REPORT TO THE TWENTY-EIGHTH HAWAII STATE LEGISLATURE 2015

IN ACCORDANCE WITH THE PROVISIONS OF ACT 240
ADOPTED BY THE 2013 HAWAII STATE LEGISLATURE

DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
December 2014

REPORT SUBMITTED BY THE DEPARTMENT OF HUMAN SERVICES TO THE 2015 LEGISLATURE PURUSANT TO ACT 240 (H.B. 1207, HD1, SD1, CD1) ADOPTED BY THE 2013 HAWAII STATE LEGISLATURE

Act 240, requires the Department of Human Services to report prior to the 2015 and 2016 legislative sessions and a final report prior to the 2017 Legislature on the Medicaid program's compliance with program integrity requirements in the federal Patient Protection and Affordable Care Act (ACA) of 2010.

Information on the following areas are provided:

1. **Implementation of provider enrollment, screening verification, and termination programs**:

   The ACA included new provisions to address increasing program integrity for the Medicaid program. The ACA requires States to terminate providers (individuals and entities) that have been terminated in other federal programs (e.g. Medicare, another State's Medicaid Program, and CHIP), suspending payments to providers based on credible allegations of fraud, and preventing inappropriate payments.

   The Centers for Medicare & Medicaid Services (CMS) established an internet-based Provider Enrollment, Chain and Ownership System (PECOS) application for Medicare providers. Medicaid staff are granted access to PECOS to check on a provider's status with the Medicare program when providers submit an application to participate in Hawaii's Medicaid program. HCSB staff has access to PECOS data and performs checks.

   In addition, Hawaii receives a monthly file from the Office of Inspector General indicating all providers who have been excluded from participating with federal programs such as Medicare and Medicaid. This file is loaded into Med-QUEST Division's (MQD) Hawaii Prepaid Medicaid Management Information System (HPMMIS) upon receipt. If there is a match with any active provider, the system will automatically suspend or terminate the provider in the system thereby preventing any claims from being paid or encounters being submitted to MQD.

   As part of the screening process Medicaid programs must have a method for verifying a provider's license status. The MQD regularly receives a file from the Department of Commerce and Consumer Affairs (DCCA) that contains state licensing information. The file

is also loaded into the HPMMIS upon receipt and the HPMMIS will terminate or suspend a provider if their license has been terminated or suspended by the DCCA. In addition, as part of the verification process, staff will verify license status utilizing the DCCA website to ensure there are no limitations placed on a provider's license. Providers must renew their license with the DCCA before their status with Medicaid can be reinstated.

Every five (5) years, the MQD is required to revalidate all providers in the fee-for-service (FFS) program that were not credentialed by one of the contracted health plans. The MQD needs to perform revalidation on all FFS providers no later than March 2016. Starting in June 2014, health plans provided MQD with credentialing data on their providers. MQD anticipates finalizing all health plan credentialing information by the third quarter of SFY15. At that time, the MQD will start revalidation of providers in the fourth quarter of SFY15. The MQD anticipates that this process will be completed by March, 2016.

The MQD is required to perform on-site visits to moderate and high categorical risk providers as part of its revalidation process. MQD will begin this process in April 2015. Pre-enrollment and post enrollment site visits to verify that information on the application of moderate or high categorical risk providers is necessary for providers who are not also Medicare providers. For providers who are also Medicare providers, Medicare is also required to conduct on-site visits, and the Medicaid program is able to utilize pre-enrollment site visit verification from Medicare to meet this requirement. The provider types in the moderate or high risk category are providers that are also covered by Medicare (e.g. durable medical equipment providers).

Another requirement is that providers utilize their National Provider Identifier to bill and register as a provider. The Medicaid agency has been requiring that providers submit their National Provider Identifier (NPI) number for over four years. In addition, providers who order services or refer Medicaid recipients for services must also submit an application to the Medicaid program.

Since December 2009, the MQD has been conducting criminal background checks on home and community based service providers consistent with Hawaii Revised Statute (HRS) §346-97. The MQD meets the requirements for the ACA through this program.

2. **Implementation of recovery audit contractor programs**

The MQD entered into a contract with the Recovery Audit Contractor (RAC) effective January 1, 2013, as required under the ACA. The RAC has been working with MQD and the Arizona Systems Office (who maintains HPMMIS) to design and generate claims data reports retrospective to January 1, 2011. The contract allows the RAC to receive 12% of all recoveries made on behalf of the Hawaii Medicaid program. A report on all FFS claims is currently under review by the RAC, and it is anticipated that recovery from providers for overpayments will begin within the next few months.

3. **Implementation of processes to provide managed care oversight of the department's mandated fraud and abuse programs**

MQD Financial Integrity Staff (FIS) have met with the health plans to discuss revisions to the quarterly reports that are submitted to MQD to include reporting of all health plan fraud, waste and abuse activities. The revised quarterly activities report requirements will assist in the oversight of the health plans.

MQD FIS participated in the Request For Proposal (RFP) process for QUEST Integration contracts. This included proposal evaluation, reviewing of health plan deliverables and participation in on site reviews of their program integrity units and meetings with their program integrity staff. With the addition of an investigator to the MQD FIS responsible for program integrity activities, there has been increased communication with the health plans such as providing clarification on program integrity issues through memoranda as well as working with health plan staff to obtain additional information on fraud referrals.

4. **Implementation of means to prohibit false statements and representations, including the department's processes of verification of the beneficiary receipt of services claimed by managed care health plans via explanation of benefits forms or other approved methods**

With the implementation of QUEST Integration contracts, health plans will be required to provide a form of verification of services (VOS) to recipients. The health plans will be required to mail each month to at least 25% of their members who received services a VOS letter with the date of service, service provided, and amount of payment made to the provider. Members may call the health plan to report that the billing information is not correct or was not provided, and the finding will be sent to the health plans' program integrity staff for further investigation. The health plans are required to report information on the VOS program to MQD.

5. **The projected cost savings per program per fiscal year**

FIS has identified and recovered overpayments primarily from the FFS program. However activities to coordinate program integrity efforts with the managed care plan staff have been initiated and FIS staff will be working more closely with the managed care plans to coordinate fraud and abuse activities.

