Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Hawaii Focused Program Integrity Review

March 2023

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity desk review to assess Hawaii's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FYs) 2017 – 2019. This focused program integrity desk review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused program integrity desk review, CMS reviewed information and documents provided by the state in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also evaluated certain program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused desk review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified one finding that creates risk to the Hawaii Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. This recommendation includes the following:

Interagency and MCO Program Integrity Coordination

> **Recommendation #1:** The State Medicaid Agency (SMA) does not have a Memorandum of Understanding (MOU) in place with the Medicaid Fraud Control Unit (MFCU), consistent with the requirements at § 455.21(c). Therefore, the SMA should enter into a written agreement with the MFCU. The agreement serves to establish certain parameters for the relationship between the MFCU and the SMA and guide the coordination of efforts between the two agencies.

Observations

CMS identified **four** observations related to Hawaii's managed care program integrity oversight. Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of

leading practices. The observations identified during this desk review include the following:

State Oversight of Managed Care Program Integrity Activities

Observation #1: CMS encourages the state to consider amending the MCO general contracts to require MCOs to develop and submit a Fraud, Waste, and Abuse (FWA) Plan to the state. In addition, CMS encourages the state to develop policies and procedures for the annual review of MCO FWA Plans and the effectiveness of the activities.

Observation #2: CMS encourages the state to ensure the MCOs establish a Special Investigations Unit (SIU) or other program integrity-focused unit with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. The state could consider including contract language addressing the organizational structure and effectiveness of the MCO's SIU.

MCO Contract Compliance

Observation #3: CMS encourages the state to consider the inclusion of an effective mechanism to monitor, track, and verify the accurate reporting of overpayments identified and recovered by the MCOs. Furthermore, CMS encourages the state to ensure the MCOs develop and maintain accurate overpayment identification/collection/reporting policies and procedures consistent with § 438.608(d) and MCO general contract requirements.

MCO Investigations of Fraud, Waste, and Abuse

Observation #4: CMS encourages the state to work with the MCOs to develop more case referrals and routinely provide specific program integrity training in identifying, investigating, and referring potential fraudulent billing practices by providers to enhance the quality and quantity of cases being referred by the MCOs.

I. Background

Program Integrity Reviews

In the most recent Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS routinely conducts focused program integrity reviews on high-

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These program integrity reviews include state onsite visits or offsite virtual reviews (as a result of the 2020 Public Health Emergency), as well as desk reviews in order to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also solicits each state's effective practices and provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Hawaii Managed Care Program and the Focused Program Integrity Review

The Med-QUEST Division (MQD) within the Department of Human Services (DHS) is responsible for the administration of the Hawaii Medicaid program. Within MQD, the Health Care Services Branch (HCSB) is responsible for programmatic oversight of the MCOs. In addition, the program integrity provisions of the MCO general contract are overseen by the Financial Integrity team in the Finance Office of the MQD. During the review period, Hawaii contracted with five MCOs to provide health services to the Medicaid population. As part of this desk review, three of these MCOs were reviewed: AlohaCare, Hawaii Medical Service Association (HMSA), and WellCare's 'Ohana Health Plan ('Ohana). Appendix B provides enrollment and expenditure data for each of the selected MCOs.

In November 2021, CMS conducted a focused program integrity desk review of Hawaii's managed care program administered by the single SMA, the MQD. This focused desk review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this desk review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. Because Hawaii did not have an open corrective action plan from a prior review, there were no unimplemented corrective actions for CMS to review.

During this desk review, CMS identified a total of one recommendation and five observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix A. The state's response to CMS' draft report can be found in Appendix C, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.

C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly referral any potential fraud, waste, or abuse that the MCO identifies to the state Medicaid Program Integrity Unit (PIU) or any potential fraud directly to the state MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

II. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring regulations at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be

submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

The Hawaii Medicaid Managed Care program utilizes a contracting approach wherein the initial RFP issued to MCOs during the solicitation process becomes an essential supplemental document for determining the adequacy of MCO provisions relating to program integrity and other standards. The compilation of RFP and contracting documents are herein referred to as the MCO general contract. The state develops an RFP based upon the requirements of relevant state plans and amendments. MCOs then bid on the RFP and, upon award, sign the RFP and an official contract. The contract is a legally binding document that requires the MCOs to meet the conditions and requirements in the RFP.

