its Medicaid program in response to House Concurrent Resolution No. 184 of the 2013 Regular Session. We conducted the audit pursuant to Section 23-4, Hawai'i Revised Statutes, which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

We wish to express our appreciation for the cooperation and assistance extended by the officials and staff of the Department of Human Services and other offices and individuals whom we contacted during the course of our audit.

Jan K. Yamane  
Acting State Auditor

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# Chapter 1

## Introduction

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This audit of the Department of Human Services, Med-QUEST Division was requested by the 2013 Legislature through House Concurrent Resolution (HCR) No. 184. The resolution asks the Auditor to conduct a comprehensive financial audit of the Med-QUEST Division, with emphasis on the Medicaid program.

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### Background

#### *What is Medicaid?*

Medicaid, a federal program created by Congress in 1965 as Title XIX of the Social Security Act, was designed to provide access to medical care for low-income populations. Medicaid was originally legislated to provide medical assistance to low-income families and children through the Aid to Families with Dependent Children Program and to low-income aged, blind, and disabled individuals through the Supplemental Security Income Program. Over the years, Congress expanded Medicaid beyond these original populations. Today, Medicaid is not only the primary source of health care for low-income families, but also pregnant women, people of all ages with disabilities, and people who require long-term care services. Medicaid covers about one in every five Americans.

The Centers for Medicare and Medicaid Services (CMS), an operating division within the U.S. Department of Health and Human Services (DHHS), administers Medicaid in partnership with the states. Medicaid is not a direct provider of healthcare. States contract with and pay providers—such as hospitals, managed care plans, nursing homes, and physicians—to deliver Medicaid services at state-determined rates. Formerly known as the Health Care Financing Administration, the CMS establishes policies for program eligibility and benefit coverage, matches state expenditures with funds for Medicaid, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse.

Traditionally, Medicaid is a fee-for-service health program for the poor that is funded by both the state and federal governments. *Fee-for-service* means that physicians and hospitals bill for each eligible service provided to a Medicaid patient. However, many states, including Hawai‘i, have pursued managed care as an alternative to the fee-for-service system for their Medicaid programs. Managed care, defined as a health care delivery system with a single point of entry, seeks to increase access to quality care in a cost-effective manner and provide several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and medications. Managed care exercises



greater control over patient visits, which reduce the potentials for unnecessary medical procedures or services and the opportunities for claims fraud. Cost savings for managed care is achieved through a monthly fee, or *capitated payment*, to a health plan, which assumes responsibility for any financial risk.

### **Who is eligible for Medicaid?**

Medicaid must provide assistance to all individuals who meet eligibility criteria and enroll in the program. Enrollment caps and waiting lists are not allowed for beneficiaries whose eligibility is mandated by federal law—unless permitted by a waiver. Federal statute defines more than 50 distinct population groups that are potentially eligible for Medicaid.

### **Mandatory and optional Medicaid services**

In the absence of federal reform, states have initiated their own health care reforms, which largely focus on the Medicaid coverage and the eligibility criteria. Medicaid reforms have expanded coverage in two ways, by: 1) redefining Medicaid coverage and utilizing managed care; and 2) utilizing “Section 1115” waivers to include more uninsured persons and serve as a pilot or demonstration project for program changes.

While the federal government requires states to provide core benefits, it also allows states the discretion to provide additional or optional benefits for Medicaid enrollees. Federal law places constraints and directives on Medicaid services. Covered services must be available statewide (with certain exceptions), comparable (equal for all in a group), and sufficient in “amount, duration, and scope” to reasonably achieve its purpose. Exhibit 1.1 lists the mandatory and optional categories of services in Hawai‘i under Medicaid coverage programs.

## Exhibit 1.1

### Mandatory and Optional Medicaid Services

#### Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment services
- Home health services
- Physician services
- Rural health clinic services
- Federal qualified health center services
- Laboratory and x-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by a state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women
- Tobacco cessation

#### Optional Benefits

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorders
- Respiratory care services
- Other diagnostic, screening, and preventive medicine
- Podiatry services
- Optometry services
- Dental services\*
- Prosthetics
- Eyeglasses
- Other practitioner services
- Hospice
- Case management
- Services in an intermediate care facility for the mentally retarded
- Self-directed personal assistance services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the secretary of health and human services

\* Hawai'i's Medicaid program covers only adult emergency dental services

Source: National Conference of State Legislatures, Med-QUEST Division, and the Office of the Auditor

## Section 1115 projects

Section 1115 of the Social Security Act outlines requirements for experimental, pilot, or demonstration projects and allows states to reform their Medicaid programs and may allow for coverage to be expanded to populations that are not generally eligible. Waivers also allow the federal secretary of health and human services to waive compliance with requirements of certain sections of statutes, including Medicaid, for any projects that promote the objectives of the Social Security Act. Forty-nine states have taken advantage of CMS waivers to introduce managed care plans tailored to their needs.

Each state's Medicaid program differs, reflecting state priorities in coverage and benefits. Within the federal structure, each state enrolls beneficiaries using its own eligibility criteria, decides which optional services to cover, and sets payment rates for providers. A state also decides other key policies, such as: eligibility groups to receive care within a managed care system, use of Medicaid to finance a range of medical services, and whether special payments are made to hospitals that serve a disproportionate share of indigent patients.

In July 1993, the Health Care Financing Administration approved Hawaii's Department of Human Services (DHS) Medicaid Section 1115 waiver application, called the QUEST<sup>1</sup> program, to provide Medicaid services through managed care plans. The QUEST program was designed to increase access to health care in Hawai'i and control the rate of annual increases in health care expenditures. In FY2012, 99 percent of all Hawai'i Medicaid beneficiaries were served through a managed care system. Hawai'i's latest Section 1115 demonstration project, the QUEST Expanded program, was set to expire on December 31, 2013, but was renewed in September 2013 through December 31, 2018 under a new QUEST Integration program name.

## Affordable Care Act

The central goal of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010—collectively referred to as the Affordable Care Act (ACA)—is

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<sup>1</sup> *QUEST* is an acronym for:

Quality care

Universal access

Efficient utilization

Stabilizing costs

Transforming the way health care is provided to QUEST members

to significantly reduce the number of uninsured patients in the U.S. by providing a continuum of affordable coverage options through Medicaid and new health insurance exchanges. The ACA, effective January 2014, is designed to increase access to health insurance through three primary strategies: 1) employer-sponsored insurance; 2) creation of an individual marketplace; and 3) expansion of Medicaid. Before ACA was passed, other low-income adults, such as childless adults, were not eligible for Medicaid unless a state chose to cover them under a Section 1115 waiver. Under ACA, states can provide coverage to adults aged 19 to 64 with incomes up to 133 percent of the federal poverty level prior to 2014, and above 133 percent beginning in 2014. This provision is expected to significantly expand enrollment and increase the cost of Medicaid programs.

***Organization of the  
Department of Human  
Services and the  
Med-QUEST Division***

The Department of Human Services, originally known as the Department of Social Services and Housing, was created in 1959. It addresses problems of human behavior, adjustment, and daily living through the administration of programs for family, child, and adult welfare; economic assistance; health care assistance; rehabilitation toward self-care and support; public housing; and other related programs.

The mission of the department is to provide timely, efficient, and effective programs; and to provide services and benefits to empower the most vulnerable to expand their capacity for self-sufficiency, self-determination, independence, healthy choices, quality of life, and personal dignity. In FY2012, the department managed an operating budget of \$2.3 billion, the State's largest.

The **Office of the Director**, headed by the director of human services, has primary responsibility for operations of the department. The office plans, organizes, directs, and monitors the State's programs of human services for families and individuals; economic assistance, including medical assistance and supplemental nutrition assistance; self-sufficiency and family support programs; and vocational rehabilitation of persons with disabilities. The office ensures effective and efficient conduct of programs and services and optimum use of fiscal, equipment, space, and manpower resources by continuously evaluating the department's activities against planned results and effectuating necessary correction and improvements. The office also establishes the mission, long-term goals, short-term objectives, and priorities for the department.

Five staff offices provide support services to the department:

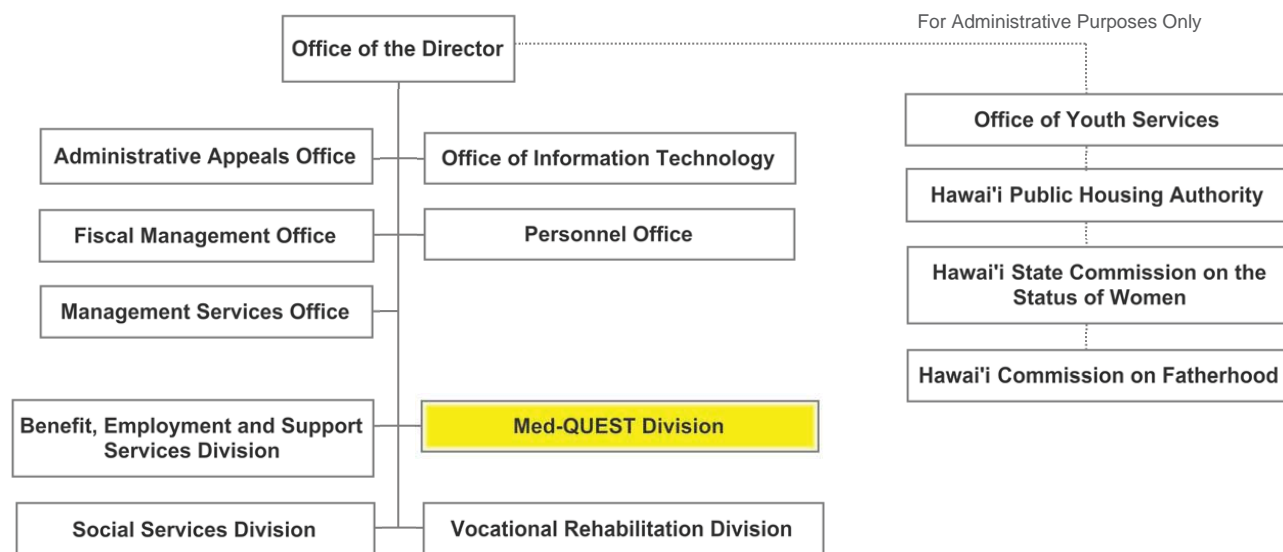
- The **Administrative Appeals Office** provides administrative due process hearings in contested cases for the department;
- The **Office of Information Technology** is responsible for the overall administration, planning, direction, management, development, implementation, and maintenance of all information technology and information systems processing for the department statewide;
- The **Fiscal Management Office** provides staff assistance and advisory services for the administrative functions of fiscal management services;
- The **Personnel Office** oversees the department's personnel programs; and
- The **Management Services Office** provides research, budget, quality assurance, program and financial evaluation, and assessment capabilities that enable the department to oversee its programs.

The **Med-QUEST Division** is one of four operating divisions that carry out the department's programs. The division administers the State's Medicaid and other health insurance programs, and provides health insurance to low-income families, children, and individuals. The other divisions are the **Benefit, Employment and Support Services Division**, the **Social Services Division**, and the **Vocational Rehabilitation Division**.

In addition, the department has two administratively attached agencies, the Office of Youth Services and the Hawai'i Public Housing Authority. The department also supports two state commissions, the Hawai'i State Commission on the Status of Women and the Hawai'i Commission on Fatherhood. Exhibit 1.2 illustrates the department's organization.

## Exhibit 1.2

## Department of Human Services Organizational Chart



Source: Department of Human Services

The Med-QUEST Division's mission is "to develop and administer high-quality health care programs serving all eligible Hawai'i residents." The division administrator reports to the director of human services and provides overall management and development of the plans, policies, regulations, and procedures for the department's health insurance programs. The division administrator implements policies and procedures for health care and health insurance programs, including preventive services, acute care services, primary care services, and long-term care services.

The division is supported by five offices:

- The **Clinical Standards Office** establishes statewide clinical standards of care to support implementation of the department's health care and health care programs;
- The **Finance Office** coordinates, manages, and administers the division's fiscal, procurement, financial integrity activities, payment error rate measurement activities, and budget activities for the department's health care and health insurance programs;
- The **Policy and Program Development Office** provides staff support and assistance to the division in establishing and maintaining program policies related to the department's health care and health insurance programs;

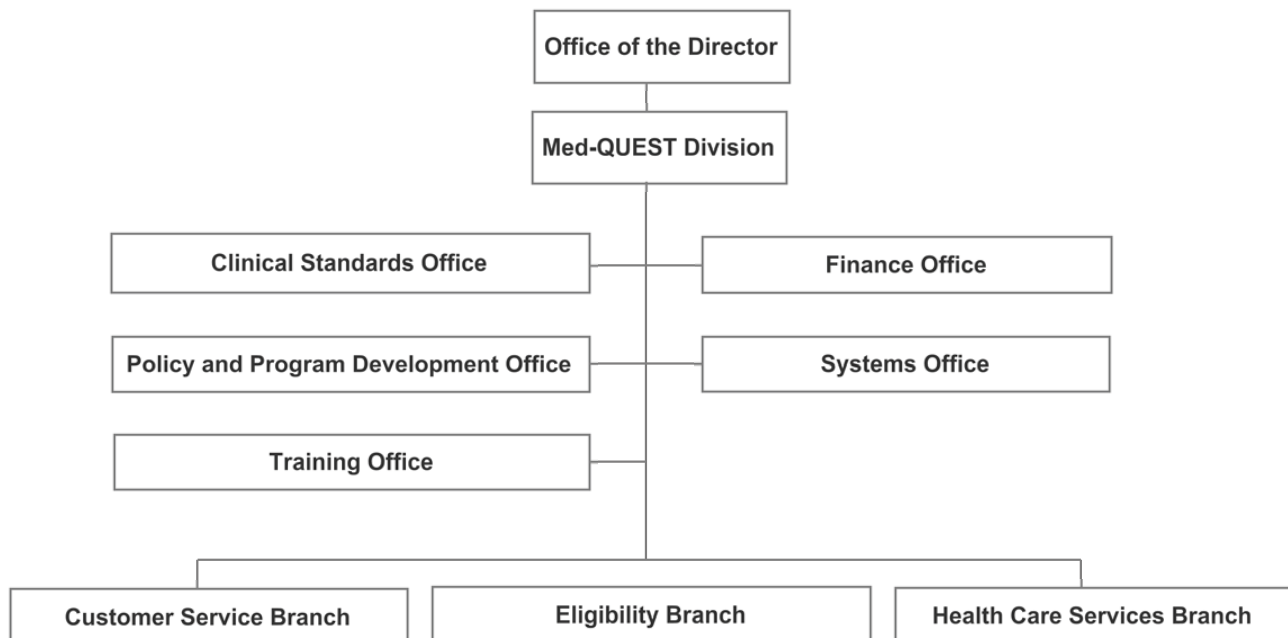
- The **Systems Office** manages and coordinates the division's information systems activities related to the department's health care and health insurance programs; and
- The **Training Office** develops and coordinates training activities and opportunities for division staff related to the department's health care and health insurance programs.

The division is also supported by three branches:

- The **Customer Services Branch** enrolls, dis-enrolls, and registers eligible populations into the department's health care delivery programs;
- The **Eligibility Branch** is responsible for establishing the statewide eligibility determination process related to the department's health care and health insurance programs; and
- The **Health Care Services Branch** administers and manages contracted managed care organizations and other contracts to deliver health care services in the state.

Exhibit 1.3 illustrates the division's organization.

**Exhibit 1.3**  
**Med-QUEST Division Organizational Chart**



Source: Department of Human Services

## ***Hawai‘i’s Medicaid program***

The Med-QUEST Division provides health insurance through several Medicaid programs under Title XIX of the federal Social Security Act. Health insurance coverage includes the Hawai‘i QUEST and QUEST Expanded Access managed care programs, and the Medicaid Fee-for-Service program. The QUEST program serves eligible individuals from birth to age 65 who are not blind or otherwise disabled. The QUEST Expanded Access program includes seniors 65 years and older, and individuals of all ages with disabilities. The Children’s Health Insurance Program covers uninsured children under age 19 whose parents may be working but do not earn enough to pay for private coverage for their children.

Hawai‘i’s other, smaller health insurance programs include QUEST-Net, QUEST-ACE (Adult Coverage Expanded), Transitional Medical Assistance, federal- and state-funded Coverage of Individuals with Breast and Cervical Cancer, and Special Programs for Medicare Beneficiaries. Additionally, the division oversees the State’s Funeral Payments Program. Collectively, these programs enable low-income adults and children to maintain and improve their health by providing payment for medical, dental, and other medically necessary health care services.