Please refer to Section 6 for additional information on recoveries.

6. **Activities taken by the Department's internal program integrity section to prevent and reduce fraud, waste, and abuse including overpayments recovered and number of fraud reports received by the department from the QUEST and QUEST Expanded Access (QExA) health plans, fee-for-service program, and the children's health insurance program (CHIP) for the fiscal year.**

FIS is involved with the coordination of CMS Medicaid Integrity Contractor (MIC) audits and RAC activities, and will begin the Payment Error Rate Measurement (PERM) claims reviews by the end of the year.

Surveillance utilization review (SUR) activities by FIS have led to the opening of ten investigations in the past year. Of those ten cases identified, four resulted in Medicaid Fraud Control Unit (MFCU)/law enforcement referrals. In addition, FIS has received sixteen complaints through the Medicaid fraud hotline, and QUEST and QExA reporting. FIS conducted initial investigations on all sixteen cases and six of those cases have been referred to MFCU/law enforcement for further investigation and possible prosecution.

In addition to the MFCU/law enforcement referrals, the FIS has identified $886,512 as potential overpayments by the Medicaid program through review of claims payments reports generated through SUR reports. These cases are in various stages of recovery/investigation. For the past state fiscal year, FIS received $81,543 in repayments. The MIC audits also have resulted in recoveries totaling $53,159.

One of the difficulties MQD faced was a lack of resources in the FIS section. The MQD filled the investigator position which has enabled the FIS to increase its monitoring and investigation activities. The MQD is currently in the process of hiring a second investigator and plans to have that individual on board by the end of the 2014 calendar year. Two additional positions which will be responsible to do detailed evaluation and analysis of reports, are awaiting establishment by the Department's Personnel Office.

In addition, the MQD will reorganize the FIS to create a separate program integrity section within the Finance Office with the new Program Integrity Section supervisor reporting to the Finance Office.

CMS conducted a comprehensive review of Hawaii's Medicaid program in June, 2013. The final report is attached along with a copy of the Corrective Action Plan (CAP). The MQD continues to work on filling Program Integrity staffing and increasing activities, and has a strong CAP to implement improvements.

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Medicaid Integrity Group

JUN 11 2014

Kenneth S. Fink
Division Administrator
Hawaii Department of Human Services Med-Quest Division
601 Kamokila Blvd, Room 518
Kapolei, HI 96707

Dear Dr. Fink:

During the week of June 24, 2013, a team from the Medicaid Integrity Group conducted a comprehensive review of Hawaii's Medicaid program integrity procedures and processes. We would like to take this opportunity to thank you and your staff for the cooperation and assistance provided to the team during the review.

The review had four objectives: a) to determine compliance with appropriate program integrity statutes and regulations; b) to identify effective practices; c) to identify potential vulnerabilities; and d) to assist the state in improving the overall integrity of its Medicaid program. The results of the review are contained in the enclosed final report.

You and your staff, as well as the Medicaid Fraud Control Unit, had the opportunity to review our draft report. We gave consideration to your comments in drafting this final report.

We have identified four major categories of risk which are outlined in the report. It is important that each of these risk areas be rectified as soon as possible. To that end, we require that you provide a corrective action plan for each risk area within 30 calendar days of the date of this letter.

The corrective action plan should address how your agency will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps you expect will occur. It should also explain why correcting any of the risks areas will take more than 90 calendar days from the date of this letter. Please indicate how the state plans to monitor its performance to make sure that the solutions are sustained, if appropriate.

Attached you will find the Corrective Action Plan Development Tool that you may find useful. Upon receipt of the corrective action plan, CMS will review and provide feedback on the acceptability of the plan. CMS is committed to assisting the state in addressing the findings described in this report. If you should require any technical assistance from the MIG in developing the corrective action plan, please contact your State Liaison, Captain Debra Tubbs (Debra.Tubbs@cms.hhs.gov), for further assistance.

If you have already taken action to correct the risk areas that were identified in this report, the plan should identify those corrections as well.

Please send your corrective action plan (in Word or PDF format) electronically to Peter Leonis, Director of the Division of Field Operations, at Peter.Leonis@cms.hhs.gov.

In addition, please provide a formal response to this final report within 30 days of the date of this letter. The response letter should also be sent electronically (in Word or PDF format) to Peter Leonis. Your response will be attached to the final report and will be published on the CMS website.

Again, we appreciate your cooperation and assistance throughout this project and look forward to working with you in your efforts to achieve compliance.

Sincerely,

Mark Majestic
Acting Director

Enclosure

cc: Shelley Siegman R.N. Med-Quest, Financial Integrity Staff
Michael Parrish, MFCU Director
Jackie Garner, CMCHO Consortium Administrator
Gloria Nagle, DMCHO Associate Regional Administrator

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Hawaii Comprehensive Program Integrity Review

Final Report

June 2014

Reviewers:
Debra Tubbs, Review Team Leader
Tonya Fullen
Elizabeth Lindner
Eddie Sottong
Joel Truman, Review Manager

EXECUTIVE SUMMARY AND INTRODUCTION

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

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

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

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

BACKGROUND

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

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

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

METHODOLOGY OF THE REVIEW

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

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

SCOPE AND LIMITATIONS OF THE REVIEW

This review focused on the activities of the FIS within the MQD but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, and contract management. Hawaii operates its Children's Health Insurance Program (CHIP) as a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Hawaii's Title XIX program. The same findings and vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP expansion program. Unless otherwise noted, Hawaii provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the MQD provided.