In Hawaii, CMS determined that the oversight and monitoring requirements set forth at §§ 438.66 and 438.602 were appropriately addressed within the MCO general contract. The state also conducts announced compliance reviews of the MCOs annually to ensure program integrity-related policies and procedures are met and consistent with federal and state requirements. The state contracts with Hawaii Service Advisory Group (HSAG) to assist with these reviews.

Although the state requires the MCOs to submit an annual monitoring plan, the state does not require MCOs to submit, on a recurring basis, a strategic Fraud, Waste, and Abuse (FWA) Plan that addresses measures to detect and prevent fraud, waste, and abuse. While not a CMS regulatory requirement, CMS encourages the state to consider developing policies and procedures to annually review MCO FWA Plans. Such oversight will allow Hawaii to measure the effectiveness of MCO program integrity activities.

The MCO general contract specifies that the MCO must establish an SIU or other program integrity-focused unit to investigate possible instances of fraud, waste or abuse. While the MCOs all had SIUs, the MCOs reported there are no investigators located on the island, limiting the ability to conduct program integrity auditing activities as well as announced or unannounced investigative site visits. While not a federal requirement, Hawaii's MCO general contract does not specify the organizational structure of the unit or provide any guidance for maintaining appropriate staffing levels within these units. Given Hawaii's unique geographical circumstances, the lack of any investigators on the island severely limits MCOs' abilities to effectively oversee their network providers.

Observation #1: CMS encourages the state to consider amending the MCO general contracts to require MCOs to develop and submit a Fraud, Waste, and Abuse (FWA) Plan to the state on a recurring basis. In addition, CMS encourages the state to develop policies and procedures for the annual review of MCO FWA Plans and to determine the effectiveness of the program integrity activities.

Observation #2: CMS encourages the state to ensure the MCOs establish a SIU or other program integrity-focused unit with sufficient resources and staffing commensurate with the size of their Medicaid managed care programs. The state could consider including contract language addressing the organizational structure and effectiveness of the MCO's SIU.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that the MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.
5. Effective lines of communication between the compliance officer and the organization's employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Although Hawaii's MCO general contract did not require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608, the MCOs did maintain compliance plans that were fully compliant with 42 CFR 438.608 during the review period. In addition, subsequent to this CMS review, the state revised the MCO general contract in 2020 to address the requirement for compliance plans under 42 CFR 438.608.

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

The MCOs are required by the MCO general contract to conduct beneficiary verifications. Section 12.2 "Verification of Services and Electronic Visit Verification" states that "the Health Plan shall send by mail [Verification of Services] (VOS) each month to at least twenty-five percent of their members who received services." The MCO general contract notes that the beneficiary verifications should be performed through written communication.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The MCO general contract requires, and all MCOs have implemented, written policies for all employees of the Health Plan and any contractor or agent that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Hawaii Medicaid MCOs are contractually required to suspend payments to providers if DHS determines there is a credible allegation of fraud, unless a good cause exception is made. DHS is responsible for the determination of a credible allegation of fraud and any good cause exception. The MCO general contract does not allow the MCOs to suspend payments to providers without the direction of the state if the MCO suspects a credible allegation of fraud. DHS notifies the MCO in writing of the suspension and will provide an update when the suspension is discontinued. When notified, the MCO is required to suspend within one business day and submit reporting on the suspension action, including the date the MCO suspended payments or discontinued the payment suspension, outcome of any appeals, and amount of any adjudicated

Medicaid payments held. The state reported that five providers were suspended at state direction during the review period.
CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at § 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Regulations at § 438.608(a)(2) require states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments from the MCO to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation required for reporting the recovery of all overpayments; and the process, timeframes, and documentation required for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for a network provider to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

