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Hawaii Medicaid Fraud Control Unit: 2019 Onsite Review

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Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections

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What OIG Found

We identified several contributing factors in three areas that affected the Hawaii Medicaid Fraud Control Unit's (MFCU's or Unit's) low case outcomes during Federal fiscal years (FYs) 2016–18. We found that the MFCU received few fraud referrals from the Medicaid Program Integrity Unit and other stakeholders, which limited the number of cases available for the Unit to investigate and prosecute. The Unit also experienced significant turnover of investigators and lacked sufficient Medicaid fraud cases to adequately train new and inexperienced investigators. Additionally, we found that the MFCU's agreement with Adult Protective and Community Services Branch (referred to as Adult Protective Services or APS) for processing patient abuse and neglect complaints was structured in such a way that it led to the Unit screening thousands of complaints unsuitable for investigation, which diverted the Unit's time and resources from working viable cases with substantial potential for criminal prosecution.

Key Takeaway

The Hawaii MFCU made important strides to improve its operations since the Office of Inspector General's (OIG's) previous onsite review in 2014. Despite these improvements, the MFCU had low case outcomes during FYs 2016–18. During our onsite review in March 2019, we identified issues related to referrals and staffing that contributed to low case outcomes. OIG has provided the MFCU with recommendations to address these issues that, if implemented, should improve its case outcomes.

What OIG Recommends and How the Unit Responded

To address these issues and improve case outcomes, we recommend that the Unit:

- develop and implement a plan to increase Medicaid fraud referrals from the Medicaid agency and other stakeholders;
- develop and expedite an in-house Medicaid fraud training program for Unit investigators; and
- revise the Unit's agreement with APS to establish minimum criteria for a complaint to be sent to the MFCU.

The Unit concurred with all three recommendations.

Full report can be found at oig.hhs.gov/oei/reports/oei-06-19-00110.asp

MFCU Case Outcomes

FYs 2016–18

- 19 indictments
- 12 convictions
- 33 civil settlements and judgments
- $4.3 million in recoveries with $4.1 million from "global"* civil cases, $66,000 from nonglobal civil recoveries, and $147,000 from criminal cases

Why OIG Did This Review

The purpose of this review was to identify and address factors that contributed to the Hawaii MFCU's low case outcomes during FYs 2016–18 and to assess Unit operations. In 2015, OIG issued a report from its 2014 onsite review of the MFCU that raised concerns about the Unit's ability to carry out its statutory functions and meet program requirements. To address the deficiencies identified during OIG's previous onsite review, the MFCU developed and implemented a corrective action plan. Despite this effort, we found that the Hawaii MFCU's case outcomes were low during FYs 2016–18, compared to other similarly sized MFCUs.

*"Global" recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are coordinated by the National Association of Medicaid Fraud Control Units.

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BACKGROUND

Objective

To identify factors contributing to the Hawaii Medicaid Fraud Control Unit's (MFCU's or Unit's) low case outcomes and examine its operations.

Medicaid Fraud Control Units

The function of MFCUs is to investigate Medicaid provider fraud and patient abuse or neglect in facility settings and to prosecute those cases under State law or refer them to other prosecuting offices.[1] Under the Social Security Act (SSA), a MFCU is a "single, identifiable entity of State government," and must be "separate and distinct" from the State Medicaid agency and employ one or more investigators, attorneys, and auditors.[2] Each State must operate a MFCU or receive a waiver.[3] MFCUs operate in 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.[4]

Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[5] In Federal fiscal year (FY) 2019, combined Federal and State expenditures for the Units totaled approximately $302 million, with a Federal share of $227 million.[6]

OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.[7, 8] As part of its oversight, OIG reviews and recertifies each Unit annually and conducts periodic onsite reviews or inspections.

[1] SSA § 1903(q)(3). Regulations at 42 CFR 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential healthcare facilities.
[2] SSA § 1903(q).
[3] SSA § 1902(a)(61).
[4] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.
[5] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal government contributes 90 percent of funding and the State contributes 10 percent of Unit funding.
[6] OIG analysis of MFCUs' FY 2019 reporting of expenditures.
[7] As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports, that detail MFCU income and expenditures.
[8] The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

In its recertification review, OIG examines the Unit's reapplication, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the following: its adherence to published performance standards;[9] its compliance with applicable laws, regulations, and OIG policy transmittals;[10] and its case outcomes. See Appendix A for the 12 performance standards and our assessment of the Hawaii MFCU's adherence to those standards.

OIG further assesses Units' performance by periodically conducting onsite reviews of selected Units. OIG selects Units for onsite reviews based on an annual risk assessment of all Units. Each of the onsite reviews conducted by OIG may identify findings and result in recommendations for improvement. OIG may also make observations on Unit operations and practices, including identifying beneficial practices that may be useful to share with other Units. In addition, OIG provides training and technical assistance to Units, as appropriate, both during the onsite review and on an ongoing basis.

Hawaii MFCU

The Hawaii MFCU is part of the Criminal Justice Division within the Hawaii Department of the Attorney General. The MFCU's office is located in Honolulu, the State capital. The Unit has the authority to prosecute Medicaid fraud and patient abuse and neglect cases. In March 2019, the Unit had 16 employees: 7 investigators, including a supervising special agent; 3 attorneys, referred to as "Deputy Attorneys General," including the MFCU director; 2 auditors; 1 accountant; and 3 support staff, including legal and office assistants.[11] During our review period of FYs 2016–18, the Unit spent approximately $5.5 million (with a State share of approximately $1.4 million).