MEDICAID PROGRAM INTEGRITY UNIT

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

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

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

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

RESULTS OF THE REVIEW

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

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

Conducting Preliminary Investigations

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

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

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

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

Statewide Surveillance and Utilization Control Program

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

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

Recommendations:

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

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

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

Suspension of Payments in Cases of Credible Allegations of Fraud

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

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

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

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

Recommendations:

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

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

Capturing Ownership and Control Disclosures at Enrollment

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

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

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

Enrollment and Screening of Providers

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

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

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

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

Screening Levels for Medicaid Providers

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

Medicaid Provider Application Fees

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

Recommendations:

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

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

Program Integrity Oversight in Managed Care

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

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

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

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

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

Verifying Beneficiary Receipt of Services

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

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

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

Capturing Ownership and Control Disclosures at Enrollment

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

Requesting Business Transaction Information

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

Capturing Criminal History Disclosures at Enrollment

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

Exclusion Searches

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

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

Reporting Adverse Actions Taken Against Providers

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

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

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

Recommendations:

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

TECHNICAL ASSISTANCE RESOURCES

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

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

SUMMARY

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

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

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

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Finance Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190

August 13, 2014

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

Dear Mr. Leonis:

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

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

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

Sincerely,

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

Enclosures

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Corrective Action Plan

ELEMENT	DESCRIPTION
Finding/Vulnerability	Risk Area 1: Risks were identified in the state's implementation of core program integrity activities. Conducting Preliminary Investigations
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Financial Integrity Staff
Action Plan	1. Investigator has been hired as of January 27, 2014. 2. A second investigator position is in the interview phase of the application process. Having a second investigator in the unit will ensure an investigator is available to perform preliminary investigations. 3. Investigator has performed 15 preliminary investigations and has referred 5 cases to MFCU, and an additional 2 cases to other agencies. 4. Supervisor position to be created. 5. Data Analyst Position description is with the State Personnel Department awaiting approval.
Policy/Procedure Development	Med-QUEST has developed a policy and procedure which outlines the handling of complaints and investigations: • Policy Handling of Complaints Investigations
Contract or Regulatory Development	No contract or regulatory changes were required for this CAP item.
Training	Any new personnel hired will undergo training as available.
Completion Date	Investigator completed first preliminary investigation on February 13, 2014. Other investigations have been completed since that date and continue to be investigated.
System Enhancements	Second Investigator is in recruitment phase. Having a second investigator in the unit will ensure an investigator is available to perform preliminary investigations.
Internal Controls/Audits	Supervisor to ensure there is an investigator in the unit.

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Corrective Action Plan

ELEMENT	DESCRIPTION
Finding/Vulnerability	Risk Area 1: Risks were identified in the state's implementation of core program integrity activities. Statewide Surveillance and Utilization Control Program
Responsible Party	Department of Human Services, Med-QUEST Division, Financial Integrity Staff/Finance Office
Action Plan	Build a Distinct Program Integrity Unit: • Program integrity unit supervisor – Position to be created. State Personnel office currently has a new employee hiring freeze. • Data Analyst position description has been created and is with the State Personnel Office for review. • Investigator – One investigator position has been filled, second investigator position is currently in the recruitment stages. Proactive SURS activities are currently being performed by investigator with the data from the Lexis Nexis SURS subsystem. SURS analysis (e.g., duplicate charges for birth deliveries, new patient charges for established patients, etc.) has resulted in two MFCU referrals and identified additional instances of overpayments which led to recovery of funds. Staff continues to work with health plans to recover overpayments.
Policy/Procedure Development	Surveillance and Utilization Control Program P&P was reviewed and signed off by administrative staff in January 2014 and February 2014
Contract or Regulatory Development	New RFP for Quest Integration contains language in Compliance Plan section 51.330 on the requirements for the Health Plans to perform Surveillance and Utilization review.
Training	Lexis Nexis (SURS) provided an interactive online training for Financial Integrity Staff in April 2014 on their Intelligent Investigator.

ELEMENT	DESCRIPTION
Completion Date	Investigator began utilizing SURS on regular basis February 2014 and continues to perform proactive data mining, conducts preliminary investigation, and is making referrals to MFCU. Med-QUEST FIS is currently working with administration and state personnel office to create and fill positions necessary to staff a distinct program integrity unit.
System Enhancements	Creation of a dedicated and distinct program integrity section with data analyst staffing for SURS activities.
Internal Controls/Audits	SURS activities are documented and logged on the public drive.

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Corrective Action Plan

ELEMENT	DESCRIPTION
Finding/Vulnerability	Risk Area 2: Risks were identified in fraud detection and investigations. Suspension of Payments in Cases of Credible Allegations of Fraud
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Financial Integrity Staff (FIS). Financial Integrity staff will collaborate with the Medicaid Fraud Control Unit (MFCU), as appropriate to complete these actions.
Action Plan	FIS will revise policies and procedures to meet the requirements of 42 CFR 455.23 and CMS guidance concerning processes and documentation in cases with a credible allegation of fraud resulting in a suspension of payments to providers or a good cause exception not to suspend upon MFCU referral/request. FIS will collaborate with the Recovery Audit Contractor (RAC) vendor to explore other options of documenting a credible allegation of fraud (e.g., standardized evaluation tool, etc.) that has been utilized by other State program integrity units. FIS and MFCU have completed draft MOUs based on program integrity requirements (included time frames for responses, CMS fraud referral performance standards, payments suspension information, reporting of criminal convictions to OIG). Issues noted in review have been addressed in draft MOU. A coordination call between the MQD and MFCU was held June 19, 2014, and there have been emails to discuss MOU revisions. Meeting with MFCU to be scheduled in September to discuss finalization of MOUs (see attachments). As recommended by CMS, the MQD is in the process of reviewing MOU's from other program integrity units, in addition to the CMS fraud referral performance standards issued September 30, 2008.

ELEMENT	DESCRIPTION
Policy/Procedure Development	FIS will revise policies and procedures 14-004 "Provider Payment Suspensions Due to Credible Allegations of Fraud", to meet the requirements of 42 CFR 455.23 and CMS guidance concerning processes and documentation in cases with a credible allegation of fraud resulting in a suspension of payments to providers or a good cause exception not to suspend upon MFCU referral/request. Provider Payment Suspension Due to Credible Allegation of Fraud or use of good cause exception are addressed in proposed MOU and will be implemented upon finalization. Policy 14-003 "Notification to OIG of State and Local Convictions of Crimes against Medicaid", contains OIG reporting language. Notification to OIG of State and Local convictions of Crimes against Medicaid has been proposed in revised MOU to be reported by MFCU. Payment suspensions proposed in MOU to be reported by FIS.
Contract or Regulatory Development	MOU has been revised to address program integrity requirements identified during PI review. MOU is in draft format and contains specific language to address identified risks.
Training	Financial Integrity Staff will receive training by the RAC on standardized CAF tool and we will determine if we will implement in our reporting procedures for a credible allegations of fraud. In addition, training will be made available to the Hawaii MFCU regarding utilization of the CAF Tool. FIS will conduct a joint meeting with the MFCU to review the revised MOU and ensure operational responsibilities are clearly understood by both parties FIS will then meet with the MFCU at least quarterly to review all open cases, referrals, criminal convictions reported to HHS-OIG, and pending payment suspension/potential credible allegation of fraud issues.
Completion Date	The MOU between the MQD and MFCU is in the first draft stage and is anticipated to be completed within 90 days, pending agreements by both parties.
System Enhancements	No system changes needed for this identified risk.