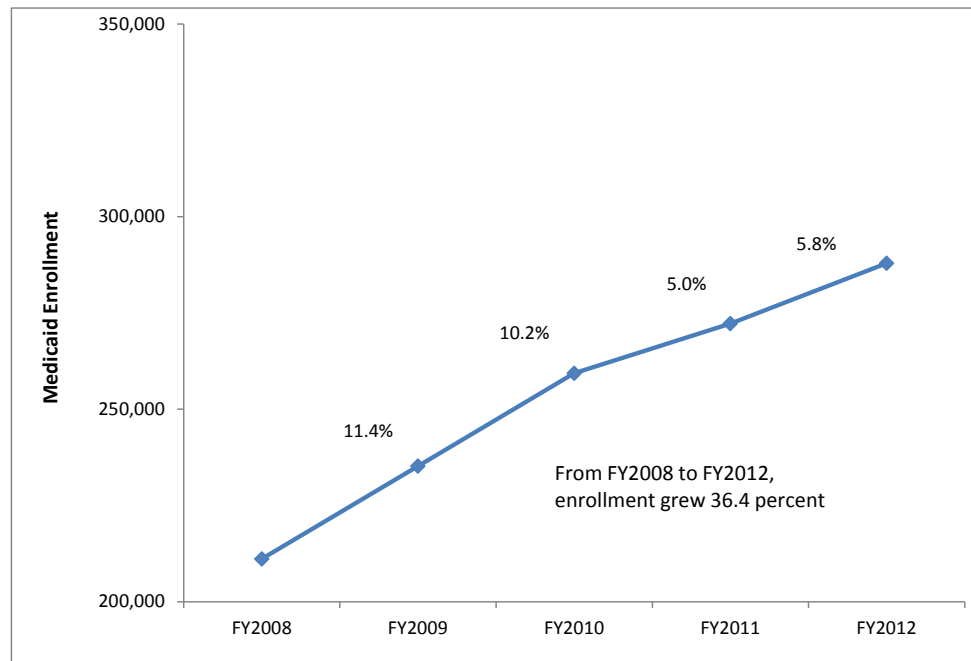
### **State Medicaid enrollment**

To be eligible for Hawai‘i’s medical assistance programs applicants must be: 1) a U.S. citizen or qualified alien age 19 years or older; 2) a Hawai‘i resident; 3) not residing in a public institution; and 4) able to provide a Social Security number. Applicants must also be within certain income and asset limits, although pregnant women and individuals under age 19 are not subject to the asset limit. In FY2012, the Med-QUEST Division Eligibility Branch made dispositions on 96,929 applications, of which 66,830 (69 percent) were approved and 30,099 (31 percent) were denied.

Since FY2008, Medicaid enrollment has risen 36.4 percent, from approximately 211,000 to almost 288,000 in FY2012. Exhibit 1.4 shows Medicaid enrollment and year-over-year growth from FY2008 through FY2012.



**Exhibit 1.4**  
**Medicaid Enrollment and Year-Over-Year Growth, FY2008–FY2012**



Source: Department of Human Services

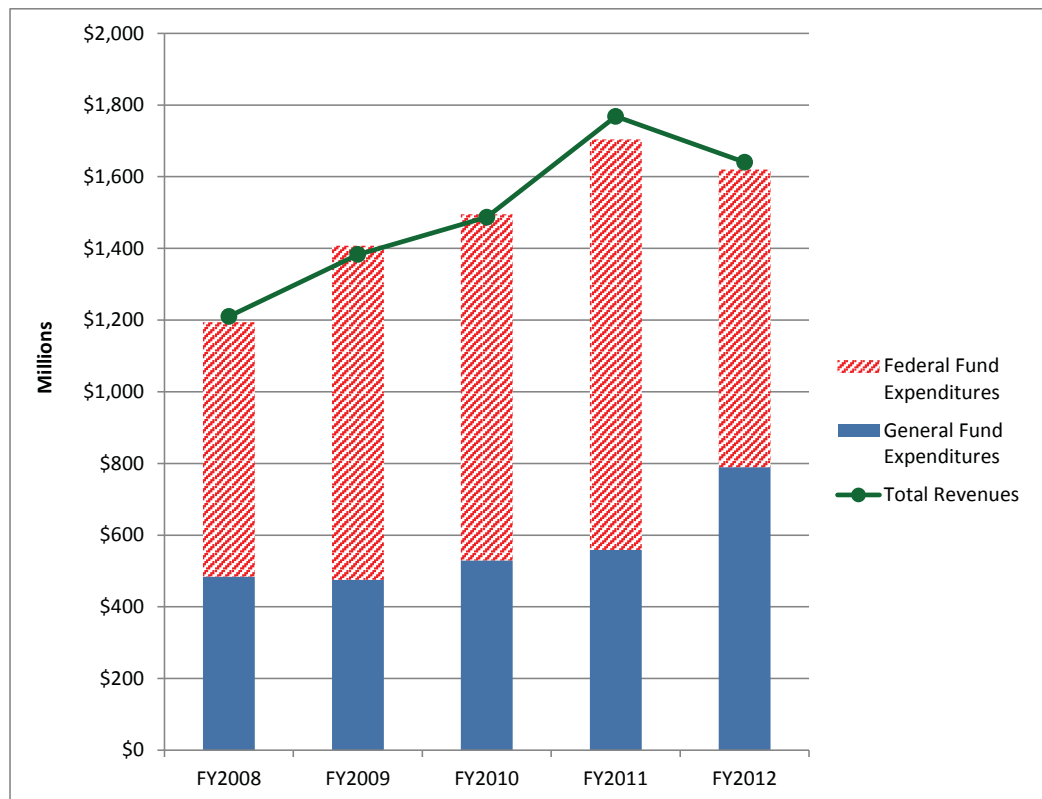
### Program funding and expenditures

The federal government and states share responsibility for financing the Medicaid program. The federal government matches state spending on an open-ended basis for services that Medicaid programs cover. The federal government's share of medical assistance expenditures is called the federal medical assistance percentage (FMAP), which is determined annually by a formula that compares a state's average per capita income level with the national income average. States with higher per capita incomes receive a smaller federal reimbursement. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In FY2010, FMAPs ranged from 50 percent in 16 states and territories to 75.7 percent for Mississippi, averaging 59.2 percent overall. Hawai'i's FMAP decreased from 51.8 percent to 50.5 percent for FY2012 and increased to 51.9 percent for FY2013.

Currently, Medicaid enrollment and the State's related health care payment expenditures are at their highest point in program history. Total Med-QUEST Division spending in FY2012 reached more than \$1.6 billion, up from \$1.5 billion in FY2010, and includes state general fund amounts and the federal share received through FMAP. Exhibit 1.5 shows Hawai'i's total Medicaid revenues and a break-out of Med-QUEST Division's expenditures by means of financing for the last five

years. The increase in revenues and expenditures during FY2011 was due to extension of the American Recovery and Reinvestment Act of 2009 funding by Congress for the period January 2011 to June 2011.

**Exhibit 1.5**  
**Total Medicaid Revenues and Expenditures by Means of Financing, FY2008–FY2012**



Source: Department of Human Services

The Med-QUEST Division has two major program IDs that provide appropriations for the Medicaid program: HMS401 for health care services provided and HMS902 for the division's administration costs. Exhibit 1.6 shows the Med-QUEST Division appropriations for the past five years compared to the department and statewide totals.

**Exhibit 1.6****Med-QUEST Division, Department of Human Services, and Statewide Appropriations, All Means of Financing, FY2008–FY2012 (in \$ thousands)**

	FY2008	FY2009	FY2010	FY2011	FY2012
Health Care Payments (HMS401)	\$1,196,394	\$1,236,505	\$1,380,547	\$1,387,615	\$1,645,461
General Support for Health Care Payments (HMS902)	\$27,948	\$29,345	\$28,821	\$23,908	\$27,461
Med-QUEST Division Total	\$1,224,342	\$1,265,850	\$1,409,368	\$1,411,523	\$1,672,922
Department of Human Services (DHS) Total	\$1,847,443	\$1,878,227	\$2,085,604	\$2,013,645	\$2,319,662
Med-QUEST Division as a percentage of DHS total	66.3%	67.4%	67.6%	70.1%	72.1%
<b>Statewide Total</b>	<b>\$10,370,710</b>	<b>\$10,789,367</b>	<b>\$10,803,950</b>	<b>\$10,241,967</b>	<b>\$11,027,264</b>
Med-QUEST Division as a percentage of statewide total	11.8%	11.7%	13.0%	13.8%	15.2%

Source: Legislative budget worksheets

Overall, for FY2012, Med-QUEST Division health care payment appropriations alone accounted for about 15 percent of State spending. Appropriations are expected to grow in the future, with health care payment appropriations increasing to 16.6 percent of State spending by FY2015.

**Prior Audits**

Our office has conducted seven prior audits of the department's QUEST-related programs. Our 1996 *Audit of the QUEST Demonstration Project* (Report No. 96-19) was initiated because of concerns that DHS was experiencing difficulty meeting the QUEST Demonstration Project's objectives. We reported that Phase I of the project had been inadequately planned and hastily implemented; lacked management controls, staff, and a required management information system (MIS) to properly administer the program; and had yet to demonstrate it was saving the State money. We also expressed concern that the federal government might require the State to revert to the traditional Medicaid program because it had not met requirements of the Health Care Financing Administration.

In our 1997 *Management Audit of the Department of Human Services* (Report No. 97-18), we found that controls for QUEST eligibility determination had not significantly improved, annual eligibility verification processes were still weak and had substantive backlogs, the required MIS was still undeveloped, and the department lacked an

effective evaluation mechanism for QUEST. After three years, QUEST's federally required encounter data had not been analyzed and the required quarterly reports had not been submitted.

In our 1998 *Financial Audit of the Department of Human Services* (Report No. 98-14), we found continued internal control and operational problems that affected the Med-QUEST Division and the QUEST Demonstration Project. Annual re-verification requirements had not been met; more than \$5 million in clients' share of QUEST premium costs were uncollected; and the Hawai'i Automated Welfare Information System lacked adequate data entry controls, resulting in overpayments.

In our 2001 *Audit of the Department of Human Services' Information Systems* (Report No. 01-05), we found that the contractor retained in 1994 to develop the QUEST information system had failed to produce a functional system. Thereafter, in 1999, the department contracted with the State of Arizona to modify its Prepaid Medical Management Information System (PMMIS) to accommodate Hawai'i's QUEST Demonstration Project. The new system, Hawai'i Arizona PMMIS Alliance, was intended to be operational by October 2000, with Arizona maintaining the system until June 2001.

Another of our 2001 reports, *Financial Audit of the Med-QUEST Division of the Department of Human Services* (Report No. 01-10), continued to find poor management control practices within the QUEST Demonstration Project. Program files lacked required documentation, certifications, and evidence of supervisory review; the backlog of eligibility applications had not been resolved; the division continued to be inconsistent in collection of reimbursements and dis-enrolling those who failed to pay required co-payments; and the division's oversight of capitation reconciliations had diminished following the transfer of reconciliation responsibility to the health plans.

In our 2003 *Follow-Up Audit of the Department of Human Services' QUEST Demonstration Project* (Report 03-07), we found that QUEST continued to experience problems from inadequate planning and design that hampered the development and expansion of a managed care approach to health care. Changes in Medicaid expenditures, provider participation, and temporary lifting of the enrollment cap placed the program in a budget shortfall and raised concerns about its ability to continue to keep costs under control. Self-declaration and presumptive eligibility practices reduced the application backlog but also increased the likelihood that ineligible applicants may receive benefits. Finally, after six years, an MIS had been implemented.

In our 2004 *Audit of the Department of Human Services' Expedited Application Process for Pregnant Women* (Report No. 04-12), we found that despite making notable improvements in processing applications for pregnant women, the division fell short of its self-imposed expedited application process standard that it would process 95 percent of completed applications from pregnant women within five business days. In addition, statistics maintained by division staff could not be reconciled with the division's computer database, which caused the division to rely on skewed figures in making its assertions of compliance with the five-day standard.

Since 2008, Hawai'i's Medicaid program has also been subject to six audits by the U.S. Department of Health and Human Services Office of Inspector General, nine reviews or audits by the CMS or CMS contractors, and five annual financial audits by independent audits contracted by our office with certified public accountant firms.

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## Objectives of the Audit

1. Assess how Hawai'i's Medicaid costs compare to other states and the U.S. average.
2. Determine whether the Department of Human Services is responsive to Legislative requests for information.
3. Assess the effectiveness of the Med-QUEST Division's efforts to detect and prevent fraud, waste, and abuse.
4. Make recommendations, as appropriate.

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## Scope and Methodology

We interviewed select legislators to determine whether they receive sufficient information from the department necessary for understanding, managing, and enacting legislation for the state's Medicaid program. We reviewed the management and fiscal practices of the DHS's Med-QUEST Division for the three-year period FY2010 through FY2012. We examined applicable strategic and operating plans, policies and procedures, operating reports, contracts, and other relevant documents and records to assess management's planning, monitoring, and reporting efforts for the Med-QUEST Division. We collected and analyzed information about the program and its cost drivers. We reviewed applicable laws and regulations; literature and best practice documents regarding Medicaid fraud; department and division files and relevant program documents; and information from sources including DHHS,

CMS, and other states. We interviewed key program staff, staff in other state agencies, and staff from federal agencies as necessary to meet our audit objectives.

Our audit was performed from June 2013 through October 2013 and conducted in accordance with the Office of the Auditor's *Manual of Guides* and generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence we obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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# Chapter 2

## Med-QUEST Reporting and Inattention to Fraud Impede Legislative Efforts to Contain Costs

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While Hawai‘i’s Medicaid program is financed with a combination of state and federal funds, we found that the Med-QUEST Division has organized its performance reporting around federal measures and requirements. Those requirements focus on quality of health care services delivered, unlike State concerns, which are largely related to costs. With significant increases in State contributions to the Medicaid program over the past five years, legislators are understandably concerned about the relevance and usefulness of the information they currently receive from the Med-QUEST Division.

After analyzing Med-QUEST Division data and other government and private sources, we found that Hawai‘i’s Medicaid costs compare favorably to other states and the national average, with costs remaining relatively stable despite rising enrollment. In addition, we found that Medicaid cost containment is largely beyond the State’s control, especially after implementation of the Affordable Care Act (ACA) in 2014. However, we also found that the division has neglected to commit sufficient resources to its efforts to curb fraud, waste, and abuse. As a result, Hawai‘i’s detection and enforcement activities lag far behind national averages, exposing the State to tens of millions of dollar in losses annually. For instance, in 2011, the Centers for Medicare and Medicaid Services (CMS) projected that improper payments from the Hawai‘i Medicaid and Children’s Health Insurance programs totaled \$66.9 million.

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### Summary of Findings

1. Although the Med-QUEST Division is generally responsive to legislative information requests, the program and cost data it provides does not fulfill legislative needs.
2. The State’s Medicaid program costs generally compare favorably to peer states and national averages.
3. The State is exposed to tens of millions of dollars in losses due to Medicaid fraud, waste, and abuse.



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## **Although the Division Is Generally Responsive to Legislative Information Requests, the Data It Provides Does Not Fulfill Legislative Needs**

### ***Division's reporting focuses on quality of health care services***

We found that the Med-QUEST Division concentrates its reporting on quality of health services delivered and recipient satisfaction to fulfill federal requirements. The division's reports to CMS and the Legislature do not include financial performance results that reflect how the division is meeting its budgetary goals.

Legislators have expressed concern about growth in the State's Medicaid costs without an accompanying effort to manage costs. Absent adequate and appropriate information, however, the Legislature is unable to make informed decisions about and enact legislation to implement cost containment measures relating to the Medicaid program. It continues to fund ever-increasing budget requests for the Medicaid program because it has no basis to challenge the requests. By funding increasing Medicaid costs without the ability to manage those costs, the Legislature may compromise funds that could be available for other government programs and services.

Hawai'i's Medicaid program is guided by the State's Section 1115 demonstration waiver, which the department first implemented in August 1994. Under the waiver, CMS sets special terms and conditions that detail the nature, character, and extent of federal involvement in Hawai'i's demonstration project and the State's obligations to CMS during the life of the project, including compliance with CMS' numerous reporting requirements.

The CMS' primary reporting focus is on the quality of health care services delivered. In the Med-QUEST Division's September 2012 *Interim Demonstration Evaluation Report* to CMS, of the 33 performance indicators documented, 27 measures (82 percent) were related to quality of healthcare and recipient satisfaction. The division's focus on quality of health care was confirmed by both the division administrator and finance officer.

The CMS also requires the division to submit selected financial data, some of which relates to federal budget neutrality, which requires that federal Medicaid expenditures cannot be more than they would have been without the waiver. In addition, the division is required to submit Medicaid enrollment, eligibility, and claims data on a quarterly basis to CMS through the Medicaid Statistical Information System.

***Legislature's need for Medicaid program cost information is largely unmet***

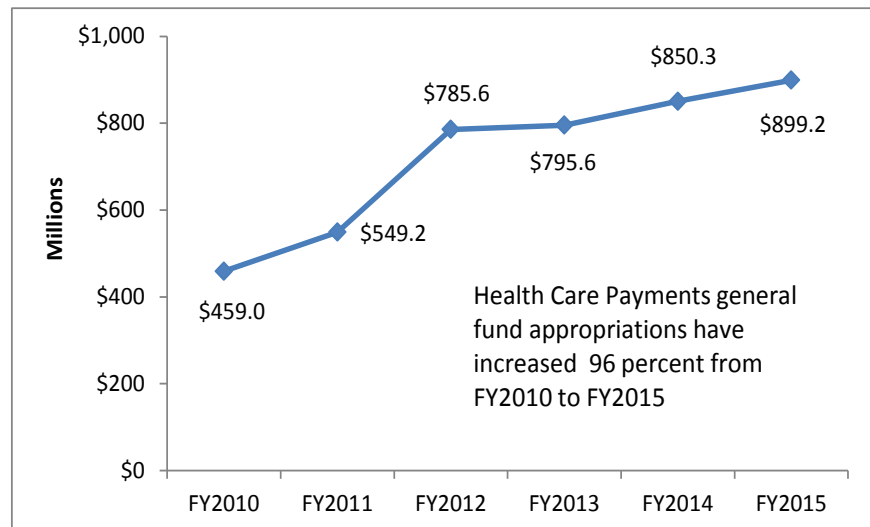
In order to make informed decisions affecting Medicaid program costs, the Legislature needs timely, reliable cost information to assess and compare alternative actions. According to *Government Auditing Standards*, government programs are responsible for providing reliable, useful, and timely information for transparency and accountability of their programs and operations. In addition, the *Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts* provides that legislators need cost information to compare alternative courses of action, make program authorization decisions by assessing costs and benefits, and make decisions about allocating state resources and evaluating program performance.