CMS determined that the state adequately addressed the requirements at § 438.608(a)(2) and (d) in the MCO general contract. Section 12.1 (D)(1)(c) of the MCO general contract states that the health plan may retain funds recovered due to audit activities it initiates during the initial eighteen (18) months from the date of services. After eighteen (18) months, DHS Program Integrity or other entities have full right to audit and pursue overpayments directly from providers. DHS or their representatives will notify the health plan of recoveries, or direct the health plan to make recoveries. In all cases, encounters should be adjusted and submitted to DHS within one hundred twenty (120) days of adjudication or adjustment. In Section 12.1 (D)(3), the health plan is further required to have a process in place for providers to report to the health plan when it has received an overpayment, and a process for the provider to return the overpayment to the health plan within sixty (60) days after the date on which the overpayment was identified. In Section 12.1 (D)(4), the health plan must also report quarterly to DHS on all recoveries, specifying those recoveries from fraud, waste or abuse. Additionally, in Section 12.1 (D)(7)(c), the health plan must report to DHS within sixty (60) days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

CMS observed that, although contract provisions address procedures for reporting overpayments in accordance with federal regulations, the state did not undertake activities to verify overpayment identifications and recoveries. Overall, the number of overpayments identified and recovered by the MCOs is low for a managed care program of Hawaii's size. CMS identified significant discrepancies in the amounts identified and recovered across MCOs, indicating that MCOs may not be equally prioritizing recovery efforts. Detailed information regarding the overpayments identified and recovered by each MCO can be found in Table 1 in Section D of

this report. ‘Ohana overpayment figures show they are the only MCO that is recovering a majority of the overpayments identified by the MCOs.

> **Observation #3:** CMS encourages the state to consider the inclusion of an effective mechanism to monitor, track, and verify the accurate reporting of overpayments identified and recovered by the MCOs. Furthermore, CMS encourages the state to ensure the MCOs develop and maintain accurate overpayment identification/collection/reporting policies and procedures consistent with § 438.608(d) and MCO general contract requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. **The state does not have a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria.** Specifically, there is no MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs as required by § 455.21(c)(3)(iv). Additionally, the state does meet with the MFCU monthly to discuss case referrals. The monthly meeting includes representatives from MCOs SIU, MFCU investigators, and the state PI unit.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. In Hawaii, the MCOs are required to work cooperatively with DHS, the MFCU, the OIG, CMS, and any other law enforcement agencies, as appropriate, to administer effective program integrity practices and participate in any subsequent legal actions. The MCOs are also required to participate in meetings with state Program Integrity, Investigations, or Fraud Control personnel, the state recovery audit contractor, and other MCO compliance staff. These meetings are facilitated by the SMA and the MFCU. MCOs are required to prepare a written update on cases, audits, recoveries, and trends to be presented at these events.

> **Recommendation #1:** Because the SMA does not have a MOU in place with the MFCU, consistent with the requirements at § 455.21(c), the SMA should enter into a written agreement with the MFCU. The agreement serves to establish certain parameters for the relationship between the MFCU and the SMA and guide the coordination of

efforts between the two agencies.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly referral any potential fraud, waste, or abuse that the MCO identifies to the state Medicaid PIU or any potential fraud directly to the state MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Section 12.1 (C)(3) of the MCO general contract outlines the process for MCOs to refer suspected fraud to the state. The MCO general contract states, "[i]f the Health Plan receives a complaint of suspected Medicaid [fraud, waste, and abuse] from any source or identifies any questionable practices, either by the Members or Providers, it shall conduct a preliminary investigation to determine whether there is sufficient basis to warrant a further investigation by DHS and/or the MFCU. If the findings of a preliminary investigation give the Health Plan reason to believe that an incident of [fraud, waste, and abuse] has occurred in the Medicaid program, the Health Plan shall promptly refer any potential [fraud, waste, and abuse]that it identifies to DHS. Health Plans are required to report all incidences of suspected [fraud, waste, and abuse]to DHS within fourteen (14) days of making such a determination."

CMS noted that in one place, the RFP stated, "The health plan shall promptly referral any potential or suspected FWA identified to DHS and the state Medicaid Fraud Control Unit (MFCU)." However, in another place, the RFP stated, "the health plan shall promptly refer any potential FWA that it identifies to DHS." This different guidance can be confusing to the MCOs as they attempt to satisfy the program integrity requirements of the MCO general contract. However, since this CMS review, the state implemented a corrective measure to revise the MCO general contract in 2022 to address the conflicting language in the RFP.