ELEMENT	DESCRIPTION
Internal Controls/Audits	Internal controls will be developed to monitor the following to: • Review of MFCU referral log to ensure referred cases meet provider payment suspension requirements. • Review of investigator's log to ensure referral to OIG has been made on provider convictions not involving the MFCU. MFCU and FIS will adhere to time constraints and reporting requirements addressed in new MOU and ensure adequate coordination between the two units.

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CORRECTIVE ACTION PLAN

The following is provided as a tool for States to use when developing the corrective action plan related to any findings, vulnerabilities or risks identified through the Comprehensive Program Integrity Review. The elements listed give States an idea as to what CMS reviews for when determining an acceptable corrective action for each finding, vulnerability or risk.

States are encouraged to contact their MIG State Liaison for clarification or if additional guidance is needed.

ELEMENT	DESCRIPTION
Capturing Ownership and Control Disclosures at Enrollment	
Finding/Vulnerability	Risk Area 3: Risks were identified in the state's provider enrollment practices. Capturing Ownership and Control Disclosures at Enrollment
Responsible Party	Department of Human Services, Med-QUEST Division, Health Care Services Branch (HCSB)
Action Plan	<u>Fee-for-Service (FFS) Provider Enrollment</u> The HCSB revised its DHS 1139 effective October 1, 2013 to collect ownership and control disclosure information required in 455.104(b) - see revised DHS 1139 and instructions attached. The following information is now collected on the DHS 1139: 1. The correspondence address (i.e., mailing address); 2. The pay to address (i.e., where payments are made); 3. All service addresses (i.e., all service locations that Medicaid beneficiaries may receive services); 4. Social Security Number (SSN) and Date of Birth (DOB) of all individuals with either direct or indirect ownership or controlling interest, officers or board members, and managing employees. 5. In addition, the revised form collects addresses of all managing employees.

ELEMENT	DESCRIPTION
Capturing Ownership and Control Disclosures at Enrollment	
	<u>Managed Care Entities (MCE) Provider Enrollment</u> HCSB is in the process of revising the form that collects the enhanced information from MCE's annually. This form will be completed by October 31, 2014. In addition, this form will collect the DOB and SSN for all persons with ownership or control interest as well as officers, board members, and managing employees.
Policy/Procedure Development	The HCSB will develop a policy and procedure that describes collection of ownership and control interest disclosures at enrollment for FFS provider enrollment. This P&P will be completed by September 30, 2014.
Contract or Regulatory Development	The HCSB has amended contract requirements to assure MCE submission of disclosure information annually - see amended QUEST, QExA, and QUEST Integration contract modifications attached.
Training	Training will be provided to MCEs by October 31, 2014 by Jon Fujii on ownership and disclosure requirements related to this Corrective Action Plan (CAP).
Completion Date	October 31, 2014
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Enrollment and Screening of Providers	
Finding/Vulnerability	Risk Area 3: Risks were identified in the state's provider enrollment practices. Enrollment and Screening of Providers
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Provider Enrollment (FFS and managed care)</u> 1. The provider enrollment requirements identified in 42 CFR 455.410 were implemented for FFS providers (to include physicians) effective October 1, 2013. 2. All fee-for-service (FFS) providers are enrolled through completion of the DHS 1139 (attached). 3. All managed care entity (MCE) providers are enrolled through submission of electronic files semimonthly (first and third Wednesday of each month). 4. All providers are enrolled in the MQD's Hawaii Prepaid Medicaid Management Information System (HPMMIS).
Policy/Procedure Development	1. The HCSB will develop a policy and procedure that describes implementation of FFS provider enrollment. This P&P will be completed by September 30, 2014. 2. The MCE process to submit files of their providers for enrollment into HPMMIS will be submitted by September 30, 2014.
Contract or Regulatory Development	No contract or regulatory changes were required for this Corrective Action Plan (CAP) item.
Training	No training was required for this Corrective Action Plan (CAP) item.
Completion Date	September 30, 2014
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Verification of Provider Licenses	
Finding/Vulnerability	Risk Area 3: Risks were identified in the state's provider enrollment practices. Verification of Provider Licenses
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Verification of Provider Licenses (FFS)</u> 1. When HCSB receives a provider from out of state that needs to be enrolled, a copy of his/her provider license is requested with the application. 2. Prior to enrolling the provider into MQD's Hawaii Prepaid Medicaid Management Information System (HPMMIS), HCSB is: • Verifying the provider license with the State that the out-of-state provider is practicing and that there are no restrictions on the license; and • Assuring that the provider is a Medicaid provider in that State.
Policy/Procedure Development	The HCSB will develop a policy and procedure that describes verifying provider licenses for out-of-state providers. This P&P will be completed by September 30, 2014.
Contract or Regulatory Development	No contract or regulatory changes were required for this Corrective Action Plan (CAP) item.
Training	No training was required for this Corrective Action Plan (CAP) item.
Completion Date	September 30, 2014
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Termination or Denial of Enrollment/Exclusion Searches	
Finding/Vulnerability	Risk Area 3: Risks were identified in the state's provider enrollment practices. Termination or Denial of Enrollment/Exclusion Searches
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Termination or Denial of Enrollment/Exclusion Searches (FFS and Managed Care)</u>: 1. HCSB has a process for screening its providers to include their ownership, control interest, officers, and managing employees (both FFS and managed care) at the time of provider enrollment/re-enrollment and monthly thereafter through databases to assure they are not excluded. 2. HCSB has a process for screening its managed care entities (MCE) to include its ownership, control interest, officers, and managing employees at the time of procurement and monthly thereafter through databases to assure they are not excluded. This information is updated annually (or within 35 days of a change in ownership, control interest, and managing employees). 3. These databases include: • HHS-OIG List of Excluded Individuals and Entities (LEIE); • The Excluded Parties List System (EPLS) on the System for Award Management (SAM); • The National Provider Identifier (NPI) on the National Plan and the Provider Enumeration System (NPPES); • Social Security Administration Death Master File; and • Medicare Exclusion Database (MED). 4. In addition, HCSB has identified that the correct database to search for those terminated from or another State's Medicaid or CHIP program is the State Medicaid Termination Server (TIBCO). Unfortunately, MQD nor Arizona Health Care Cost Containment System (AHCCCS) is able to obtain access to it to perform required checks.