To assess the adequacy of Medicaid information received by the Legislature, we interviewed and surveyed legislators and staff from key subject-matter committees, and House Finance and Senate Ways and Means committees. Survey respondents rated the division generally “good” at responding to legislative requests for information; however, legislators also expressed frustration about the lack of Medicaid program and performance data.

Specifically, Medicaid data provided by the division is limited to statutorily required reports and aggregate budgetary costs year-over-year. For example, information contained in budget documents for program ID HMS401 (Health Care Payments) include aggregate health care payments for both Medicaid and non-Medicaid programs. Some legislators desire Medicaid data in more detail than is currently provided by the division. Examples include costs by program, average cost per enrollee by various categories (that is, children, QUEST, disability types, etc.), average Medicaid cost for particular services, enrollment numbers for each program, number of enrollees served by category, and how costs compare to other states and/or national averages.

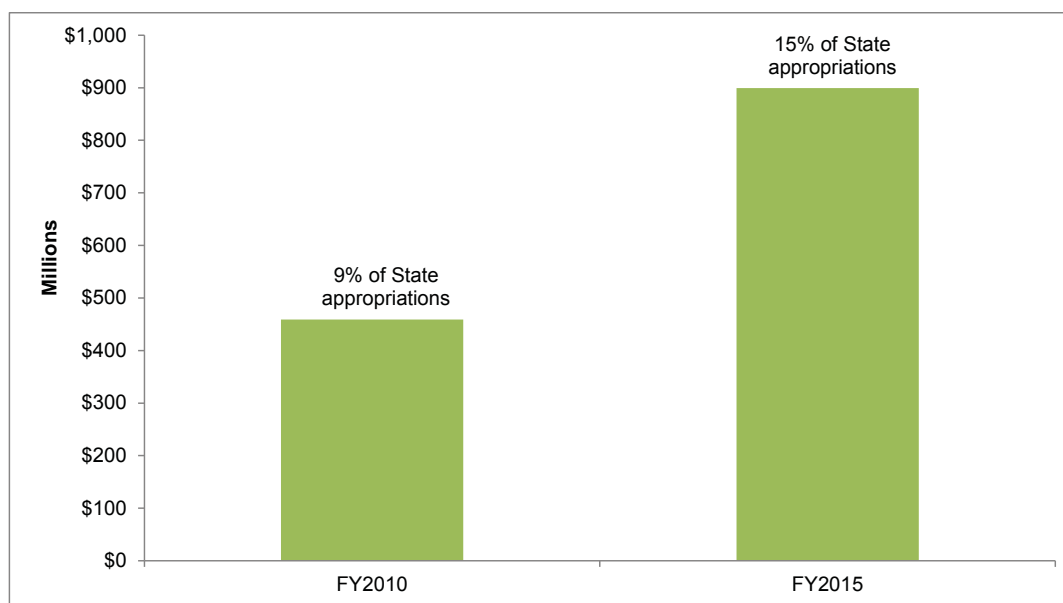
Before the Legislature can begin to curb Medicaid costs, it needs to understand the reasons behind the increases. The Med-QUEST Division administrator agreed that growth in the State’s general fund portion of Medicaid expenditures is unsustainable, adding that over the past five years the general fund portion for Medicaid program HMS401 has nearly doubled. Exhibit 2.1 shows State health care appropriations growth by 96 percent from FY2010 to FY2015.

**Exhibit 2.1**  
**Health Care Payments General Fund Appropriations,**  
**FY2010–FY2015 (in \$ millions)**



Source: State appropriation acts, SLH 2009 to SLH 2013

During the same period—FY2010 to FY2015—statewide general fund appropriations increased by only 19 percent. Health care payments from the general fund during this period thus consumed a larger proportion of the State’s general fund appropriations, increasing from 9 percent in FY2010 to almost 15 percent in FY2015, as shown in Exhibit 2.2.

**Exhibit 2.2****Appropriations for Health Care Payments as a Percentage of Statewide Appropriations, FY2010 and FY2015**

Source: Office of the Auditor

Measuring and reporting actual performance against established goals is essential for assessing governmental accountability. The division considers the Section 1115 demonstration waiver with CMS as its key planning document, but admits that the waiver's goals and objectives are for quality of health care delivered and are not agency performance goals. The administrator said the division has no cost goals because these are difficult to document due to changes brought about by legislative action and growth in Medicaid populations.

Although the division has the capability to prepare reports based on program data, it lacks an overall strategy to generate such reports in a manner useful to the Legislature. The division administrator expressed willingness to provide such reports to the Legislature upon request, but added that the Legislature has yet to ask for those reports. This was confirmed by a legislator who stated that legislative information requests to the division may be too generic or vague.

To address concerns about the rising cost of public assistance, including medical payments, the Legislature directed, through Section 346-54, Hawai'i Revised Statutes (HRS), the department to report cost increases and recommend cost containment actions should general fund expenditures for financial assistance and medical payments increase faster than the increase in general fund tax revenues in any given year. Recommendations are to include, but are not limited to: 1) changes in eligibility standards; 2) adjustments to the assistance allowance;

3) alternatives to financial assistance for meeting needs essential to maintaining an adequate standard of living; and 4) adjustments to medical payment fees and levels of service. For the five-year period FY2008 through FY2012, we found that the rate of change in health care general fund expenditures exceeded the rate of change in the State's general fund tax revenues for each of those years. The department, however, did not submit the required cost containment recommendations reports because the division administrator was not aware of the statutory reporting requirement.

We also found the division does not produce performance reports containing operational, financial, or compliance-related information. The division administrator acknowledged the division does not provide reports to the Legislature that demonstrate the Medicaid program is run in an efficient or effective manner. He also admitted that communicating with the Legislature is an area that needs improvement. The division has started to design reports for the Legislature containing operational, financial, and compliance-related information.

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## **Hawai'i's Medicaid Costs Compare Favorably to Other States and the U.S. Average, and Options for Cost Containment are Limited**

We found that Hawai'i's Medicaid costs compare favorably to other states and the national average. While Hawai'i has a higher Medicaid enrollment as a percentage of its population compared to other states, its Medicaid costs are below the national average and the spending growth rate remains relatively stable.

Determining how to optimally balance the demand for health care with the limited ability to fund such care is one of the challenging policy dilemmas facing states. Hawai'i has some flexibility in containing costs, but the options are becoming more limited. Near-minimum federal assistance means the State must pay for a higher proportion of its total Medicaid costs. In addition, requirements associated with the Compacts of Free Association (COFA) agreements and Affordable Care Act (ACA) prevent the division from making certain adjustments to benefits and eligibility. Moreover, since the division has already implemented significant organizational cost-cutting initiatives, further cuts in one area may negatively impact other areas, thereby negating or lowering cost savings.

***Despite a higher enrollment as a percentage of its population, Hawai'i's Medicaid costs are below the national average***

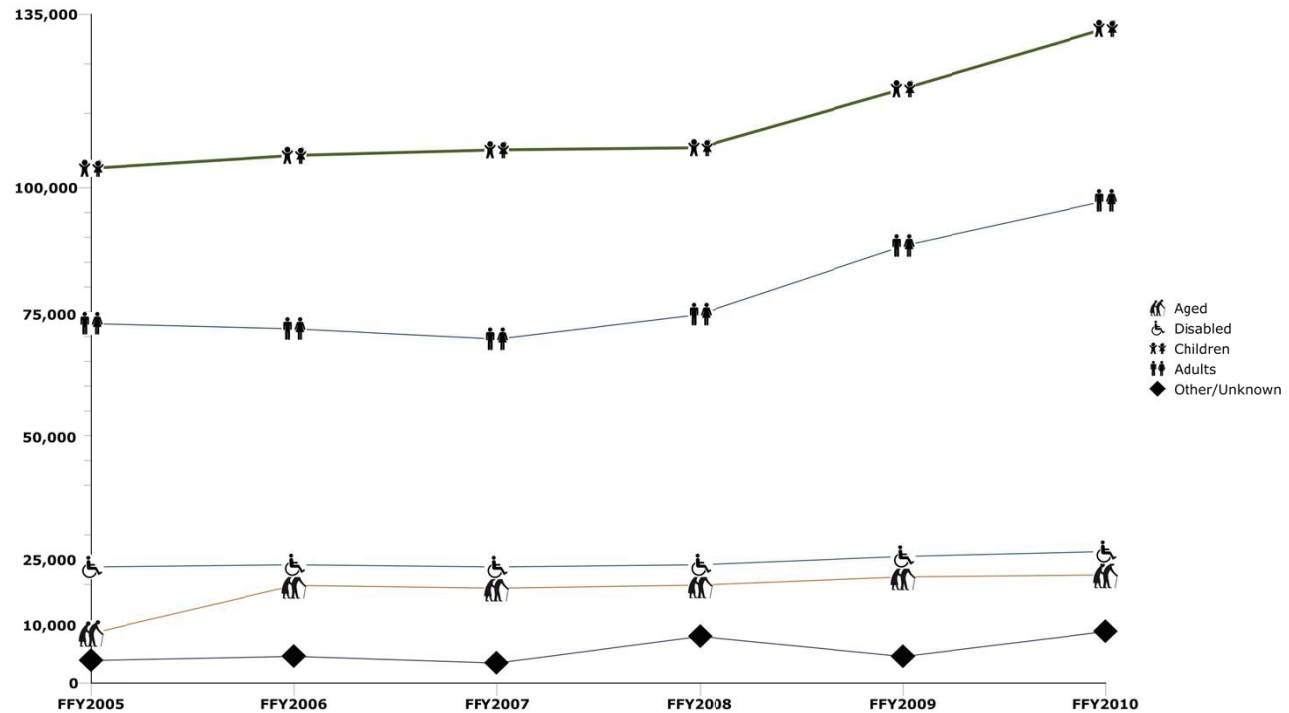
Our analysis of federal and state Medicaid enrollment and spending statistics revealed that Hawai'i's Medicaid program compares favorably with peer states and national averages. Despite growth in the percentage of Hawai'i's population enrolled in Medicaid, the division has been relatively successful in controlling spending per enrollee and stabilizing program costs.

We based our conclusion on data collected from the division, the National Association of State Budget Officers (NASBO), and CMS. The CMS data is reported by federal fiscal year (FFY)—October 1 through September 30—which may differ from states’ data reported by respective fiscal years as compiled by NASBO. To assess how Hawai‘i’s Medicaid program compares to other states, we worked with the division to identify a list of comparable or peer states with comprehensive managed care programs: Arizona, New Mexico, Oregon, Utah, and Washington.

**Hawai‘i’s growing Medicaid enrollee population comprises a larger percentage of the State’s population than the national average**

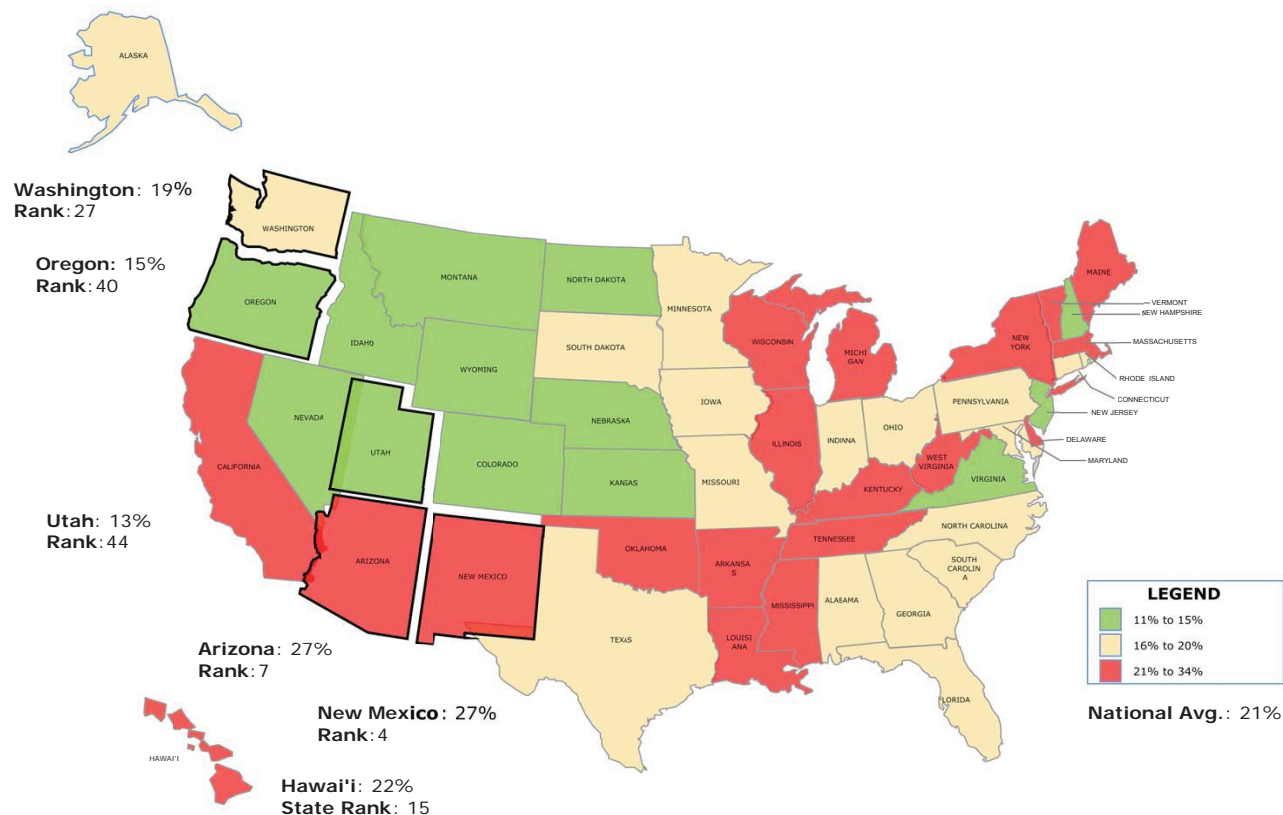
Medicaid enrollment and spending rise when the economy stagnates and employment rates and incomes fall. Conversely, enrollment and spending slows when the economy recovers. The division attributes growth in the State’s Medicaid enrollment during FFY2009 and FFY2010 to the downturn in Hawai‘i’s economy in 2007 and 2008. As a result of the 28.8 percent increase in total enrollment—from 223,933 in FFY2005 to 288,320 in FFY2010—the percentage of the State’s population enrolled in the Medicaid program, 22.2 percent, exceeded the national average of 21.1 percent in FFY2010. Exhibit 2.3 shows the growth in enrollment for each Hawai‘i Medicaid eligibility category from FFY2005 to FFY2010. Of the five enrollment categories, two—adults and children—grew the fastest during the FFY2005–FFY2010 period. The other three enrollment categories—aged, disabled, and other—grew at a much slower pace, as shown in Exhibit 2.3.

### Exhibit 2.3 Growth in Hawai'i Enrollment for Each Medicaid Eligibility Category, FFY2005–FFY2010



Source: Centers for Medicare and Medicaid Services

Exhibit 2.4 presents a comparison of the Medicaid enrollment across states in FFY2010.

**Exhibit 2.4****Percentage of State Populations Enrolled in Medicaid, FFY2010**

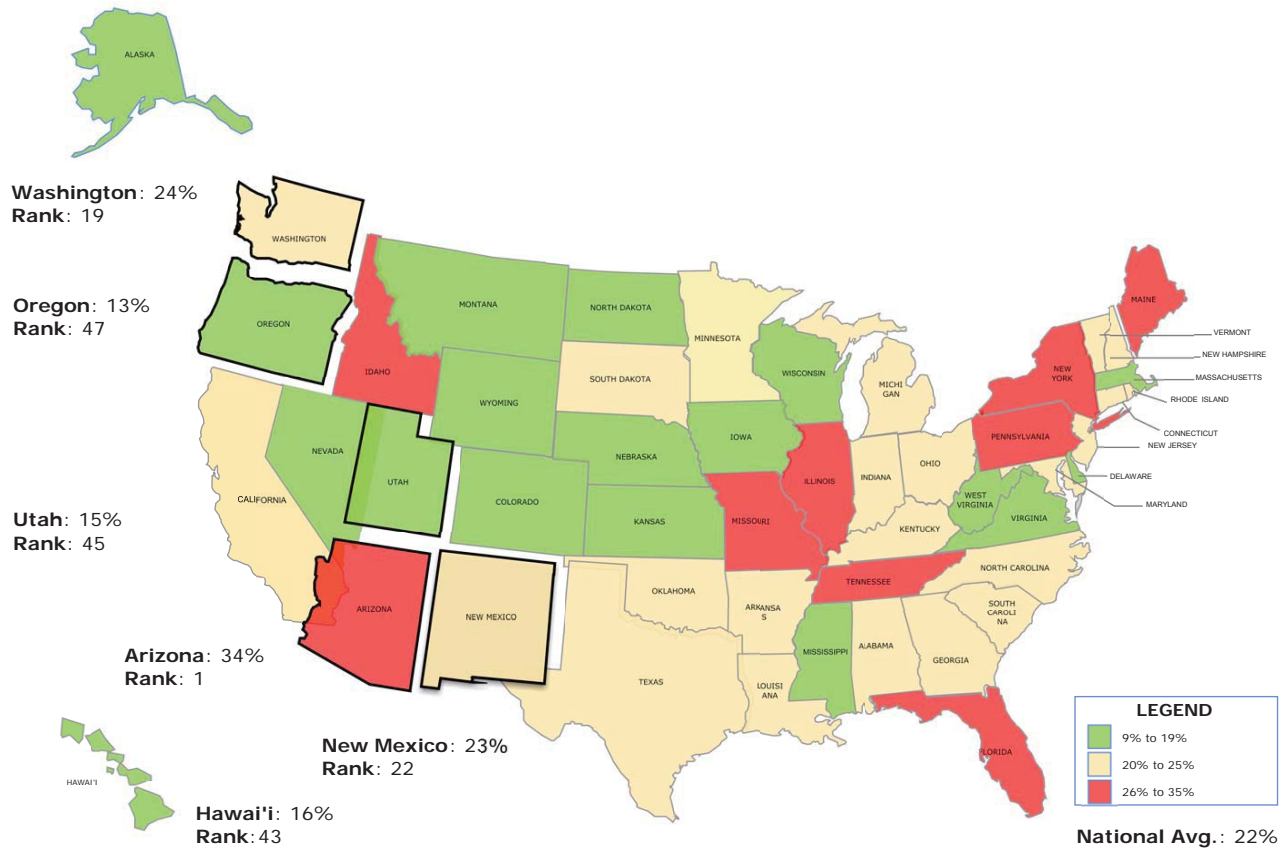
Source: Centers for Medicare and Medicaid Services

### **Hawai'i's Medicaid cost per recipient compares favorably to peer states and national averages**

Despite Hawai'i's higher than average Medicaid enrollment, the State has been successful in controlling Medicaid spending when compared to other states. According to NASBO, Hawai'i's FY2011 Medicaid costs comprised almost 16 percent of the State's total expenditures. By comparison, Arizona's FY2011 Medicaid costs were almost 34 percent of its statewide expenditures, the highest in the nation. Exhibit 2.5 shows the national and selected peer state Medicaid costs as a percentage of statewide expenditures for FY2011.