CMS did not identify any findings or observations related to these requirements.

MCO Oversight of Network Providers

CMS verified whether the Hawaii MCOs had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

AlohaCare: Aloha Care's SIU investigates reported potential fraud, waste, and abuse activities and, as appropriate, refers suspected or confirmed fraud, waste, and abuse to the MQD and MFCU. AlohaCare conducts a preliminary investigation on all cases of suspected activities. The preliminary investigations activities may include but are not limited to claim history and analysis; prescription history; credentialing record; provider contract; member and provider phone calls; media and social networks; relevant policies; medical record review; and conducting internal and external interviews as needed. A full investigation will be completed if there is

credible evidence of suspected fraud, waste, and abuse. The results from the full investigation can include but are not limited to referral to an outside agency; no further action; provider/member education; prepayment reviews; corrective action plan; contract termination; or enhancement of policies. **AlohaCare referred two investigations to the state during the three FYs reviewed.**

HMSA: HMSA's SIU investigates reported potential fraud, waste, and abuse activities and, as appropriate, refers suspected or confirmed fraud, waste, and abuse to the MQD and MFCU. The preliminary investigation is conducted to assess if there is a credible allegation of fraud. Preliminary investigations may include but are not limited to research; claims review; and document and/or medical request and review. A preliminary investigation may lead to a full investigation if allegations are substantiated. The results from the full investigations will be sent to the MQD, and HMSA will place the investigation on hold until advised by the MQD to proceed with administrative actions. The SIU conducts the following program integrity activities that include, but are not limited to, excluded provider screening; preliminary and full fraud, waste, and abuse investigations; fraud, waste, and abuse case expansions; audits and reviews; provider education; overpayment identification and recoupment; prepayment claims review; information sharing at the monthly MFCU meeting; and implementation of policies and/or claim edits. The SIU also takes preventive measures, such as placing providers on a prepayment review; provider education; and implementation of policies or claim edits that are effective in mitigating future overpayments for known fraud, waste, and abuse. **HMSA referred nine investigations to the state during the three FYs reviewed.**

'Ohana: 'Ohana SIU investigates reported potential fraud, waste, and abuse activities and, as appropriate, refers suspected or confirmed fraud, waste, and abuse to the MQD. The Attorney General's Office and MFCU receive a copy of the investigative report. The preliminary investigations are completed when there is a suspected allegation of FWA. The full investigations include but are not limited to medical record review; coder review; document verification; and a final determination. 'Ohana evaluates the effectiveness of program integrity through its fraud, waste, and abuse plan; by monitoring and tacking investigative activities, including case review; outcomes and provider education; actual recoveries; and cost avoidance measures. 'Ohana also has hired external auditors to review the effectiveness of the Compliance Department, including the SIU. The audits include, but are not limited to, reviewing the organizational structure and processes that are in place to combat fraud, waste, and abuse. The audits also evaluate and recommend programmatic corrections and future state considerations. Lastly, the audits evaluate data mining activities; referral-based investigations process; and procedures for reporting to other departments and regulatory agencies. **'Ohana referred twenty-five investigations to the state during the three FYs reviewed.**

Overall, the submitted MCO written policies and procedures for the investigation of suspected fraud, waste, and abuse comply with the state contract requirements.

Figure 1 describes the number of investigations referred to Hawaii by each MCO. CMS notes that there were a limited number of provider investigations being conducted by the MCOs.