ELEMENT	DESCRIPTION
Termination or Denial of Enrollment/Exclusion Searches	
	5. HCSB will fulfill the requirement for searching for those providers terminated from another State when either Hawaii or Arizona is able to gain access to this database. 6. MQD will issue guidance to all providers in the FFS program to screen all of their employees and subcontractors monthly against the following databases: • LEIE; • SAM; and • Social Security Administration Death Master File; and A memorandum will be issued before August 30, 2014.
Policy/Procedure Development	The HCSB will develop a policy and procedure for searching for exclusions. This P&P will be completed by September 30, 2014.
Contract or Regulatory Development	No contract or regulatory changes were required for this CAP item.
Training	No training was required for this Corrective Action Plan (CAP) item.
Completion Date	#1, #2, #3 (From Action Plan) - October 1, 2013 #4 and #5 (From Action Plan) - The date for this CAP item is delayed due to time it will take to: 1. Obtain access to [database]; and 2. Make system enhancements (see below). #6 - August 30, 2014
System Enhancements	1. System enhancements will be necessary for this CAP item. 2. MQD will modify its Hawaii Prepaid Medicaid Management Information System (HPMMIS) when either Hawaii or Arizona Health Care Cost Containment System (AHCCCS) obtains access to the TIBCO database.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Conducting Site Visits/Screening Levels for Medicaid Providers	
Finding/Vulnerability	Risk Area 3: Risks were identified in the state's provider enrollment practices. Conducting Site Visits/Screening Levels for Medicaid Providers
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Conducting Site Visits/Screening Levels for Medicaid Providers (FFS)</u>: 1. HCSB determined providers who are considered low, moderate, and high risk - see Provider Types by Categorical Risk. 2. All providers who are only participating in the fee-for-service (FFS) program are being screened prior to enrollment, request for new practice location, or reenrollment into Hawaii Prepaid Medicaid Management Information System (HPMMIS). 3. In addition, HCSB will perform site visits on all FFS only providers who meet moderate or high risk as part of their revalidation. 4. HCSB relies on its managed care entities (MCE) to perform site visits during credentialing for managed care moderate or high risk providers.
Policy/Procedure Development	The HCSB will develop a policy and procedure that describes screening of Medicaid providers that includes site visits per risk category. This P&P will be completed by September 30, 2014.
Contract or Regulatory Development	No contract or regulatory changes were required for this Corrective Action Plan (CAP) item.
Training	No training was required for this Corrective Action Plan (CAP) item.
Completion Date	- Initial application, new practice locations, or re-enrollment August 1, 2014 - Revalidations will occur by March 23, 2016 in accordance with Federal regulations.
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Medicaid Provider Application Fees	
Finding/Vulnerability	Risk Area 3: Risks were identified in the state's provider enrollment practices. Medicaid Provider Application Fees
Responsible Party	Department of Human Services, Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Medicaid Provider Application Fees (FFS)</u> HCSB started collecting $500 application fees from all providers in the fee-for-service program except for Physicians, Psychiatrists, Podiatrists, Optometrists, Advance Practice Registered Nurses (APRNs), Physician Assistants, Registered Nurses (RNs), and Dentists on October 1, 2013.
Policy/Procedure Development	The HCSB will develop a policy and procedure that describes collection of provider application fees. This P&P will be completed by September 30, 2014.
Contract or Regulatory Development	No contract or regulatory changes were required for this Corrective Action Plan (CAP) item.
Training	No training was required for this Corrective Action Plan (CAP) item.
Completion Date	September 30, 2014
System Enhancements	No system enhancements will be necessary for this CAP item; system enhancements were completed earlier.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Verifying Beneficiary Receipt of Services	
Finding/Vulnerability	Risk Area 4: Risks were identified in the state's oversight of managed care. Verifying Beneficiary Receipt of Services
Responsible Party	Department of Human Services (DHS), Med-QUEST Division (MQD), Health Care Services Branch (HCSB) and Finance Office, Fiscal Integrity Section (FIS)
Action Plan	<u>Verifying Beneficiary Receipt of Services</u> The DHS has reprocured its managed care contracts under a program called QUEST Integration (QI). The QUEST Integration program combines the QUEST and QExA programs into one. The QI RFP has information that describes a robust verification of services (VOS) program for all of the health plans. The VOS section describes in detail the requirements of the QI health plans. In addition, all health plans are required to submit information on their VOS program quarterly to MQD as part of their fraud and abuse reporting.
Policy/Procedure Development	Not applicable
Contract or Regulatory Development	Section 50.455, Verification of Services, QUEST Integration (RFP-MQD-2014-005)
Training	No training was required for this Corrective Action Plan (CAP) item.
Completion Date	January 1, 2015 - date VOS program implemented for QUEST Integration.
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Capturing Ownership and Control Disclosures at Enrollment/Requesting Business Transaction Information/Capturing Criminal History Disclosures at Enrollment	
Finding/Vulnerability	Risk Area 4: Risks were identified in the state's oversight of managed care. Capturing Ownership and Control Disclosures at Enrollment/Requesting Business Transaction Information/Capturing Criminal History Disclosures at Enrollment
Responsible Party	Department of Human Services (DHS), Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Capturing Ownership and Control Disclosures at Enrollment/Requesting Business Transaction Information/Capturing Criminal History Disclosures at Enrollment</u>: 1. The DHS revised the QUEST and QUEST Expanded Access (QExA) contracts to include language to meet requirements identified in 42 CFR 455 Subpart B. This change in contract language is in Section 40.400, Provider Credentialing, Recredentialing, and other Certification. 2. MQD required its External Quality Review Organization (EQRO) to perform oversight of implementation of these additional provider credentialing standards at a compliance review that occurred in May and June 2014. 3. All five health plans will need to complete a corrective action plan (CAP) to come into compliance with these standards. The CAP is overseen by the EQRO.
Policy/Procedure Development	Not applicable
Contract or Regulatory Development	QUEST and QExA contract amendments - provider credentialing.
Training	Training will be provided to MCEs by October 31, 2014 by Jon Fujii on ownership and disclosure requirements related to this Corrective Action Plan (CAP).
Completion Date	November 30, 2014 - All five health plans will be in compliance with their CAPs with Hawaii's EQRO by this date.
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