## Exhibit 2.5 National Medicaid Costs as a Percentage of Statewide Costs, FY2011

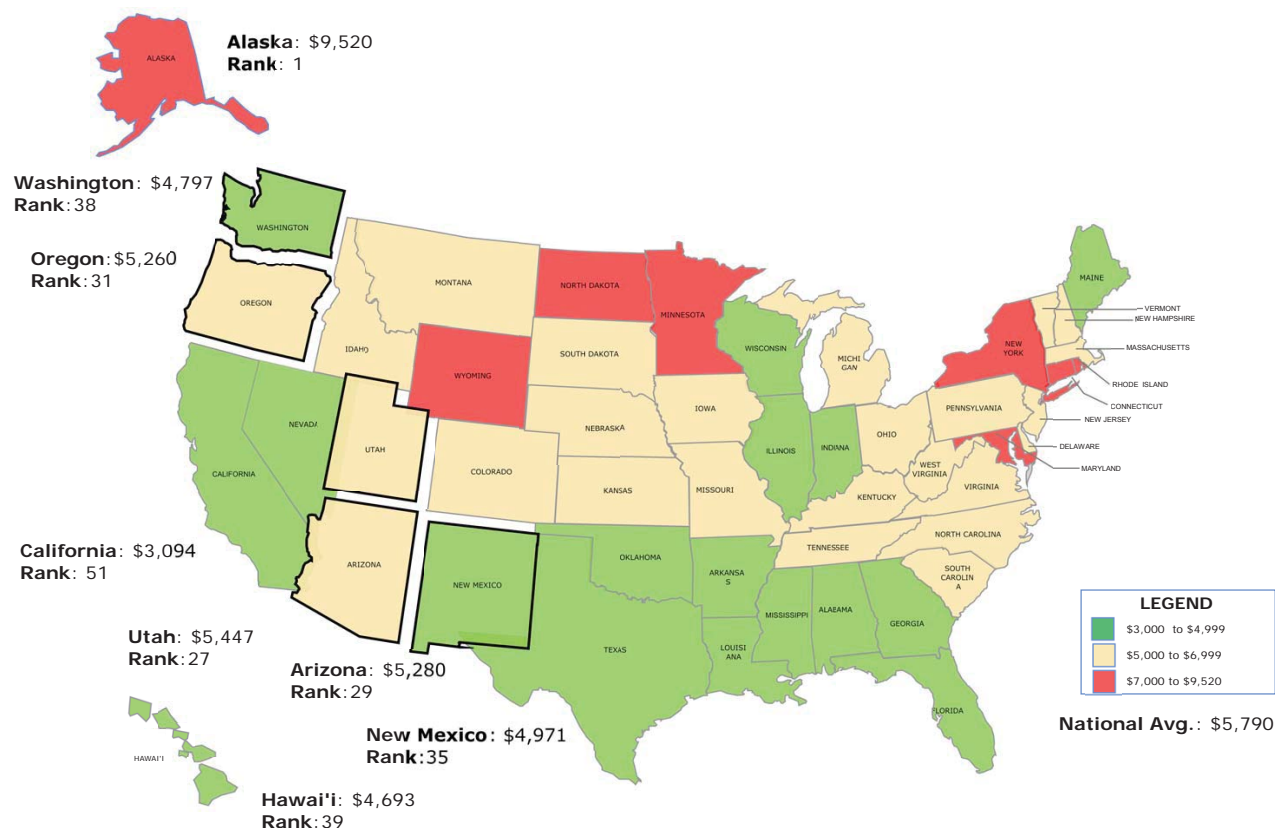


Source: National Association of State Budget Officers

Hawai'i's FFY2010 annual cost per Medicaid recipient of \$4,693 also compares favorably to selected peer states, and is below the national average of \$5,790. Exhibit 2.6 shows the national average and selected peer state costs per Medicaid recipient for FFY2010.

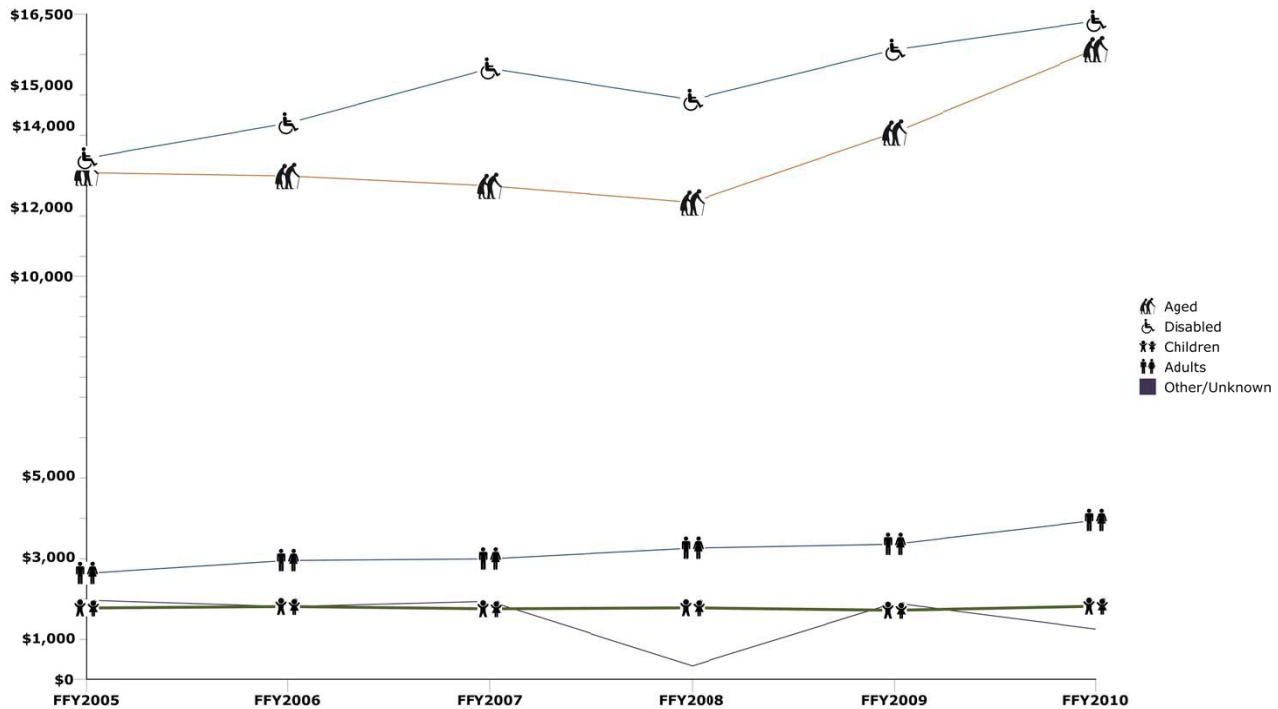
## Exhibit 2.6

### Medicaid Costs Per Recipient, FFY2010



Source: Centers for Medicare and Medicaid Services

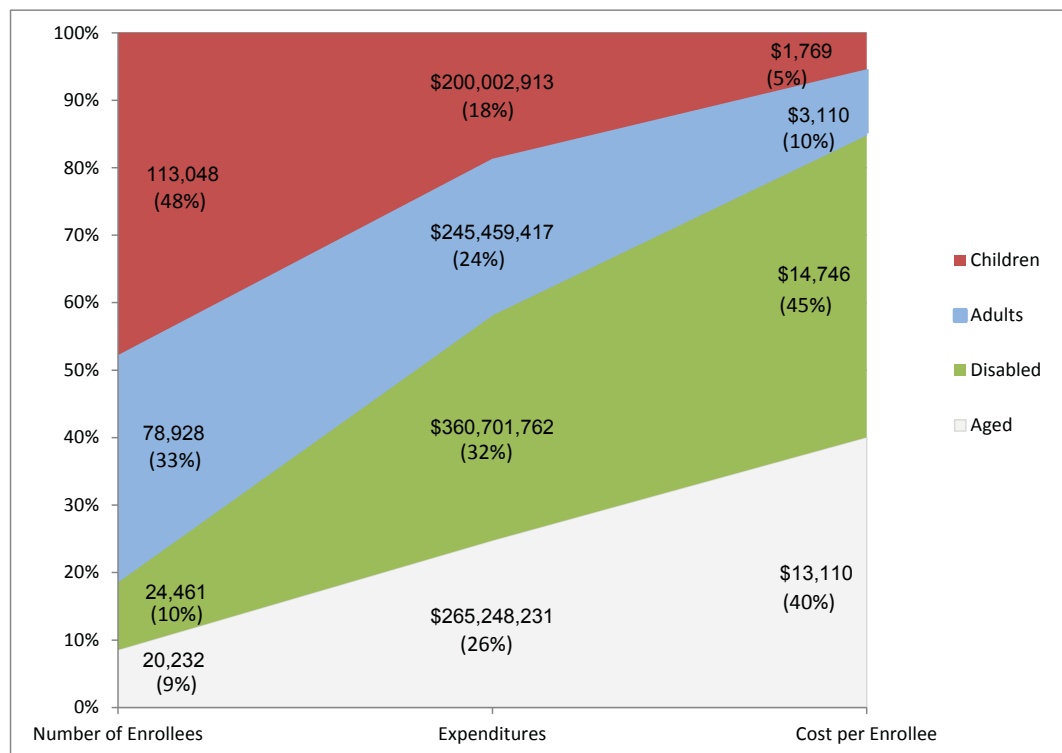
Hawai'i's aged and disabled populations disproportionately drive the growth in Hawai'i's total Medicaid spending because the services they require—extensive acute and long term care—cost more. While the State has successfully controlled the growth in per capita spending for the adult, children, and other/unknown populations, per capita spending for the aged and disabled have grown significantly, particularly since FFY2008. Exhibit 2.7 shows the growth in Hawai'i's Medicaid costs per recipient for each eligibility category between FFY2005 and FFY2010.

**Exhibit 2.7****Hawai'i's Growth in Medicaid Costs Per Recipient by Eligibility Category, FFY2005–FFY2010**

Note: The other/unknown line at the bottom of this chart remains unmarked due to the overlap with the Children line.

Source: Centers for Medicare and Medicaid Services

Based on average enrollment and spending for the six-year period from FFY2005 to FFY2010, we found that Hawai'i's aged and disabled Medicaid populations constituted a combined 19 percent of all Medicaid recipients but 58 percent of the State's total Medicaid costs, as shown in Exhibit 2.8. The remaining adults and children made up 81 percent of Medicaid recipients, but accounted for only 42 percent of the State's Medicaid costs.

**Exhibit 2.8****Hawai‘i’s Six-Year Average of Medicaid Enrollees and Costs by Eligibility Category, FFY2005–FFY2010**

Source: Centers for Medicare and Medicaid Services

### **Hawai‘i’s Medicaid costs per program remain relatively stable despite rising enrollment**

Because the most recent NASBO and CMS data are for FY2011 and FFY2010, respectively, we also analyzed Hawai‘i’s current enrollment and cost trends using data provided by the division covering the period FY2010 through FY2013. We focused on the State’s managed care capitated payment delivery system because 99 percent of the State’s Medicaid enrollees are in the managed care Medicaid programs, which consist of QUEST, QUEST Expanded (QExA), Children’s Health Insurance Program (CHIP) and other programs. These recent data are organized differently than the data contained in CMS reports, categorized by program rather than by eligibility.

Our analysis revealed that the division continues to control growth in Medicaid spending, as evidenced by relatively stable per capita program costs despite continually rising enrollment, as shown in Exhibit 2.9.

In response to a legislative request to cut \$75 million in general funds spending over the 2011–2013 fiscal biennium, the division proposed and received approval from CMS to reduce managed care capitated rates by

3 percent, which saved approximately \$22 million in general funds. The reduction is reflected in the FY2012 decline in total cost per person as shown in Exhibit 2.9. Overall, the State has successfully controlled the per capita cost growth of QUEST and CHIP, the State's largest programs covering non-disabled adults (under age 65) and children.

### Exhibit 2.9

#### Hawai'i's Medicaid Managed Care Program Costs Per Person, FY2010–FY2013

	FY2010	FY2011	FY2012	FY2013	% Change
QUEST	\$ 2,710	\$ 2,847	\$ 2,781	\$ 2,806	3.5%
QExA	\$ 13,023	\$ 15,547	\$ 14,582	\$ 15,235	17.0%
CHIP	\$ 1,123	\$ 1,130	\$ 1,079	\$ 1,126	0.3%
<b>Total</b>	<b>\$ 4,309</b>	<b>\$ 4,745</b>	<b>\$ 4,504</b>	<b>\$ 4,544</b>	<b>5.5%</b>
% change		10.1%	-5.1%	0.9%	2.0%

Source: Med-QUEST Division

Between FY2010 and FY2013, the average growth rates in Hawai'i's managed care enrollment and costs were 6.6 percent and 8.8 percent, respectively. Contributing to the growth in total enrollment was the division's ACA-related expansion of Medicaid benefits in the QUEST programs covering non-disabled adults and children. Contributing to the growth in total program costs were the increases in enrollment in QUEST and CHIP and the increases in the costs of the QExA managed care program. The significant increase in spending in FY2011 reflects the temporary increase in the State's federal medical assistance percentage (FMAP) pursuant to the American Recovery and Reinvestment Act of 2009 (ARRA).

Exhibit 2.10 shows the average annual enrollment for Hawai'i's managed care programs, the year-to-year percentage growth for all programs, and the four-year percentage growth by program for the period FY2010 through FY2013. The largest overall enrollment growth occurred within the QUEST program, which increased by 24 percent (42,135 recipients).

**Exhibit 2.10****Average Annual Hawai'i Medicaid Enrollment Per Managed Care Program, FY2010–FY2013**

	<b>FY2010</b>	<b>FY2011</b>	<b>FY2012</b>	<b>FY2013</b>	<b>% Change</b>
QUEST	175,855	191,585	202,920	217,990	24.0%
QExA	42,164	43,106	45,023	46,004	9.1%
CHIP	27,060	28,217	30,389	33,001	22.0%
<b>Total</b>	<b>245,079</b>	<b>262,908</b>	<b>278,332</b>	<b>296,995</b>	<b>21.2%</b>
% Change		7.3%	5.9%	6.7%	6.6%

Source: Med-QUEST Division

Exhibit 2.11 shows Hawai'i's total managed care costs by program and in total. Total costs for all programs grew between 22 and 28 percent over the four-year period. Increases in total cost of the QUEST and CHIP programs were a result of increases in enrollment. Increases in the total cost of the QExA program was a result of the division's realignment of its rates following the transfer of the aged, blind, and disabled populations from fee-for-service delivery system into the QExA managed care program in FY2009 and rising program costs.

**Exhibit 2.11****Total Hawai'i Medicaid Managed Care Costs Per Program, FY2010–FY2013**

	<b>FY2010</b>	<b>FY2011</b>	<b>FY2012</b>	<b>FY2013</b>	<b>% Change</b>
QUEST	\$ 476,637,160	\$ 545,524,198	\$ 564,276,866	\$ 611,648,443	28.3%
QExA	\$ 549,091,634	\$ 670,149,754	\$ 656,516,440	\$ 700,864,112	27.6%
CHIP	\$ 30,396,374	\$ 31,876,999	\$ 32,777,956	\$ 37,167,731	22.3%
<b>Total</b>	<b>\$1,056,125,168</b>	<b>\$1,247,550,951</b>	<b>\$1,253,571,262</b>	<b>\$1,349,680,286</b>	<b>27.8%</b>
% Change		18.1%	0.5%	7.7%	8.8%

Source: Med-QUEST Division

***Medicaid cost containment is largely beyond the State's control***

The Medicaid program is a complicated budget puzzle with a seemingly endless number of policy choices and trade-offs. While the State has some flexibility to contain costs, we found that its options are becoming more limited. Requests to exercise traditional cost containment options—reducing benefits and eligibility—were not approved by CMS, and one that was approved—reducing payment rates to managed care plans—was already exercised several years ago. Changes in delivery system, such as focusing on home and community-based services for its aged and disabled, were implemented in FY2009. However, further cuts in one cost area may negatively impact other areas, thereby negating or lowering anticipated cost savings.