Figure 1. Number of Investigations Referred to Hawaii by each MCO

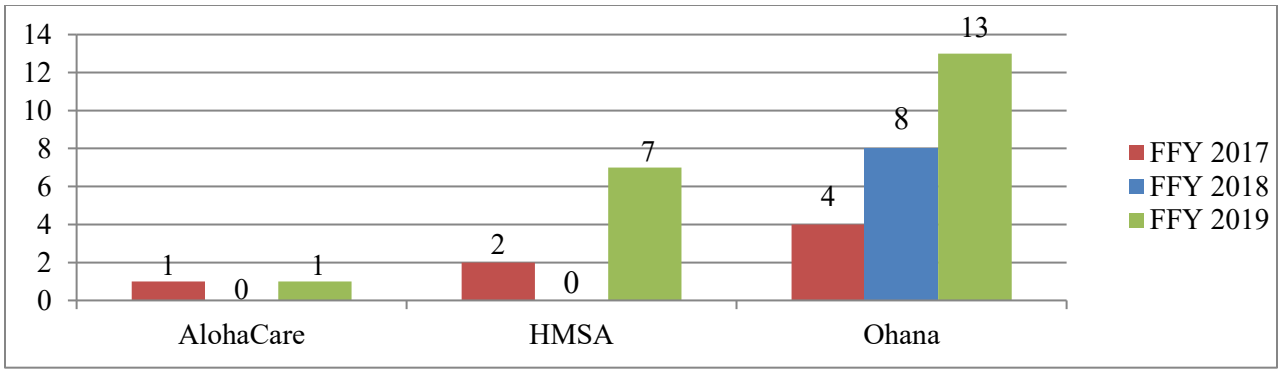

Table 1, below, describe each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

Table 1: MCO Recoveries from Program Integrity Activities

AlohaCare 's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	59	1	-0-	$282,000.00
2018	24	-0-	-0-	-0-
2019	26	1	-0-	-0-

HMSA's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	8	14	$1,790,690.19	-0-
2018	12	12	$3,285,138.44	$179,432.00
2019	24	24	$1,739,053.02	$1,442,053.32

Ohana 's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	71	-0-	$20,214.52	$19,809.78
2018	52	-0-	$64,135.79	$97,098.19
2019	52	-0-	$41,374.84	$38,821.84

Observation #4: CMS encourages the state to work with the MCOs to develop more case referrals and routinely provide specific program integrity training in identifying, investigating, and referring potential fraudulent billing practices by providers to enhance the quality and quantity of cases being referred by the MCOs.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. Through a review of the Hawaii MCO general contract and responses from each of the MCOs, CMS determined that Hawaii was in compliance with § 438.242. Specifically, the contract language states the MCOs must have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and dis-enrollment for other loss of Medicaid eligibility.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO. CMS found Hawaii in compliance with § 438.602(e).

While it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Hawaii has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the contracts with the MCOs require all claims data to be provided to the state at least once a month. The encounter data is loaded into the Hawaii Prepaid Medical Management Information System (HPMMIS) and can be used for audits/investigations; identification of improper payment; and other program integrity activities. MQD utilizes Lexis Nexis as its software to conduct data mining to look for fraud, waste, and abuse schemes for the encounter data received. The state also utilizes Cognos IBM Analytics to query, extract, and analyze the encounter data in HPMMIS.

CMS did not identify any findings or observations related to these requirements.

III. Conclusion

CMS supports Hawaii's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused desk review identified one recommendation and four observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action

plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.
CMS looks forward to working with Hawaii to build an effective and strengthened program integrity function.

IV. Appendices

Appendix A:

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: HI_22_Focused_PI_Final.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix B:

Table B-1 and Table B- 2 below provide enrollment and expenditure data for each of the selected MCOs.

Table B-1. Summary Data for Hawaii MCOs Data

Hawaii MCO Data	AlohaCare	HMSA	Ohana
Beneficiary enrollment total	64,301	160,279	43,296
Provider enrollment total	6,769	7,561	3,314
Year originally contracted	1994	1994	2008
Size and composition of SIU	1	7	1
National/local plan	Local	Local	National

Table B-2. Medicaid Expenditure Data for Hawaii MCOs

MCOs	FY 2017	FY 2018	FY 2019
AlohaCare	$286,930,435.39	$275,351,649.38	$234,050,729.04
HMSA	$584,209,766.65	$619,259,017.77	$572,971,596.05
Ohana	$107,713,104.59	$119,848,363.15	$116,511,383.23
Total MCO Expenditures	$978,853,306.63	$1,014,459,030.30	$923,533,708.32

Appendix C:

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	The SMA does not have a MOU in place with the MFCU, consistent with the requirements at § 455.21(c). Therefore, the SMA should enter into a written agreement with the MFCU. The agreement serves to establish certain parameters for the relationship between the MFCU and the SMA and guide the coordination of efforts between the two agencies.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)