ELEMENT	DESCRIPTION
Exclusion Searches	
Finding/Vulnerability	Risk Area 4: Risks were identified in the state's oversight of managed care. Exclusion Searches
Responsible Party	Department of Human Services (DHS), Med-QUEST Division (MQD), Health Care Services Branch (HCSB)
Action Plan	<u>Exclusion Searches</u> 1. The DHS revised the QUEST and QUEST Expanded Access (QExA) contracts to include language to perform checks on the following databases upon enrollment and monthly thereafter: • HHS-OIG List of Excluded Individuals and Entities (LEIE); • The Excluded Parties List System (EPLS) on the System for Award Management (SAM); • National Plan and the Provider Enumeration System (NPPES); and • Social Security Administration Death Master File. 2. MQD will validate at on-site reviews in August 2014 that all five health plans are conducting these searches upon enrollment and monthly thereafter. 3. Any health plan out of compliance will need to complete a corrective action plan (CAP) to come into compliance with these standards. The CAP is overseen by the MQD.
Policy/Procedure Development	The HCSB will develop a policy and procedure for monitoring the health plans process for searching for exclusions. This P&P will be completed by September 30, 2014.
Contract or Regulatory Development	QUEST and QExA contract amendments - provider standards (Section 40.220)
Training	No training will be provided for CAP item.
Completion Date	November 30, 2014 - All five health plans will be in compliance with their CAPs with MQD by this date.
System Enhancements	No system enhancements will be necessary for this CAP item.
Internal Controls/Audits	None for this CAP item.

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Corrective Action Plan

ELEMENT	DESCRIPTION
Finding/Vulnerability	Risk Area 4: Risks identified related to the state's oversight of managed care. Program Integrity Oversight in Managed Care
Responsible Party	Department of Human Services, Med-QUEST Division, Financial Integrity Staff/Finance Office
Action Plan	1. New Quest Integration RFP has been awarded to five Managed Care plans. Financial Integrity Staff is currently reviewing the Program Integrity sections of the RFP 51.300 Fraud & Abuse, 51.320 Reporting and Investigating Suspected Provider Fraud and Abuse, 51.330 Compliance Plan deliverables submitted by the Managed Care Plans. 2. Onsite review with the health plan's Program Integrity health plan staff is planned for August 2014. Discussion will be held with the health plans on their reporting and how their fraud prevention activities can be more transparent with the State. 3. Managed Care plans' quarterly fraud and abuse summaries – The Fraud and Abuse reporting form has been revised to include the health plans reporting all their program integrity activities even if it does not result in a fraud referral and provider suspensions & terminations. 4. MQD Financial Integrity Staff is now monitoring fraud and abuse quarterly reports submitted by Managed Care plans. Contact program integrity staff for clarification/additional information.
Policy/Procedure Development	P&P Oversight of Managed Care Organizations Program Integrity Units, developed by pending approval from Supervisor and Administration.
Contract or Regulatory Development	RFP Sections RFP 51.300 Fraud & Abuse, 51.320 Reporting and Investigating Suspected Provider Fraud and Abuse, 51.330 Compliance Plan with the Managed Care Plans.
Training	Training with managed care plan - program integrity staff.
Completion Date	August 2014 and ongoing.

ELEMENT	DESCRIPTION
System Enhancements	Tracking log created for Managed Care Plan quarterly fraud and abuse reports. Reports also maintained by investigator. Folder located in Public drive-FO-SURS Fraud and abuse.
Internal Controls/Audits	FIS will monitor quarterly Managed Care Reports.

	Med-QUEST Division FINANCE OFFICE OFFICE INTERNAL PROCEDURE	NUMBER	PAGE 1 of 1
		ISSUE DATE: July 31, 2014	
	SUBJECT: OVERSIGHT OVER MANAGED CARE ORGANIZATIONS PROGRAM INTEGRITY UNITS	REVISION DATE:	

1.0 POLICY

The Med-QUEST program shall provide oversight and monitoring of Managed Care Entities (MCE) Program Integrity Units activities to prevent and detect fraud and abuse. Monitor MCE's to ensure policies, processes and procedures in place are sufficient to provide reasonable assurance that they are compliant with Federal and State regulations to help prevent and detect fraud and abuse.

2.0 REFERENCES AND DEFINITIONS

2.1 REFERENCES

Program Integrity Compliance Requirements:

- 42 CFR 438.608(a) The MCE must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.
- 42 CFR 438.608 (b) (1) The MCE must have written policies, procedures, and standards of conduct that articulate its commitment to comply with all applicable Federal and State standards.
- 42 CFR 438.608(b) (2) The MCE must designate a compliance officer and a compliance committee accountable to senior management.
- 42 CFR 438.608 (b) (3) The MCE must provide effective training and education for the compliance officer and its employees.
- 42 CFR 438.608 (b) (4) There must be effective lines of communication between the compliance officer and the organization's employees.
- 42 CFR 438.608 (b) (5) The MCE must enforce standards through well publicized disciplinary guidelines.
- 42 CFR 438.608(b) (6) The MCE must have provisions for internal monitoring and auditing.
- 42 CFR 438.608 (b) (7) The MCE must have provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCE's contract.