In addition, Hawai‘i receives near-minimum federal assistance, which means the State must pay a higher proportion of its total Medicaid costs. Moreover, the federal Compacts of Free Association (COFA) agreements continue to impact State health care payments by \$40 million annually. Also, a federal mandate precluding the State from removing the passive renewal policy exposes the State to millions of dollars in losses annually. Finally, the Federal Affordable Care Act further limits state Medicaid cost containment options.

### **Cost containment options are limited**

In its latest 2012 actuary report, CMS projects that nationally, Medicaid costs will increase at an average rate of 6.4 percent per year over the next ten years. Average enrollment is also projected to increase 3.4 percent per year over the same period. The division reported that the State’s total Medicaid annual costs are expected to exceed \$2 billion by 2016.

Medicaid cost per enrollee is driven by eligibility and enrollment plus capitation payment rates—including rising prices—and to some degree by fraud, waste, and abuse. Costs are also affected by the types of services provided and the expenditures of the optional programs a state implements. Traditionally, states have contained rising Medicaid costs by limiting eligibility, reducing provider reimbursements, and/or cutting benefits. Options for lowering these cost drivers are limited due to federal restrictions. There are also issues that need to be considered when changing prices and eliminating programs. Federal law requires reimbursements be consistent with efficiency, economy, and quality of care and that managed care rates are actuarially sound. Proposed rate cuts must assure quality and access are maintained.

As a general matter, any cuts to the Medicaid budget or services require approval from CMS. For benefits and eligibility/enrollment, a federal Maintenance of Effort (MOE) requirement originally in ARRA, prevents states from adopting more restrictive standards, methodologies, or procedures. *Maintenance of effort* means “a requirement that a State spend at least a specified amount of State funds for Federal assistance program purposes.” The MOE requirement was extended for children in the Children’s Health Insurance Program Reauthorization Act (CHIPRA) until 2019 and for adults in the Affordable Care Act until 2014.

Reducing payment rates to providers is the most common strategy used by states, including Hawai‘i, to respond to budget challenges. The division cautioned that any effort to further lower managed care rates could reduce physicians’ participation in the State’s Medicaid program, especially on the neighbor islands, thereby negatively impacting access



to care. With decreased physician participation, the State would also incur additional transportation costs to fly Medicaid patients to O‘ahu to obtain necessary medical services.

Reducing and restricting benefits is another cost containment option, which the State has already done. The State’s Medicaid-covered benefits are separated into mandatory benefits, which must be included for all beneficiaries, and optional benefits, which may be covered at a state’s discretion. According to the division, mandatory benefits make up 65 percent of the State’s Medicaid costs. Prescription drugs and intermediate care facility services make up 81 percent of optional benefit costs. If these two services are viewed as not eligible for removal from the optional benefits, the remaining benefits account for only 6.6 percent of the State’s Medicaid costs, which does not provide much room for cost savings.

Elimination of certain optional benefits and programs may increase costs elsewhere; or rate reductions for one provider type may affect the use of another, thus negating or lowering anticipated savings. For example, the division reported that prescription drugs cost the State about \$200 million a year. However, eliminating the prescription drug benefit program would eventually result in more emergency room visits, which is the most expensive treatment option. A few visits to an emergency room would quickly outweigh any anticipated savings from eliminating the prescription drug program. In addition, there are new federal requirements for coverage to the new adult groups, and some of the currently optional services may become mandatory for this group.

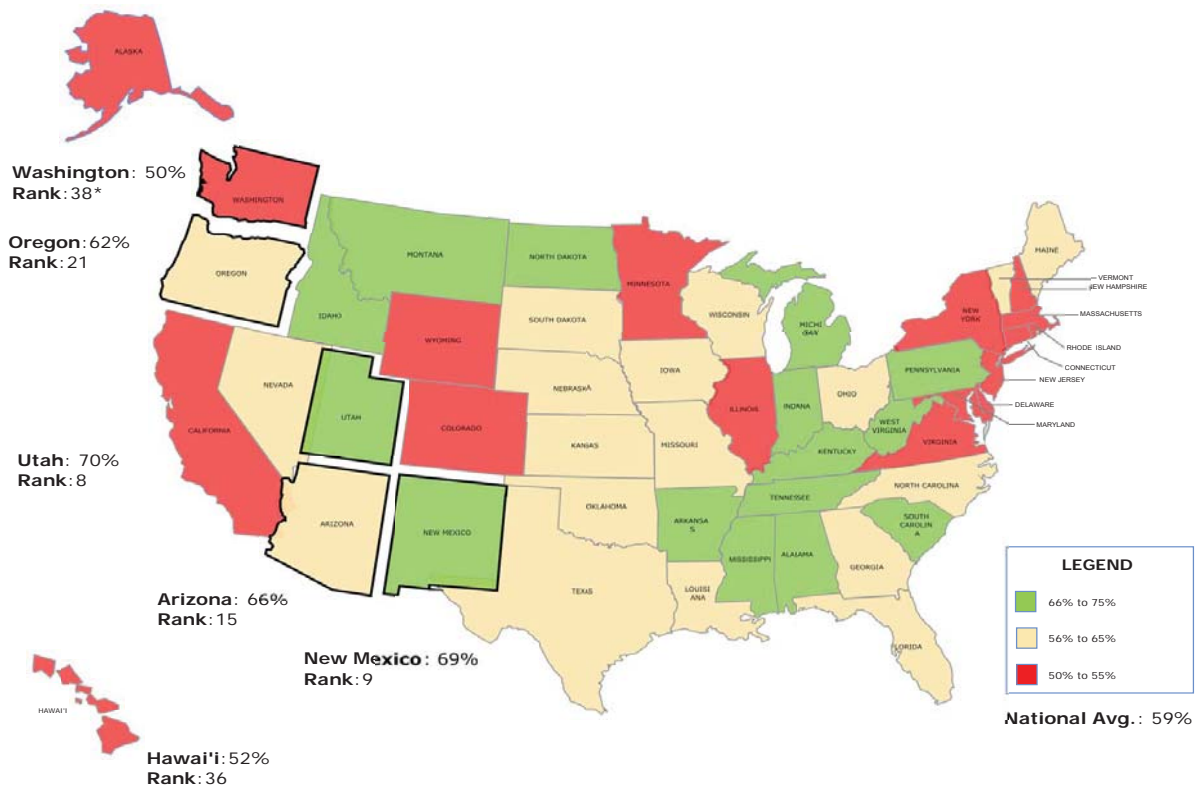
Another way to contain costs is to change the delivery of services. Other states are shifting long-term care away from institutions to community settings. Medicaid is the nation’s primary payer for long-term care services, covering a range of services including home and community-based services, which allows people to live independently in their own homes or communities. One goal of Hawai‘i’s QExA program was to increase the availability of home and community-based services as an alternative to nursing home care. Providing these services in place of costly institutional long-term care services saves taxpayers money. The department stated in its FY2011 annual report that since QExA’s inception, the number of Medicaid recipients in nursing facilities has decreased 17 percent and those receiving home and community-based services has increased 97 percent.



### Hawai'i receives near-minimum federal assistance for Medicaid expenditures

Hawai'i's Medicaid program receives federal funding based on the federal medical assistance percentage (FMAP)<sup>1</sup>, a formula that compares each state's per capita income relative to U.S. per capita income and provides higher reimbursement to states with lower average incomes. Unfortunately for Hawai'i, the FMAP does not consider cost of living. Of the ten areas with the highest cost of living, eight (Massachusetts, Maryland, New York, New Jersey, Connecticut, California, New Hampshire, and Alaska) receive minimum (50 percent) federal assistance, one (Hawai'i) receives near-minimum federal assistance (52 percent), and one (Washington, D.C.) receives 70 percent federal assistance for its Medicaid costs. The FMAP for Washington, D.C. was permanently raised from 50 percent to 70 percent in the Balanced Budget Act of 1997. Exhibit 2.12 shows Hawai'i's FMAP relative to peer states and the nation.

**Exhibit 2.12**  
**National and Peer States Federal Medical Assistance Percentage (FMAP) for Medicaid, FY2013**



\*Note: There are 14 states tied at rank 38 with a minimum 50% FMAP

Source: Kaiser Family Foundation

<sup>1</sup> The formula is  $FMAP(\text{state}) = 1 - ((\text{per capita income of state})^2 / (\text{per capita income of U.S.})^2 \times 0.45)$ .

Hawai'i's Medicaid programs received near-minimum federal assistance due to a relatively high per capita income (in the top third of the nation between 2008 and 2013). Exhibit 2.13 shows per capita income and federal financial contribution percentages for FY2008 through FY2013.

### **Exhibit 2.13**

#### **Hawai'i Federal Medical Assistance Percentage for Medicaid, FY2008–FY2013**

<b>Fiscal Year</b>	<b>Hawai'i's FMAP</b>	<b>Hawai'i's Per Capita Income National Rank</b>
2008	57%	16 <sup>th</sup>
2009	67%	16 <sup>th</sup>
2010	67%	17 <sup>th</sup>
2011	52%	18 <sup>th</sup>
2012	50%	17 <sup>th</sup>
2013	52%	16 <sup>th</sup>

Source: Office of the Auditor

However, when adjusted for inflation, Hawai'i's per-capita income ranked among the lowest in the nation in 2011, registering at \$32,500 compared to the national average of \$36,500. Thus, Hawai'i's inflation-adjusted average income suggests that Hawai'i should receive a higher FMAP rate.

Of note, ARRA raised Hawai'i's effective rates of federal share for Medicaid costs to 67 percent for FY2009 and FY2010. The significant increase in state spending in FY2011 as shown in Exhibit 2.11 reflects the end of the enhanced Medicaid match rate from ARRA, which temporarily increased FMAP as well as provided additional amounts for those states facing the highest unemployment rates.

#### **Federal Compacts of Free Association (COFA) agreement increases State health care payments by \$40 million annually**

When Congress passed the Compacts of Free Association (COFA) Act in 1985, it made a promise to provide specified protections, economic benefits, and domestic programs to the Federated States of Micronesia, the Republic of Marshall Islands, and the Republic of Palau in exchange for certain military permissions in these associated states. Under COFA, the U.S. agreed to provide economic assistance to compact nation citizens, allowing them to enter, reside, and work in the United States and participate in certain federal programs including Medicaid.

As a result, over the years, states have taken on the obligations of this federal mandate. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted access to federal public benefit programs and eliminated federal Medicaid benefits for COFA migrants. The COFA migrants are also currently ineligible for expanded Medicaid benefits under the ACA. After the enactment of PRWORA, states like Hawai‘i and the Territory of Guam were required to fully absorb the costs of providing social service and health care benefits to COFA migrants in the absence of federal funding.

Until July 1, 2010, COFA residents were able to enroll in QUEST. During the Clinton administration, COFA migrants were excluded from federal funding for the Medicaid program. Since then, the division has successfully restored federal funding for children and pregnant women under the CHIPRA.

In response to the 2009 economic downturn and the subsequent budget shortfall, one of the Hawai‘i’s cost-cutting measures was to dis-enroll COFA migrants from QUEST and place them in a program with fewer benefits. Attorneys filed a legal action on behalf of COFA migrants in federal district court, which reinstated full QUEST benefits for COFA migrants. The State has appealed the ruling and is currently awaiting a decision.

“Compact Impact” funding from the federal government, designed to offset health and educational costs for these migrants, has been inadequate. According to the governor, Hawai‘i spent nearly \$115 million in 2010 for COFA residents but received only \$10 million from the federal government. More than \$52 million of these costs were absorbed by the Department of Human Services, which reported that annual Medicaid costs for non-pregnant adult compact nation migrants alone are nearly \$40 million. The burden for these costs falls entirely on Hawai‘i taxpayers.

### **Federal mandate precluding State from removing the passive renewal policy exposes the State to millions of dollars in losses annually**

All Medicaid beneficiaries must be annually re-determined as eligible to continue medical coverage. The division sends beneficiaries a pre-printed form which includes client information on file; beneficiaries must sign and return the form, indicating whether eligibility status has changed. However, under passive renewal, beneficiaries are only required to return the form when there are changes to existing information. The policy of passive renewal was instituted in 2004 specifically for beneficiaries who are families with children to ensure continuity of receiving medical coverage. The division interprets a

non-response to mean that information has not changed, and automatically renews the beneficiaries for another year. After review of various eligibility cases, the division determined that its passive renewal process resulted in continued coverage for some ineligible individuals. As a result, the division sought to discontinue this process by requesting permission from CMS to stop passive renewals in 2009. The CMS, however, denied the request, citing federal regulations that specifically prohibit any changes that would make eligibility standards more restrictive or burdensome than what was already in effect from 2008. In 2011, the division again petitioned CMS to stop passive renewals; again CMS denied the request.

In 2013, there were approximately 89,000 passive renewal beneficiaries with an estimated cost per beneficiary in excess of \$2,000 per year. We applied an error rate of 10.5 percent, which was noted by the division's internal review of passive renewal cases and projected an error amount of \$19.6 million. Based on the 2013 FMAP rate of 52 percent, the State's share of these overpayments is \$9.4 million.

The division plans to use a new eligibility system and criteria under the ACA to improve program integrity. However, it is not clear whether renewal forms for the new eligibility system will have to be signed and returned or interpreted as correct for non-responses, as under the passive renewal process. At the time of our review, the division was in the process of clarifying this issue with CMS.

### **Affordable Care Act further limits state Medicaid cost containment options**

The ACA limits state Medicaid cost containment options by setting a federal mandate on eligible enrollees. The impact of ACA Medicaid expansion will vary across states depending on current coverage levels and the number of uninsured, who will become new enrollees in the Medicaid program. New enrollees will consist of two groups: newly eligible beneficiaries and "woodwork effect" beneficiaries—individuals who are already eligible for Medicaid assistance, but are only applying now due to expanded outreach. The division estimates that ACA may bring an expected 48,000 new enrollees. The estimate makes it difficult to predict additional program costs or minimize eligibility offerings to provide cost containment for its Medicaid programs.

Regardless of cost increases due to the ACA, incremental costs will likely be less in Hawai'i than in other states because Hawai'i's current Medicaid eligibility standards are already similar to those set forth in ACA. Hawai'i will see a smaller influx of new enrollees than other states.

Although the majority of costs for new enrollees will be paid by the federal government, the federal mandate on enrollee eligibility removes the State's flexibility regarding cost containment options. For example, the ACA effectively removes the possibility of an enrollment cap for Medicaid enrollees, a tool previously used to control Medicaid costs. Further, the ACA removes an asset limit requirement for eligibility, which may allow previously ineligible individuals to now qualify for Medicaid assistance. These two consequences of the ACA affect the State's limited ability to contain the costs of its expanding Medicaid program.

In addition, the ACA will likely increase the amounts paid by Hawai'i's Medicaid programs. In 2010, an actuarial firm, Milliman, Inc., estimated the cost impacts of the ACA through calendar year 2023. Milliman estimated that additional costs to the State would be \$659.6 million for the first ten years of ACA.

Woodwork effect enrollees will also cost the State, since the federal government will only provide FMAP contributions—not 100 percent contributions—for these enrollees. Further, primary care physicians will receive increased compensation under ACA's Primary Care Physicians Fee Schedule. These increases will be covered by federal funds for the initial two years of ACA implementation, but solely by the State thereafter. However, we note that the 2010 Milliman estimates were created before ACA rules were finalized, so enrollment and expenditure amounts need to be updated. Nevertheless, Hawai'i stands to incur numerous additional costs over the life of ACA and its Medicaid expansion.

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## **Management's Inattention to Medicaid Fraud Exposes the State to Tens of Millions of Dollars in Losses Annually**

Combating Medicaid fraud and abuse is essential to sound fiscal management of the Medicaid program, and states have primary responsibility for policing fraud and abuse in their programs. Despite this, the division's management has not ensured that Hawai'i has a robust Medicaid fraud and abuse detection program, exposing the State to tens of millions of dollars in losses each year. In 2011, CMS projected that improper payments from the Hawai'i Medicaid and Children's Health Insurance Programs totaled \$66.9 million. Division management has demonstrated a minimal commitment to its Medicaid fraud and abuse detection program, resulting in fraud and abuse detection efforts that lag behind other states. As the federal government removes program flexibility for cost containment options, the division needs to do a better job of detecting Medicaid fraud and abuse.

***Management's commitment to detecting and remedying Medicaid fraud is minimal and reactionary***

Division management has demonstrated a minimal commitment to safeguarding the Medicaid program against unnecessary or inappropriate use of services and excess payments. Management has not developed a formal plan to govern its fraud and abuse detection and investigation program, nor has it been proactive in establishing formal policies and procedures for detecting, investigating, and remedying fraud. In addition, it has not dedicated sufficient resources for detecting and investigating Medicaid fraud and is unable to produce complete information about the results of these efforts. These deficiencies increase the risk that the State will fail to identify abusive practices and potential fraud in its Medicaid program, exposing the State to unnecessary Medicaid costs from ongoing fraud and abuse and unrecovered improper payments.

**Management has not developed a formal plan for Medicaid fraud detection**

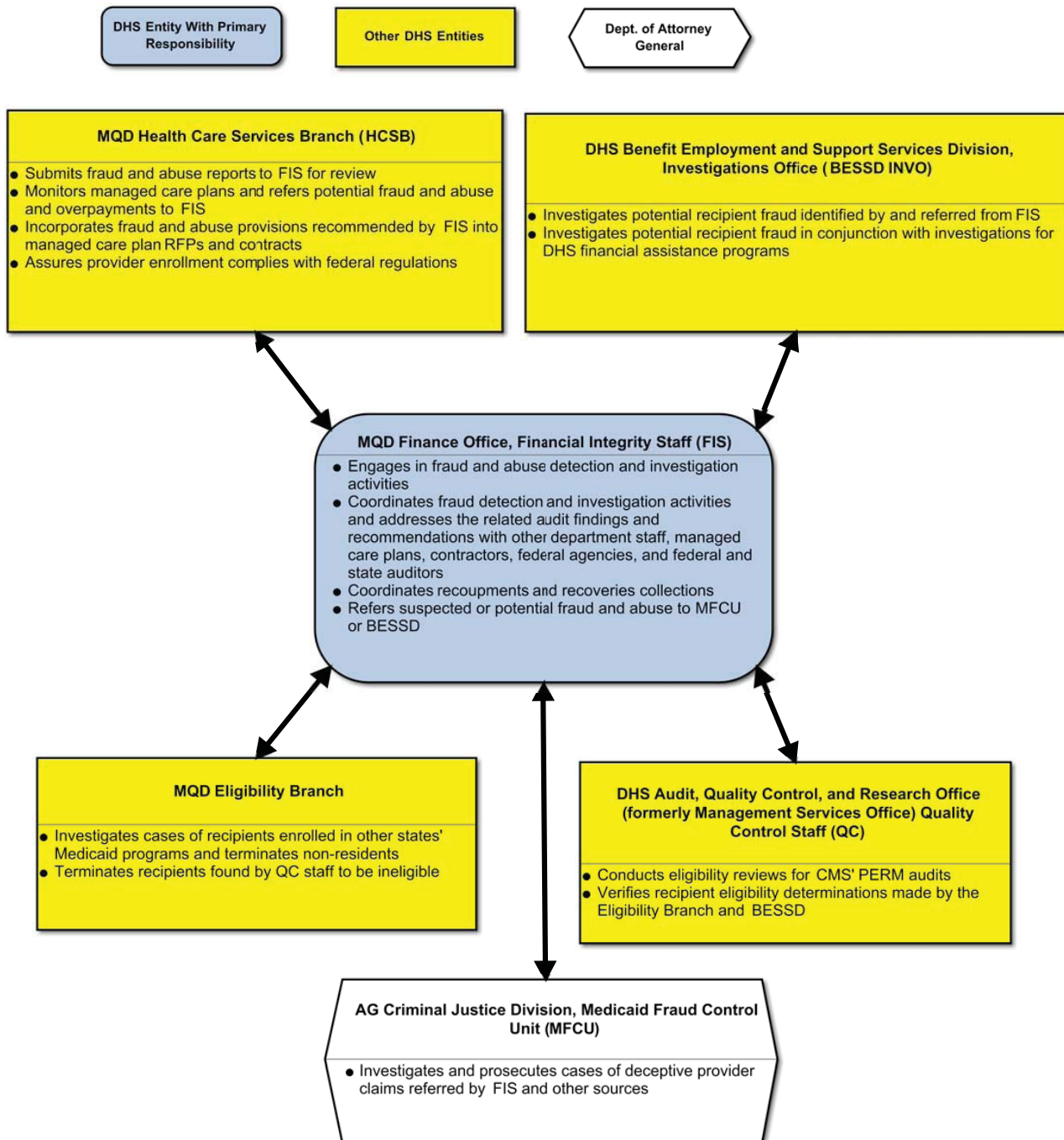
The Financial Integrity Staff (FIS) within the division's Finance Office has primary responsibility for the State's fraud and abuse detection program, which encompasses a multitude of activities coordinated among numerous entities. Exhibit 2.14 shows the integral role FIS plays in these efforts to detect, investigate, report, and resolve cases of fraud, waste, and abuse in the Hawai'i Medicaid program.



## Exhibit 2.14

### Roles of State Entities for Detecting, Investigating, Reporting, and Resolving Medicaid Fraud and Abuse

Legend:



Source: Office of the Auditor

Despite the numerous entities involved, the division lacks documents that outline all of Hawai‘i’s activities specific to Medicaid fraud and abuse detection and investigation, its key partners and stakeholders, and their respective roles and responsibilities. The division’s FIS develops annual work plans that detail its own roles, responsibilities, and planned fraud detection activities; however, it neither outlines goals or milestones for the completion of key activities, nor provides a mechanism for measuring performance and progress toward established goals.

### **Management has not been proactive in establishing policies and procedures for fraud detection**

The CMS’ 2011 review of Hawai‘i’s Medicaid program found that the FIS had very few policies and procedures for identifying and investigating suspected fraud cases and that the policies that did exist had not been revised since 1991. The division’s scarce and outdated policies and procedures leave it vulnerable to inconsistent operations, especially when the division loses experienced fraud and abuse detection staff. In addition, the division is unable to provide necessary fraud and abuse detection oversight of managed care plans. Only subsequent to CMS’ review conducted in June 2010, did the division begin formalizing and implementing draft policies and procedures to govern its fraud and abuse detection activities, nearly 20 years after the original policies were written. Although FIS has new policies and procedures, management has reviewed and approved only one of 12 documents at the time of our audit.

### **Limited resources allocated to fraud and abuse detection activities indicate a “minimal commitment” to this function**

The CMS’ 2011 review also found that the resources allocated to Hawai‘i’s Medicaid program fraud and abuse detection activities are indicative of a “minimal commitment” to this function. Both CMS and the FIS cited information system limitations and staffing issues as reasons for the division’s inability to effectively detect and investigate Medicaid fraud and abuse and to comply with applicable federal regulations. The division’s inability to address these deficiencies prevents it from identifying and recovering improper payments.

The key to an effective anti-fraud and abuse program is gathering and analyzing data for managed care health plans and providers. Surveillance and utilization review subsystems enable states to systematically analyze medical care and service delivery data for aberrant patterns indicative of potential fraud or abuse, but management did not implement such a subsystem until 2012. Although the division previously had different systems to perform these functions, CMS concluded that those systems were ineffective.

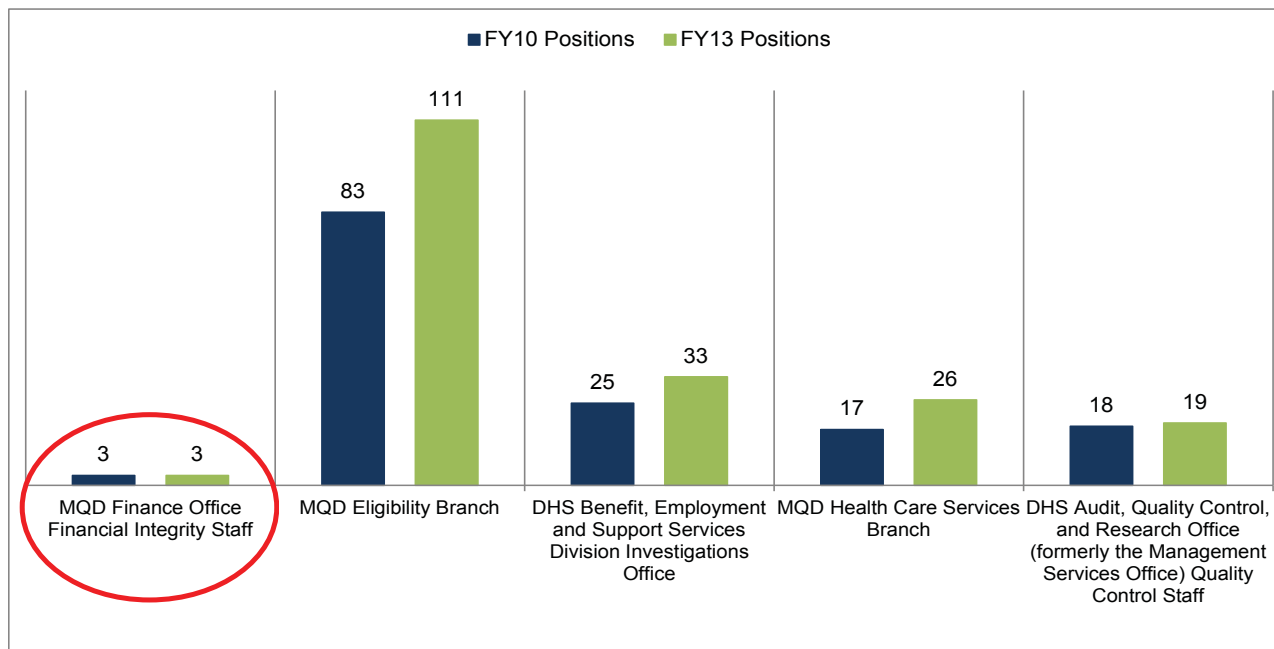


Further, only three staff positions were allocated to the FIS in 2013, compared to 189 positions in other offices and branches with related fraud and abuse detection and investigation responsibilities. According to the department's functional statements, the FIS is the only group within the department responsible for "maintaining a robust fraud and abuse detection program covering potential or actual fraud and abuse by program populations and providers." Its functions include analyzing data to detect potential and suspected fraud and abuse; investigating cases of suspected fraud and abuse; and coordinating these activities with division staff, the Department of the Attorney General's Medicaid Fraud Control Unit (MFCU), managed care health plans, and federal and state auditors.

However, management has allocated significantly more staff to the division's Eligibility and Health Care Services Branches and to the department's Benefit, Employment and Support Services Division and Audit, Quality Control, and Research Office (formerly the Management Services Office), which are assigned to various utilization review and/or enrollment and eligibility activities. In addition, the FIS is the only group that did not gain positions when the department recouped staff lost during the FY2010 reduction-in-force. Exhibit 2.15 shows the number of authorized positions for each department division, office, and branch involved in fraud and abuse detection and investigation activities as of June 30, 2010, and June 30, 2013.

#### Exhibit 2.15

#### Authorized Positions for Fraud and Abuse Detection and Investigation Activities as of June 30, 2010 and June 30, 2013



Source: Office of the Auditor

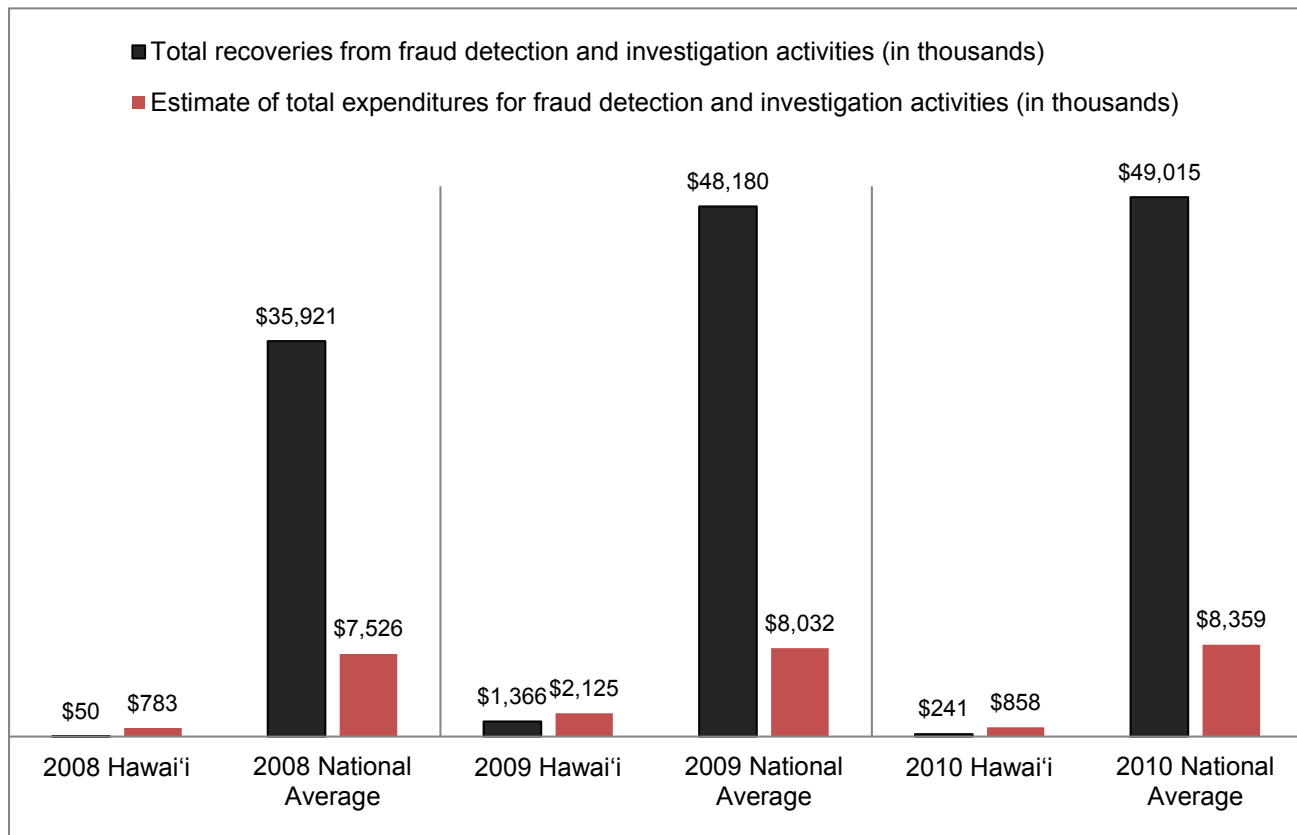
Following the retirements of an FIS investigator and a registered nurse in 2008 and 2013, respectively, only one of the FIS' authorized three positions was filled at the time of our audit. The one remaining FIS registered nurse has a significant workload and lacks the expertise to perform all required functions. Without an experienced investigator, the division cannot comply with federal and state regulatory requirements for preliminary investigations of all suspected Medicaid fraud cases. The FIS has been working to fill the vacant investigator position. In addition, during the 2013 Legislative regular session, it received approval for five additional positions dedicated to fraud and abuse detection and investigation: an auditor, a second investigator, a third registered nurse, and two analysts. However, filling those vacancies will likely be delayed since the division has yet to draft the relevant position descriptions, an initial step in the recruitment process.

### **Management produces incomplete fraud detection program performance information**

The division is unable to produce performance reports containing information about its fraud and abuse detection and investigation efforts that management can use to manage and improve such efforts. The FIS uses logs to track the status and disposition of all cases of suspected fraud identified, cases referred from other sources, and cases investigated and referred to the MFCU. However, the division does not track and reconcile related expenditures, improper payments identified, and related recoveries and recoupments. Furthermore, the division only records recoveries obtained by the U.S. Department of Health and Human Services Office of Inspector General and Hawai'i MFCU as collections from fraud and abuse. Recoupments, which are overpayment amounts held back or deducted from future provider payments, are recorded but not in a manner that allows management to track such amounts.

### ***Hawai'i's Medicaid fraud and abuse detection efforts lag behind other states***

The CMS' 2011 review of Hawai'i's Medicaid program found that Hawai'i lags behind other states of similar size in expenditures for and recoveries from fraud and abuse detection and investigation activities. For example, one state with comparable number in Medicaid enrollment spent \$2.3 million in fiscal year 2008 on fraud and abuse detection and investigation activity; Hawai'i only spent \$783,000. Exhibit 2.16 shows a comparison of the Med-QUEST Division's recoveries from and expenditures for fraud detection and investigation activities against national averages for FY2008 to FY2010, the most recent year for which data are available.

**Exhibit 2.16****Comparison of Hawai'i Med-QUEST Division's Recoveries From and Expenditures for Fraud Detection and Investigation Activities Against National Averages, FY2008–FY2010**

Source: CMS State Program Integrity Assessment Reports, FY2008 to FY2010

Hawai'i's Medicaid program is losing opportunities to prosecute cases and recover moneys attributed to Medicaid provider fraud and abuse because the division is unable to analyze Medicaid data effectively. Moreover, the division's managed care plan contract provisions for fraud and abuse reporting do not require the plans to report data that would allow the division to perform data analyses to generate leads for fraud investigations.

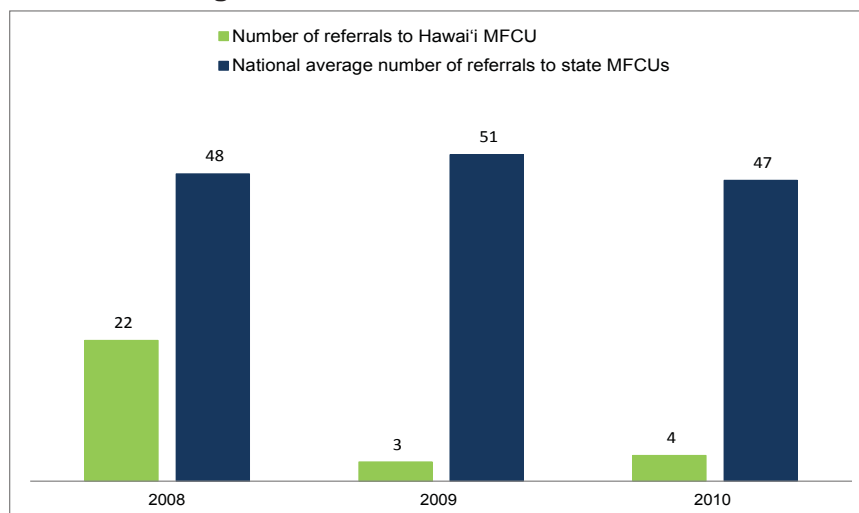
### **The division cannot effectively analyze Medicaid data to detect fraud**

The division's FIS works with the MFCU within the Department of the Attorney General, Criminal Justice Division, to investigate and prosecute Medicaid providers for deceptive and inappropriate claims. Although the FIS and MFCU efforts are generally well-coordinated, the FIS is unable to perform more effective data analytics to identify and refer more cases of suspected or potential fraud and does not always provide data and information needed for investigations by MFCU in a timely manner.