2.2 DEFINITIONS (IF REQUIRED)

3.0 PROCEDURE

1) Review Quarterly Fraud and Abuse reports (actions taken against provider suspensions/ terminations, program integrity activities) submitted by the Managed Care plans.

2) Provide technical assistance to managed care organizations for program integrity issues – to assist them to identify fraud and abuse, promote best practices and guidelines from Centers of Medicare and Medicaid Services (CMS) and improve program outcomes.

3) Reviews contract provisions relating to Fraud and Abuse requirements by the managed care plans as appropriate.

4) Provide training to MCO's as needed.

5) Meets with MCO's program integrity staff on an as needed basis or during quarterly health plan meetings to discuss program integrity issues.

APPROVED:

Finance Officer, Med-QUEST Division — Date

APPROVED

Administrator, Med-QUEST Division — Date

PROVIDERS TYPES BY CATEGORICAL RISK

Categorical Risk Level	Provider Types	License Verification	Database Checks	On-site Visit	Background Checks	Comments
Low	Physicians Non-physician practitioners Medical groups or clinics except for physical therapists and physical therapy groups Ambulatory surgery centers End-state renal disease centers Federally qualified health centers (FQHC) Hospitals Mammography screening centers Pharmacies Radiation therapy centers Rural health clinics (RHC) Skilled nursing facilities	Yes, for the following provider types: - Physician - Non-physician practitioners - Occupational Therapy - SLP - ASC - FQHC - Hospital - RHC - Pharmacy - RHC - SNF	Yes, for the following databases: - NPI - LEIE - SAM - Social Security Death Master File - As applying - Monthly	Not unless become moderate risk category.	Yes for SNF.	Offices in Hawaii to see patients. Those without offices to see patients and performing services by telemedicine are in the moderate risk category.
Moderate	Ambulance suppliers Community mental health centers Comprehensive outpatient rehabilitation facilities Hospice organizations Laboratories Diagnostic testing facilities Physical therapy including group practices Home health agencies (currently enrolled)	Yes, for the following provider types: - Hospice - Lab - Physical therapy - Home Health	Yes, for the following databases: - NPI - LEIE - SAM - Social Security Death Master File - As applying - Monthly	Yes.	No.	Offices in Hawaii to see patients. Those without offices to see patients or performing services by telemedicine are in the high risk category.

Categorical Risk Level	Provider Types	License Verification	Database Checks	On-site Visit	Background Checks	Comments
High	Home health agencies (newly enrolling) Suppliers of Durable Medical Equipment and Medical Supplies (new and currently enrolled) Home and community based service (HCBS) providers including but not limited to personal care attendant, skilled nursing, community care foster family homes (CCFFH), expanded adult residential care home (E-ARCH).	Yes, for the following provider types: - Home Health - Durable Medical Equipment - HCBS provider (i.e., CCFFH, E-ARCH)	Yes, for the following databases: - NPI - LEIE - SAM - Social Security Death Master File - As applying - Monthly	Yes.	Yes.	All providers are required to have offices in Hawaii.

MEMORANDUM OF UNDERSTANDING BETWEEN

THE DEPARTMENT OF HUMAN SERVICES

MED-QUEST DIVISION

AND

THE DEPARTMENT OF THE ATTORNEY GENERAL

MEDICAID FRAUD CONTROL UNIT

This Memorandum of Understanding is made between the Department of Human Services, Med-QUEST Division, State of Hawaii (hereinafter referred to as "MQD") and the Department of the Attorney General, Criminal Justice Division, Medicaid Fraud Control Unit, State of Hawaii (herein after referred to as "MFCU").

I. PURPOSE

The MFCU is the Medicaid Fraud Control Unit for the State of Hawaii. The MQD implements, administers, and regulates the Hawaii Medicaid Program and the Medicaid State Plan. MFCU and the MQD enter into this Memorandum of Understanding (Agreement) pursuant to the federal regulations establishing Medicaid Fraud Control Units and Surveillance and Utilization Review Sections. These two parties hereby delineate their respective responsibilities and identify areas where they work jointly to identify, investigate, and process cases of suspected fraud, waste, or abuse as those terms are defined by state or federal law, or other violations under the state Medicaid program.

II. PRINCIPLES

This Agreement is to be interpreted in accordance with the following principles:

(1) The MOD and MFCU are separate and distinct entities of state government with joint and complementary responsibility for the prevention, detection, and investigation of fraud in the Medicaid program.

(2) The MOD and MFCU have a common interest in the prevention, detection, investigation, and prosecution of fraud in the Medicaid program.

(3) The MQD and MFCU recognize that effective administration of the Medicaid program is a prerequisite to efficiently delivering health services and maintaining the fiscal integrity of the State. The MQD and MFCU agree to coordinate their activities whenever necessary to ensure that all Medicaid funds paid by the State shall be for reasonable and proper Medicaid services actually delivered and that any overpayments made by the state Medicaid system will be expeditiously recovered.

(4) The MQD and MFCU recognize the importance of effective criminal and civil prosecution of Medicaid fraud, abuse, and waste in the Medicaid program, and agree to coordinate their activities to achieve that objective.

(5) This Agreement does not give MFCU authority to review the activities of MQD, or to overrule the MQD determination regarding the detection, prevention and recovery efforts of non-fraud related overpayments.

(6) This Agreement does not give MQD authority to review MFCU's activities or to review or overrule MFCU's determination regarding the prosecution or referral for civil or criminal prosecution of suspected civil or criminal fraud.

(7) The prevention, detection, and investigation of fraud in the Medicaid program can best be accomplished by frequent and complete communication and cooperation between the MQD and MFCU.