The division's Data Warehouse is a database of historical data from the Hawai'i Prepaid Medicaid Management Information System. The Data Warehouse and the division's newly implemented surveillance and utilization review subsystem enhance FIS' capability to identify potentially fraudulent behavior or abusive activity. These information systems generate reports FIS can analyze to identify outliers and aberrant patterns in medical care and service delivery data; however, the FIS lacks staff with the necessary data analysis expertise to carry out these tasks. Furthermore, the FIS staff lacks formal training on structuring queries to generate meaningful data analysis reports from the Data Warehouse, which does not automatically generate standardized reports. As a result, the FIS requests Data Warehouse reports from the division's Systems Office, which in turn requests an out-of-state agency to generate the reports, a process that can take months to fulfill.

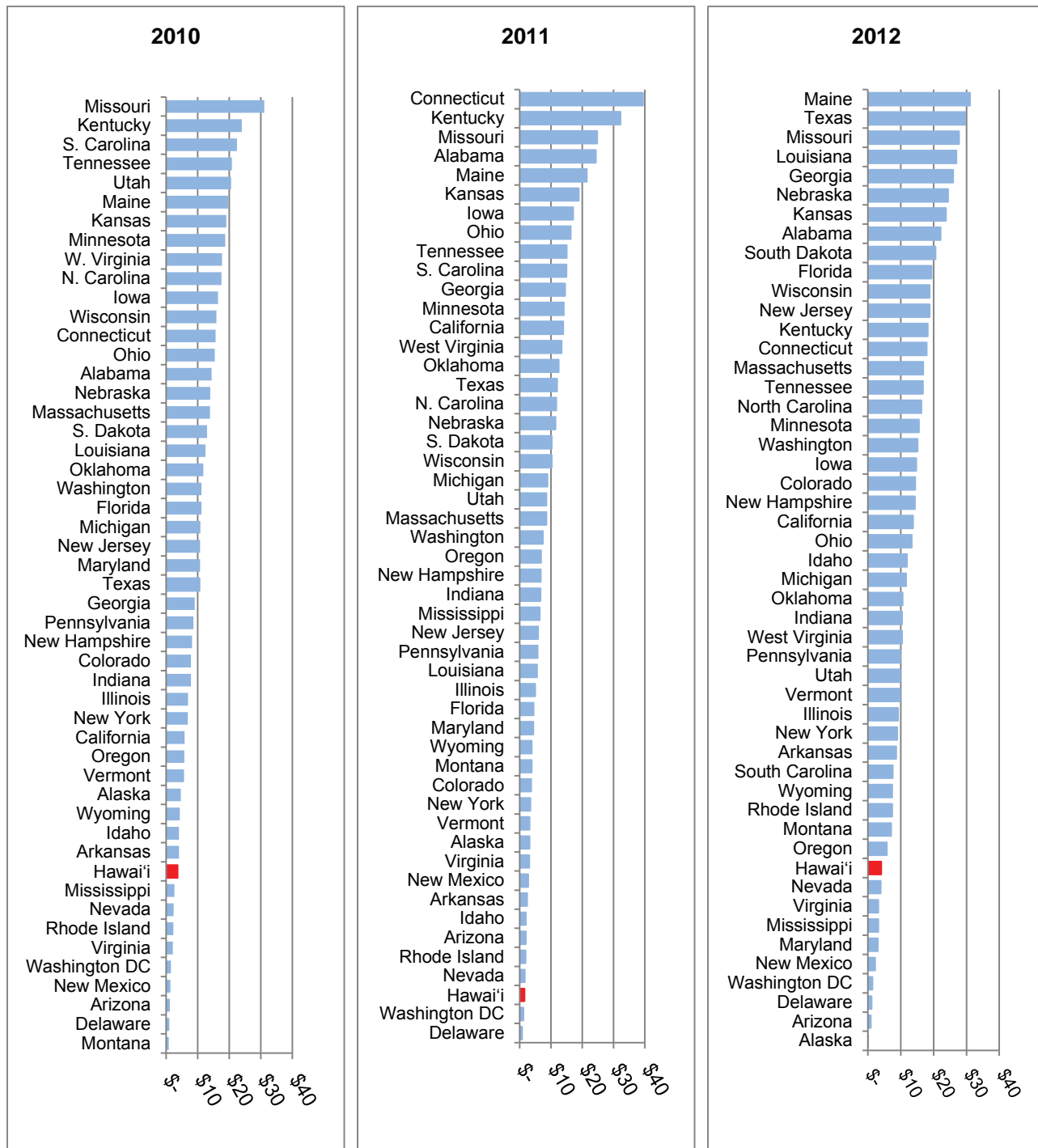
Ineffective internal FIS fraud detection activities result in few fraud referrals to the MFCU. The bulk of internal fraud investigation leads in Hawai'i are generated from external complaints. Exhibit 2.17 shows Hawai'i's fraud referrals made to the MFCU compared to national referral averages for FY2008 to FY2010, the most recent year for which data are available.

**Exhibit 2.17**  
**Comparison of Hawai'i MFCU Fraud Referrals Against**  
**National Averages, FY2008–FY2010**



Source: CMS State Program Integrity Assessment Reports, FY2008 to FY2010

Lack of fraud referrals from the division hampers MFCU's recovery efforts, as measured by recoveries per dollar of MFCU expenditures. Exhibit 2.18, which presents a comparison of states' MFCU recoveries per dollar of MFCU expenditures for FY2010 to FY2012, shows Hawai'i lagging in the bottom ten of all states and the District of Columbia for all years shown.

**Exhibit 2.18****Comparison of States' MFCU Recoveries Per Dollar of MFCU Expenditures, FY2008–FY2010**

Source: U.S. Department of Health &amp; Human Services Office of Inspector General MFCU Statistical Data for 2010 to 2012

### **The division's managed care plan contracts do not require sufficient fraud detection reporting**

The Hawai'i Medicaid program's managed care health plan contracts require health plans to perform fraud and abuse detection activities and preliminary investigations, refer cases of suspected or potential fraud identified, and report the results of such activities quarterly. Because the risk of fraud exists within the managed care environment and FIS relies heavily on managed care plans' fraud detection programs, the FIS recognizes the need for improved coordination with and reporting from the plans. The FIS can use its new surveillance and utilization review subsystem to analyze managed care plan data to identify potential fraud or abuse activities. However, the current reporting requirements for the plans' fraud and abuse reports do not require details from cases investigated that the FIS could use in its data analysis, if it could perform such an analysis.

The FIS informed us that they are considering adding discussions of fraud and abuse issues during regular meetings with managed care plan representatives and amending fraud and abuse reporting requirements to include details such as provider numbers, billing codes, and recovery/recoupment amounts for all cases investigated to address these issues, but have yet to do so. Best practices include regular meetings with managed care plans which provide a forum to discuss cases, action plans for occurrences of potential fraud and abuse, provide training, present and exchange strategies to combat fraud and abuse, and address non-compliance with contract requirements regarding fraud and abuse by managed care plans.

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## **Conclusion**

Hawai'i's Medicaid program is faring well compared to peer states and the rest of the nation. For instance, while Medicaid enrollment is growing as a percentage of the state's population, the division has managed to control its costs on a per-enrollee basis. However, the complex natures of health care and the Medicaid program limit the division's and the Legislature's ability to contain costs. In addition, the impending implementation of the federal Affordable Care Act will further limit State cost containment options. However, these factors should not preclude the division from providing detailed and thorough program and cost information to the Legislature, an important stakeholder. More importantly, the division needs to be more proactive in containing the costs that it can control. Specifically, it needs to establish and implement an effective and efficient fraud, waste, and abuse detection program.

---

## Recommendations

The Med-QUEST Division should:

1. Take a proactive role in improving communication of its Medicaid program's performance with the Legislature. Specifically, the division should:
  - a. Conduct an informational briefing for interested legislators to gain an understanding of their needs and expectations for information and metrics;
  - b. Adopt and implement reporting methods that convey requested Medicaid operational and financial objectives, goals, and key performance indicators; and
  - c. Provide annual updates on how Hawai'i's enrollment and cost data compare nationally and to other states;
2. Establish a formal fraud and abuse plan that ensures the department's fraud and abuse detection program adheres to federal and state regulations and includes adequate resources to execute the plan. Such a plan should include:
  - a. Goals, objectives, and action plans for the fraud and abuse detection and investigation program;
  - b. Program's key partners and stakeholders and their respective functions and fraud and abuse detection and investigation responsibilities and activities;
  - c. Areas of vulnerability and approaches to address them;
  - d. Milestones for completion of key action plan activities;
  - e. Baseline metrics against which the Medicaid fraud and abuse detection and investigation program can be compared to gauge performance and progress; and
  - f. Process and methodology for measuring performance progress toward goals and objectives;
3. Communicate the results of its fraud and abuse detection and investigation program with the director of human services and the Legislature;

4. Direct and work with the Department of Human Services Personnel Office to develop position descriptions for the newly authorized dedicated fraud and abuse detection and investigation positions and reevaluate position descriptions for current FIS positions to ensure that:
  - a. The duties and responsibilities of each position satisfy federal and state regulatory requirements, best practices, and the division's needs; and
  - b. The required skills, qualifications, and experience of the respective positions are consistent with their duties and responsibilities;
5. Prioritize recruitment and hiring of recently authorized FIS fraud and abuse detection and investigation staff;
6. Develop policies and procedures governing functions related to detecting and remedying fraud and abuse performed by the various department and Med-QUEST Division units. The division should review policies and procedures periodically and update them as needed to reflect revised and new regulatory requirements and best practices. Management should review and approve new and amended policies and procedures in a timely manner;
7. Maintain complete information and perform periodic reconciliations of fraud and abuse detection and investigation activities. This process may include a reconciliation of case referrals, cases accepted and declined, convictions, recoveries, and status of investigations and settlements, fraud and abuse detection and investigation expenditures, overpayments and fraudulent payments identified. A full accounting of all such indicators will allow the division to better understand the results of its fraud and detection and investigation activities (e.g., recoveries and recoveries per dollar expended on fraud detection and investigation) and measure its performance; and
8. Adopt strategies or plans to combat fraud, waste, and abuse by:
  - a. Utilizing its new eligibility system and eligibility criteria under the ACA to improve program integrity, limit eligibility errors, and facilitate reporting and monitoring;
  - b. Enhancing its capacity to utilize its data analysis capabilities effectively by:



- i. Ensuring that all fraud detection and investigation staff receive training on how to identify and generate Surveillance and Utilization Review subsystem and Data Warehouse reports needed to effectively fulfill their respective fraud detection data analysis and investigations functions, including those necessary for referring cases of suspected or potential fraud to MFCU; and
- ii. Reevaluating fraud and abuse reporting requirements for the managed care plans to ensure that the FIS receives the information needed to better analyze managed care data; and
- c. Meeting regularly with and providing training to managed care organizations to improve fraud and abuse detection coordination efforts to ensure that fraud and abuse is identified and that preliminary investigations are occurring as required by contract.

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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 on January 6, 2014. A copy of the transmittal letter is included as Attachment 1. The department's response, dated January 13, 2014 and received on January 15, 2014, is included as Attachment 2.

The department expressed its appreciation for the Legislature's and the State Auditor's assistance in identifying areas to reduce medical assistance program costs and improve medical assistance program integrity.

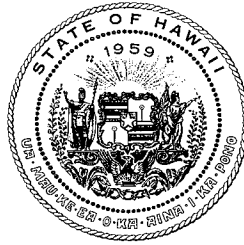
The department generally agreed with our conclusions and recommendations and reports that it has already undertaken actions to address several of our recommendations.

For example, it agreed Hawai'i's Medicaid program fares well compared to peer states and the rest of the nation, and that it has managed to control costs on a per-enrollee basis even while enrollment has increased. It pointed out that despite keeping costs down, in 2013, the Commonwealth Fund ranked Hawai'i as having the best healthcare system for low-income individuals.

The department also said it is committed to eliminating all fraud, waste, and abuse, and that it has made substantial improvements in program integrity to address the adverse findings we cited in the Centers for Medicare and Medicaid Services' reports. Since the 2011 federal comprehensive program integrity review, the department reported, its program integrity efforts have improved. And it stated that implementation of its new eligibility system, KOLEA, which interfaces with the federal data services hub and the Department of Labor and Industrial Relations, will reduce eligibility errors. The department identified four efforts it plans to pursue this legislative session to improve support for additional program integrity efforts.

On the other hand, the department contends that our fraud, waste, and abuse finding was primarily based on outdated documentation. We point out the department provided that documentation and told us it was the most current available. Accordingly, we stand by our finding. Finally, we made minor technical corrections for clarity and style prior to publication.

STATE OF HAWAII  
**OFFICE OF THE AUDITOR**  
465 S. King Street, Room 500  
Honolulu, Hawai'i 96813-2917



**JAN K. YAMANE**  
Acting State Auditor

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

January 6, 2014

**COPY**

The Honorable Patricia McManaman  
Director  
Department of Human Services  
Queen Lili'uokalani Building  
1390 Miller Street  
Honolulu, Hawai'i 96813

Dear Ms. McManaman:

Enclosed for your information are three copies, numbered 6 to 8, of our confidential draft report, *Audit of the Department of Human Services' Med-QUEST Division and Its Medicaid Program*. We ask that you telephone us by Wednesday, January 8, 2014, 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, January 13, 2014.

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

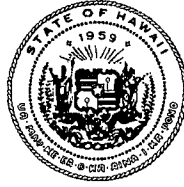
Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Jan K. Yamane  
Acting State Auditor

Enclosures

NEIL ABERCROMBIE  
GOVERNOR



PATRICIA MCMANAMAN  
DIRECTOR

BARBARA A. YAMASHITA  
DEPUTY DIRECTOR

STATE OF HAWAII  
DEPARTMENT OF HUMAN SERVICES

Office of the Director  
P. O. Box 339  
Honolulu, Hawaii 96809-0339

January 13, 2014

RECEIVED

2014 JAN 15 AM 9:56

Ms. Jan K. Yamane, Acting State Auditor  
Office of the Auditor  
465 South King Street, Room 500  
Honolulu, Hawaii 96813-2917

OFF. OF THE AUDITOR  
STATE OF HAWAII

Dear Ms. Yamane:

Enclosed are the Department of Human Services' comments in response to your January 6, 2014 draft report, *Audit of the Department of Human Services' Med-QUEST Division and Its Medicaid Program*.

Thank you for the opportunity to comment on the draft report. Please contact me if you have any questions or your staff may contact Dr. Kenneth Fink, Administrator of the Med-QUEST Division for more clarification at (808) 692-8050.

Sincerely,

A handwritten signature in black ink, appearing to be "Patricia McManaman", written over a horizontal line.

Patricia McManaman  
Director

Enclosures

## SUMMARY

- The Legislative Auditor's Report expressly recognizes that Hawai'i's Medicaid program fares well when compared to peer states in the rest of the nation and notes that DHS has managed to control its costs on a per-enrollee basis, even while enrollment increased.
- Hawaii's efforts that effectively controlled costs did not come at the expense of quality. In 2013, the Commonwealth Fund ranked Hawaii as the state with the best healthcare system for low-income individuals.<sup>1</sup>
- From 2008 to 2011 Medicaid enrollment increased 29%; however DHS reduced the Medicaid fee-for-service (FFS) error rate by 42% and the eligibility error rate by 75%. The managed care error rate was 0% for both years. In 2011, the actual identified dollar amount in error was \$45,650, and the FFS, managed care, and eligibility error rates were each lower than the national average.<sup>2,3</sup>
- Despite DHS performing better than the national average, DHS believes that no fraud, waste, and abuse is acceptable, and DHS is committed to working to eliminate all fraud, waste, and abuse. Since the 2011 federal comprehensive program integrity review of DHS, DHS has responded to all findings of that review and continued its efforts to eliminate fraud, waste, and abuse by implementing:
  - Increased accessibility to reports
  - Best practices for DHS's Medicaid program integrity unit's interactions with the Attorney General's Medicaid Fraud Control Unit (MFCU)
  - Additional policies and procedures
  - A Surveillance and Utilization Review Subsystem (SURS)
  - Verification with the Public Assistance Reporting Information System (PARIS)
  - A Recovery Audit Contractor (RAC)
  - Provider screening and enrollment requirements
  - Additional contractual requirements of health plans regarding fraud, waste, and abuse
  - Increased percentage of services provided through managed care
  - Improved third part liability contributions
  - A new eligibility criteria and a new eligibility system
  - Increased program integrity staffing
- DHS has implemented a new state-of-the-art eligibility system, KOLEA, which has an electronic interface with the federal data services hub and will interface with DLIR to verify eligibility criteria. This technology will further reduce eligibility errors.
- DHS intends to pursue support for additional program integrity efforts this legislative session by:
  - Seeking permanent exemption from Chapter 76 for program integrity positions in order to more effectively attract and retain staff;
  - Requesting three positions: investigator, auditor, and program integrity manager;
  - Seeking funding for an asset verification system to interface with KOLEA to improve program integrity for individuals still subject to an asset limit; and
  - Supporting an Attorney General measure to clarify the State's ability to prosecute Medicaid eligibility fraud on Oahu.

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<sup>1</sup> <http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Sep/Low-Income-Scorecard.aspx>

<sup>2</sup> CMS FY 2011 Hawaii Medicaid Payment Error Rate Measurement (PERM) Cycle 3 Summary Report

<sup>3</sup> CMS Notification of Recalculate FY 2011 Medicaid Error Rates dated January 9, 2013

## DISCUSSION

### Overview

The Department of Human Services (DHS) appreciates the assistance of the Legislature and State Auditor's Office to help identify areas to reduce medical assistance program costs and improve medical assistance program integrity.