III. TERMS

(1) Pursuant to federal regulation 42 CFR 455.14, MQD will conduct a preliminary investigation of suspected cases of Medicaid fraud by providers from any source to determine if there is sufficient

evidence to warrant a full investigation by MFCU. That determination shall be based on the existence of a credible allegation of fraud.

a. A credible allegation of fraud is defined under federal regulations as an allegation that has been verified by a State and that has indicia of reliability that comes from any source; fraud includes willful misrepresentation; an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

2. MQD will begin the preliminary investigation no later than the 30th day after the date MQD receives the complaint of, or discovers, the suspected fraud.
3. MQD will complete the preliminary investigation not later than the 90th day after the preliminary investigation begins.
4. If, after the preliminary investigation, MQD has reason to believe there is a credible allegation of fraud or abuse has been perpetrated on the Medicaid system, MQD will refer the suspected case to MFCU in writing no later than the 30th day after the completion of the preliminary investigation.

a. The written referral to MFCU should contain (when practical):

a) Subject (name, Medicaid provider ID, address, provider type)

b) Source/origin of complaint

c) Date reported to State: This is the date on which MQD received the information that the provider being referred might be engaged in illegal behavior. If MQD developed the information on its own, then it should provide the date when MQD initiated an investigation of the provider.

d) Description of suspected intentional misconduct: with specific details including category of service, factual explanation of allegation, specific Medicaid or state statutes, rules, policies, or regulations violated.

e)Date(s) of conduct

f) Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater.

g)All communications between the State Medicaid agency and the provider concerning the conduct at issue.

h) Contact information for State Medicaid agency staff persons with practical knowledge of the workings of the relevant programs.

i) Sample/exposed dollar amount, when available.

5. If a credible allegation of fraud is found, MQD must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud unless the agency has good cause to not suspend payments or to suspend payment only in part as outlined by federal statute 42 CFR 455.23.

    a. MFCU or other law enforcement officials may specifically request that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation. Such a request will be in writing and will be maintained with the preliminary investigation case file. The written good cause request must be submitted to MQD not later than 5 business days after receiving the credible allegation of fraud referral.

    b. If MQD intends to exercise a good cause exception to payment suspension for the benefit of the Medicaid program, that intent will be expressed to MFCU in writing not later than 5 days after referring the credible allegation of fraud to MFCU.

6. On a quarterly basis the MQD must request a certification from MFCU, or other law enforcement agency, that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension or good cause exception.
7. Pursuant to federal regulations, MFCU will review all referrals of fraud received from the MQD, as well as from other sources. MFCU will determine whether the matter requires further investigation for potential criminal or civil prosecution, and shall take such action as deemed warranted in its discretion. MFCU shall advise the MQD in writing as to the resolution of all cases referred by the MQD to MFCU no later than 30 days after the resolution of the case.
8. MQD must provide prior written notice of any planned administrative or civil actions against a provider which has been referred to MFCU while that provider is still under investigation.
9. If MFCU has determined that a referral does not warrant criminal prosecution, the MFCU will return the referral to MQD with recommendation on further action as appropriate.
10. MFCU may initiate judicial proceedings or administrative action to recover overpayments to a health care facility or other provider of assistance under the state Medicaid plan. Alternatively, MFCU may refer collection of overpayment to MQD. This referral should include any evidence of the overpayment to the provider which was uncovered during the MFCU investigation, and summary of the investigation. Upon referral from MFCU and pursuant to federal regulations, MQD will initiate any available administrative or judicial action to recover improper payments to a provider. MQD shall notify MFCU in writing as to the resolution of all cases referred by MFCU to the MQD no later than 30 days after the resolution of the case.

11. The MQD will, as allowed by and in accordance with applicable federal and state confidentiality laws, promptly comply with requests from MFCU for the following:

    a. Access to, and free copies of, any records or information kept by the MQD or its contractors;

    b. Direct computer access to, and computerized data stored by, the MQD or its contractors. This data must be supplied without charge and in the form requested by MFCU;

        i. Requests for data mining projects should be submitted from MFCU to MQD in writing. These requests should list the date requested, time frame of data, data fields needed, and desired format. MQD will maintain a log of data mining projects submitted from MFCU to prevent duplication of efforts. If the request results in substantial cost to MQD or exceeds the requirements of a contract between MQD and another agency, MQD and MFCU will work to modify the request to minimize the financial or workload impact, and remain in compliance with existing contracts.

        ii. MFCU will share with MQD any findings from data mining activities that do not result in fraud investigations, but may indicate overpayments.

    c. Access to any information possessed or maintained by any provider of service under the Medicaid State Plan to which the MOD is authorized access.

12. In using records or information obtained under section III (11), above, MFCU agrees to protect the privacy rights of patients in accordance with the applicable laws and to maintain the records or information in confidential files.
13. The MQD will make its personnel and its contractors, together with the appropriate documentation, available without charge for consultation and as witnesses for such judicial or administrative proceedings as MFCU may pursue.
14. The MQD will provide MFCU with copies of all procedural and policy statements and directives, and all proposed or adopted regulations concerning the MQD. MFCU may also request that the MQD provide other information relevant to the work of MFCU.
15. MFCU will be responsible for reporting criminal convictions to federal authorities, including the Center for Medicare and Medicaid Services (CMS) and the HHS-OIG.
16. MQD will be responsible for reporting provider payment suspensions as well as provider terminations initiated by MQD for cause to the HHS-OIG.
17. The MQD and MFCU will develop and implement cross-training programs as necessary to facilitate their coordinated effort.
18. The MFCU will meet on a quarterly basis with the MQD for purposes to include reviewing the terms of this Memorandum of Understanding, communication between MFCU and MQD, and reviewing the referrals made between MFCU and MQD. The schedule of the meetings will be agreed upon by the MFCU and the MQD.
19. It is expressly understood and agreed by the MQD and MFCU that MFCU operates as a Unit within a division of the DEPARTMENT OF THE ATTORNEY GENERAL, and as such is independent of DHS; MFCU's activities are not subject to review or control by DHS or the MQD.

20. It is expressly understood and agreed by the MFCU and MQD that MQD operates as a unit within a division of the DEPARTMENT OF HUMAN SERVICES, and as such is independent of MFCU. MQD's decision to refer or sanction any provider is not subject to review or control by MFCU.

21. It is recognized that both DHS and the MQD may find it necessary to provide information to government agencies other than MFCU for review, and civil or criminal enforcement.