The Legislative Auditor's Report expressly recognizes that Hawai'i's Medicaid program fares well when compared to peer states in the rest of the nation and notes that even in the face of growing Medicaid enrollment, the Department of Human Services has managed to control its costs on a per-enrollee basis. In 2010, Hawaii's per-enrollee costs were 19% lower than the average among peer states; the average per Medicaid recipient costs in peer states in FFY 2010 was \$5,790 compared to \$4,693 for Hawai'i. DHS's effective cost control has not compromised quality. In 2013, the Commonwealth Fund identified Hawaii as the state with the best healthcare system for low-income individuals.<sup>1</sup> These successes align with the Department of Human Services five-year strategic goals to improve health, lower costs, and improve patient experience by:

- Minimizing administrative burdens, streamlining access to care for enrollees with changing health status, and improving health outcomes by integrating the demonstration's programs and benefits;
- Alignment with Affordable Care Act;
- Improving care coordination by establishing a "provider home" for members through the use of assigned primary care providers;
- Expanding access to home and community based services (HCBS) and allowing individuals to have a choice between institutional services and HCBS;
- Maintaining a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establishing contractual accountability among the contracted health plans and health care providers;
- Continuing the predictable and slower rate of expenditure growth associated with managed care; and
- Expanding and strengthening a sense of member responsibility and promoting independence and choice among members that leads to more appropriate utilization of the health care system.<sup>1</sup>

### Historical Program Integrity Performance

DHS has demonstrated a significant commitment and made substantial improvements in program integrity since initial adverse findings in the Centers for Medicare & Medicaid Services' (CMS) Payment Error Rate Measurement (PERM) report in 2008. In 2011 as compared to 2008, the DHS fee-for-service (FFS) and eligibility error rates improved by 42% and 75% respectively and were better than the national average.<sup>2,3</sup> For managed care, the error rate was 0% for both 2008 and 2011.<sup>2</sup> However, no fraud, waste, and abuse is acceptable, and DHS is committed to continuing to work to eliminate all fraud, waste, and abuse.

Table. Medicaid Error Rates 2008-2011

	Hawaii 2008-2011 Improvement	Hawaii 2008	Hawaii 2011	National 2011
Fee-for-service	42%	5.7%	3.2%*	3.3%
Managed care	n/a	0.0%	0.0%	0.3%
Eligibility	75%	13.4%	3.0%	3.3%

\*CMS revised rate

The 2011 PERM report initially identified 37 errors in its Medicaid samples with a total cost of \$45,650,<sup>2</sup> and DHS needed to return the federal share, approximately half, of this amount to CMS. Through statistical extrapolation of these small samples, CMS projected \$15.5 million in error for fee-for-service and \$48.6 million in error for eligibility.<sup>2</sup> CMS subsequently recalculated the FFS error rate reducing it from 4.4% to 3.2%. Due to the limitations of statistically projecting such a small sample to the hundreds of thousands of Medicaid beneficiaries, the CMS PERM report stated that the actual error rates could have been as low as 1.7% for FFS(based on the recalculated error rate) and 0% for eligibility.<sup>3</sup>

### Improvements Since 2011

Since the 2011 PERM report and comprehensive program integrity review, DHS has continued its efforts to eliminate all fraud, waste, and abuse, and these efforts include implementing:

- *Increased accessibility to reports*

DHS produces numerous reports including performance reports containing operational, financial, or compliance-related information, and certain reports are available to the public on the Med-QUEST Division website.<sup>2,3,4,5,6</sup> DHS has also prepared a report for the Legislature in response to Act 134, Part VII, Section 119, SLH 2013 that will also comply with HRS 346-54.

The Attorney General's Medicaid Fraud Control Unit captures the amounts it obtains from fraudulent activities through settlements or other legal proceedings. DHS tracks its recovery of fraudulent claims but then includes them with recovered overpayments. DHS will begin to track its recovered fraudulent claims separately from overpayments in its FFS program and require health plans to report these separately.

- *Best practices for DHS's Medicaid program integrity unit's interactions with the Attorney General's Medicaid Fraud Control Unit (MFCU)*

Notable efforts by DHS to address fraud, waste, and abuse not mentioned in the State Auditor's Report include the \$82 million in settlements with drug manufacturers in 2010 and ongoing efforts to recover \$8 million in overpayments to a provider.<sup>7</sup>

The Med-QUEST Division (MQD) makes eligibility determinations for Medicaid. Any suspicion of eligibility fraud is sent to the Benefit, Employment & Support Services Division's INVO for investigation. MQD is responsible for investigating potential provider fraud, waste, and abuse. Credible allegations of provider fraud are referred to MFCU with whom DHS has executed a memorandum of understanding. To facilitate MFCU access to

data to support their investigations, DHS has given MFCU staff access to and training on its Medicaid Management Information System, which contains claims and encounter data. DHS supports the Attorney General's effort to clarify the State's ability to prosecute Medicaid eligibility fraud on Oahu.

- *Additional policies and procedures*

DHS has implemented all policies and procedures that were identified as outstanding in the 2011 federal comprehensive program integrity review. These policies include but are not limited to:

- Verifying whether services billed by providers were received by FFS beneficiaries
- Verifying whether services billed by providers were received by managed care beneficiaries
- Conducting complete searches for provider individuals and entities excluded from Medicaid participation
- Collecting provider criminal conviction information
- Notifying U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) of local provider convictions
- Reporting to HHS-OIG actions adverse actions taken on FFS provider applications
- Reporting to HHS-OIG actions adverse actions taken on managed care provider applications
- Capturing required ownership, control and relationship information from FFS providers
- Collecting required ownership, control and relationship information from managed care organization network providers
- Requiring disclosure of business transaction information from managed care organization network providers
- Referral cases of suspected fraud to MFCU
- Initiating provider exclusions

- *A Surveillance and Utilization Review Subsystem (SURS)*

To help identify fraud and abuse, DHS has implemented a data warehouse and SURS using EDI watch. The data warehouse includes health plan encounter data as well as fee-for-service claims data. SURS can retrieve current data that can then be manipulated with software to analyze aberrant patterns. Certain standard reports are generated to monitor, and staff can also produce timely ad-hoc reports as needed to target questionable billing practices.

- *Verification with the Public Assistance Reporting Information System (PARIS)*

PARIS is a series of databases that preceded development of a federal data services hub. Data from the Department of Defense, Department of Veterans Affairs and other states are included in PARIS. PARIS is the best source to identify whether individuals are enrolled in multiple Medicaid programs. DHS has identified hundreds of beneficiaries who were enrolled in Hawaii's Medicaid program and another state's and taken appropriate action.

- *A Recovery Audit Contractor (RAC)*



The Affordable Care Act (ACA) requires Medicaid programs to contract with a RAC for the purpose of identifying underpayments and overpayments with respect to all services for which payment is made to any entity. The contractors work on a contingency bases, and the Medicaid RAC program is based on the Medicare RAC program. The DHS has implemented a RAC and is in compliance with this requirement.

- *Provider screening and enrollment requirements*

Establishes new provider screening and enrollment requirements for providers participating in Hawaii's fee-for-service program. The level of screening is according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier. DHS relies on the results of screening performed by Medicare and by its contacted managed care organizations, and DHS performs screening of FFS-only providers, which includes verification of licensure, criminal background checks, and federal database checks.

- *Additional contractual requirements of health plans regarding fraud, waste, and abuse*

The QUEST and QUEST Expanded Access (QExA) health plan contracts have requirements regarding fraud, waste, and abuse. Not only are the managed care plans not precluded from performing data analyses to identify fraud, waste, and abuse, they are contractually required to do such. ACA requires the inclusion of additional program integrity requirements in contracts with managed care organizations. These contract amendments were executed with the QUEST and QExA health plans. The program integrity requirements in the QUEST Integration request for proposal, which becomes part of the contract, are included as an Appendix.

- *Increased percentage of services provided through managed care*

Increasing the number of beneficiaries enrolled in managed care has reduced fraud, waste, and abuse. Nearly all Medicaid beneficiaries are now enrolled in a managed care health plan, and managed care had an error rate of 0.0%; these enrollees would otherwise be in fee-for-service, with a higher error rate. Services remaining FFS are primarily dental and organ transplantation, as well as and services provided to Medicaid beneficiaries through the Department of Health's Developmental Disability Division, Child and Adolescent Mental Health Division, Adult Mental Health Division, and Early Intervention Program.

- *Improved third party liability contributions*

DHS had sought and the Legislature enacted legislation to increase DHS's ability to have third party liability information by requiring commercial insurers to report enrollment to DHS. In compliance with HRS §431L-2.5, DHS is in the process of procuring for a vendor to match DHS Medicaid enrollment with the information submitted and providing DHS with the matches.

- *A new eligibility criteria and a new eligibility system*

DHS has implemented a new eligibility system, KOLEA. This state-of-the-art system has an interface with the federal data services hub and will interface with the Hawaii Department of

Labor and Industrial Relations to verify eligibility criteria. This technology will substantially reduce eligibility errors. In addition, ACA eliminates an asset limit for groups with eligibility determined using the modified adjusted gross income methodology, thus removing this criterion as a risk for potential error. DHS intends to seek funding for an asset verification system to interface with KOLEA to improve program integrity for individuals still subject to an asset limit.

- *Increased program integrity staffing*

DHS had lost one vacant program integrity nurse position with the reduction-in-force but has since replaced this. Recognizing the need for increased program integrity staffing, DHS requested five additional positions, which were authorized by the legislature. Currently, two investigator and two nurse positions are under recruitment, and DHS is working to recruit for two analysts and an auditor. DHS believes that another investigator, auditor and a program integrity manager are needed.

DHS has had difficulty hiring and retaining investigators and may have similar experience with its other program integrity positions. Given the importance of filling these positions and their return on investment, DHS intends to seek permanent exemption from Chapter 76 for program integrity positions. When the Med-QUEST Division completes a reorganization, it intends to create a new program integrity and data management office.

DHS completed another federal program integrity audit in 2013. CMS was going to perform the audit remotely, but at DHS's insistence agreed to do an onsite audit; DHS wanted a thorough audit to identify areas for improvement. The audit report is not yet available, but during the exit conference CMS recognized that DHS had become compliant with findings of the 2011 audit, but there is still room for improvement. At the time of the 2013 federal program integrity audit, DHS had not yet fully implemented the new provider screening and enrollment requirement under the Affordable Care Act but has since done so. The 2013 federal program integrity audit report will be provided to the Legislature once available.

## CONCLUSION

The DHS Medicaid program is a high value program with low costs and high quality. In 2013, the Commonwealth Fund ranked Hawaii as the state with the best healthcare system for low-income individuals.

DHS is committed to continuing to work to eliminate all fraud, waste, and abuse. Collectively since 2008, DHS activities to improve program integrity and reduce fraud, waste, and abuse have been substantial. In 2011, DHS program integrity had improved to be in the top half of states nationally. Since 2011, DHS had implemented numerous additional program integrity activities to further reduce fraud, waste, and abuse.

DHS understands that the scope of the State Auditor's audit was vast, and that given time constraints they primarily relied on outdated documentation. DHS appreciates the opportunity to provide this response and to provide the Legislature with a more current and accurate picture of DHS's program integrity.

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- <sup>1</sup> <http://med-quest.us/PDFs/Submitted%201115/Final%20Application.pdf>  
<sup>2</sup> <http://med-quest.us/ManagedCare/MQDquestenroll.html>  
<sup>3</sup> <http://med-quest.us/ManagedCare/CmsReport.html>  
<sup>4</sup> <http://med-quest.us/ManagedCare/consumerguides.html>  
<sup>5</sup> [http://med-quest.us/providers/ProviderExclusion\\_ReinstatementList.html](http://med-quest.us/providers/ProviderExclusion_ReinstatementList.html)  
<sup>6</sup> <http://med-quest.us/ManagedCare/qualitystrategy.html>  
<sup>7</sup> <http://ag.hawaii.gov/wp-content/uploads/2012/12/2010-21.pdf>

**51.300      Fraud & Abuse**

**51.310      General Requirements**

The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. This should include a description of the specific controls in place for prevention and detection from potential or suspected fraud and abuse, such as: claims edits, post-processing review of claims, prior authorization, written provider and member material regarding fraud and abuse referrals. In addition, as part of these internal controls and policies and procedures, the health plan shall have ways to verify services were actually provided using random sampling of all members though VOS requirements identified in Section 50.455. The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.400) and resources to identify and investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health plan shall describe its organizational arrangement identifying personnel roles and responsibilities for preliminary investigation(s) of provider fraud and abuse. The health plan's fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR Section 438.608.

All suspected fraud and abuse committed by a member should be reported to the appropriate entity. The health plan shall report eligibility fraud affecting medical assistance to the Investigations Office (INVO) of the Benefit, Employment and Support Services Division (BESSD). The reporting shall be done either through written notification or a telephone call to the INVO Hotline. The health plan shall report member fraud for instances such as fraudulently obtaining controlled substances, other medical services, or collusion between provider and member to obtain services to the DSH after a preliminary investigation is complete.

The health plan and all subcontractors shall cooperate fully with Federal and State agencies in investigations and subsequent legal actions to include but not limited to the DHS and the Secretary. Such cooperation shall include providing, upon request, information, access to records, access to claims, and access to interview health plan employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical questions or in any matter related to an investigation.

**51.320      Reporting and Investigating Suspected Provider Fraud and Abuse**

If the health plan becomes aware of suspected fraud or abuse from any source or identifies any questionable practices, it shall conduct a preliminary investigation. If the findings of the preliminary investigation determines there is a credible allegation of fraud, the health plan must report to the DHS within 30 days of completing the preliminary investigation. A credible allegation of fraud and/or

abuse is defined as an allegation that has indicia of reliability that comes from any source and has been verified. Fraud is not determined by either the DHS or the health plan. Based on all the evidence gathered, the DHS or the health plan only determines that there is the potential that an identified activity could be fraudulent.

The health plan shall use the report form to be provided by the DHS to report or refer suspected cases of Medicaid fraud or abuse. At a minimum, this form shall require the following information for each case:

- Subject (Name and ID number);
- Source of complaint;
- Type of provider;
- Health plan contact;
- Contact information for health plan staff with practical knowledge of the workings of the relevant programs;
- Date reported to state;
- Description of suspected intention misconduct, with specific details;
  - Category of service.
  - Factual explanation of the allegation. (The health plan (HP) should provide as much detail as possible concerning the names, positions and contact information of all relevant persons; a complete description of the alleged scheme as it is understood by the HP, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the HP came to learn of the conduct; and the actions taken by the HP to investigate the allegations.)
  - Date(s) of conduct. (When exact dates are unknown, the HP should provide its best estimate.)
- Specific statutes, rules, regulations, or policies violated includes all applicable for Federal/Medicaid as well as health plan policies;
- Amount paid to the provider during the past 3 years or during the period of the alleged misconduct, whichever is greater;
- Sample/exposed dollar amount when available;
- Legal and administrative disposition of the case; and
- All communications between the health plan and the provider concerning the conduct at issue.

In addition to the core information required on the form, this report shall include any and all evidence obtained in the preliminary investigation including but not limited to, claims, interviews, and previous provider education.

Once the health plan has filed its report to the DHS, it shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter into or attempt to negotiate any settlement or agreement, or

accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation in connection with the incident.

If the provider is not billing appropriately, but the health plan has found no evidence of fraud or abuse, the health plan shall provide education and training to the provider in question. In addition the health plan is required to recover any payments made inappropriately. The health plan shall maintain documentation of the education and training provided in addition to reporting the recovered amounts as income or revenues. A summary report shall be provided on a report form provided by the DHS.

51.330

#### Compliance Plan

The health plan shall have a written fraud and abuse compliance plan that shall have stated program goals and objectives, stated program scope, and stated methodology. Refer to CMS publications: "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A product of the National Medical Fraud and Abuse Initiative, October 2000 as well as the CMS publication: "Guidelines for Constructing a Compliance Program for Medicaid and Prepaid Health Plans", a product of the Medicaid Alliance for Program Safeguards, May 2002 for reference regarding Compliance Plans. The health plan shall submit its compliance plan to the DHS for review and approval by the due date identified in Section 51.700, Readiness Review.

At a minimum, the health plan's fraud and abuse compliance plan shall:

- Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Sections 51.310 and 51.320;
- Submit health plan disclosures timely as described in Section 51.570.6;
- Ensure that all of its officers, directors, managers and employees know and understand the provisions of the health plan's fraud and abuse compliance plan;
- Have processes in place to monitor all providers and their officers/directors/agents/managing employees as described in Sections 40.210 and 40.400;
- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud and abuse identification and reporting, and include information in the provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;
- Ensure the enforcement of standards through well-publicized disciplinary guidelines;

- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts;
- Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
- Ensure that no individual who reports health plan violations or suspected fraud and abuse is retaliated against;
- Include a monitoring program that is designed to prevent and detect potential or suspected fraud and abuse. This monitoring program shall include but not be limited to:
  - Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
  - Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
  - Reviewing providers for over-utilization or under-utilization;
  - Verifying with members the delivery of services as claimed; and
  - Reviewing and trending consumer complaints on providers;
- Ensure that all suspected instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, health plan employees/management, providers, subcontractors, vendors, be reported to DHS. Additionally, any final resolution reached by the health plan shall include a written statement that provides notice to the provider that the resolution in no way binds the State of Hawaii nor precludes the State of Hawaii from taking further action for the circumstances that brought rise to the matter; and
- Ensure that the health plan shall cooperate fully in any investigation by federal and state oversight agencies and Federal and State law enforcement agencies and any subsequent legal action that may result from such an investigation.

51.340

#### Employee Education About False Claims Recovery

The health plan shall comply with all provisions of Section 1902(a)(68) of the Social Security Act as it relates to establishing written policies for all employees (including management), and of any subcontractor or designee of the health plan, that includes the information required by Section 1902(a)(68) of the Social Security Act.