Referrals. During FYs 2016–18, the Unit reported receiving fraud referrals from several sources, including the State Medicaid agency and private citizens. The Unit reported receiving nearly all of its patient abuse and neglect referrals from Adult Protective and Community Services Branch (referred to as Adult Protective Services or APS), the State agency responsible for providing crisis intervention, including investigation and emergency services for vulnerable adults who are reported to be abused,

[9] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). OIG developed the performance standards in conjunction with the MFCUs, and the standards were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

[10] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals may be found at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

[11] In December 2019, subsequent to our onsite review, one of the MFCU attorneys retired. One of the support staff left the Unit in February 2020. According to the MFCU, both of these positions remained vacant as of March 2020.

neglected, or financially exploited by others, or seriously endangered due to self-neglect.[12] According to the Unit's agreement with APS, the agency forwards all incidents of patient abuse or neglect to the Hawaii MFCU.[13] After APS sends an unscreened complaint to the MFCU, APS evaluates the complaint to decide whether to open its own investigation. If APS opens an investigation, APS shares any relevant information and results from the investigation with the Hawaii MFCU.

When the Unit receives a fraud referral or a patient abuse or neglect complaint, Unit staff enter the information as a "matter" into an electronic case tracking system. Staff then route the matter to one of the Unit attorneys, who screens all incoming referrals on a rotating weekly basis with the other two Unit attorneys. The screening attorney reviews the referral to ensure that it is within the Unit's grant authority and determines whether the referral warrants an investigation. If the attorney determines that the referral is outside of the Unit's jurisdiction or otherwise decides not to proceed with the referral, the Unit closes the matter and possibly refers it to another agency. If the referral requires a jurisdictional check or additional information before the attorney can determine whether to open or close an investigation, the attorney instructs the supervising special agent to conduct a preliminary investigation of the referral.

Investigations and Prosecutions. Once the Unit attorney accepts a referral, the supervising special agent opens a case and assigns an investigator. The attorney meets with the investigator and other team members (e.g., an auditor) to outline and assign key investigative tasks. The Unit stores all case records, including opening documentation, interviews, summaries, case-file reviews, and closing requests, in its electronic case tracking system. If, after the investigation concludes, the attorney determines that the case warrants prosecution, the MFCU director must obtain approval from the supervising Deputy Attorney General within the Criminal Justice Division in the Department of the Attorney General.

[12] Hawaii Department of Human Services, *Adult Protective and Community Services Branch*. Accessed at http://humanservices.hawaii.gov/ssd/home/adult-services/ on August 26, 2019.

[13] Hawaii Administrative Rules § 17-1421-8, February 11, 2010. From this regulation, the MFCU and APS developed an agreement stating that APS shall report all incidents of vulnerable adult abuse or neglect that may involve a crime to the MFCU, regardless of whether the incident is accepted for investigation by APS.

Hawaii Medicaid Program

The Hawaii Medicaid program is administered by the Department of Human Services Med-QUEST Division (MQD). In FY 2018, Hawaii's Medicaid expenditures were approximately $2.3 billion.[14] MQD administers the State's Medicaid fee-for-service and managed care programs.[15] There are five managed care organizations (MCOs) in the State of Hawaii.[16] In FY 2018, 98 percent of Hawaii's approximately 300,000 Medicaid beneficiaries received their services through these 5 MCOs.[17, 18]

Medicaid Program Integrity. MQD and the State's five MCOs are responsible for Medicaid program integrity efforts in Hawaii. Under managed care, MQD contracts with MCOs to process, pay, and monitor claims of providers in the MCOs' networks. Each MCO operates Special Investigative Units that identify and investigate potential fraud and abuse in their networks and refer suspected cases of provider fraud or abuse to MQD.[19] MQD's Program Integrity Unit conducts preliminary investigations on all referrals received (mostly from MCOs, but also including complaints from the public), as well as referrals that are self-generated from the analysis of Statewide Medicaid data. If MQD determines, during its preliminary investigation, that there is a credible allegation of fraud, then MQD refers the allegation to the MFCU. After receiving the referral from MQD, the MFCU has 45 days to decide and inform the program integrity unit whether the MFCU will open a full investigation or decline the referral.

Previous OIG Oversight

In 2015, OIG issued a report from its 2014 onsite review of the MFCU that raised concerns about the Unit's ability to carry out its statutory functions and meet program requirements.[20] OIG recommended that the Unit develop and implement a corrective action plan to address the deficiencies found during the onsite review and to improve the Unit's

[14] OIG, *MFCU Statistical Data for FY 2018*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf on August 22, 2019.
[15] CMS, *Managed Care in Hawaii*. Accessed at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/hawaii-mcp.pdf on August 7, 2019.
[16] The five MCOs in Hawaii include Aloha Care, HMSA, Kaiser Permanente, Ohana Health Plan, and UnitedHealthcare Community Plan. Accessed at https://medquest.hawaii.gov/en/members-applicants/already-covered/health-plans.html on April 23, 2019.
[17] CMS, *2018 09 Preliminary Applications, Eligibility Determinations, and Enrollment Data*. Accessed at https://data.medicaid.gov/Enrollment/2018-09-Preliminary-applications-eligibility-deter/r2w5-6hdx/data on January 28, 2019.
[18] In March 2018, the Hawaii MFCU self-reported, in its annual recertification data submitted to OIG, that approximately 294,000 Medicaid beneficiaries received Medicaid services through MCOs.
[19] 42 CFR § 438.608.
[20] OIG, *Hawaii State Medicaid Fraud Control Unit: 2014 Onsite Review*, OEI-09-14-00540, September 2015.

effectiveness. OIG recommended that the corrective action plan address, at a minimum, how the Unit would accomplish the following: (1) develop and implement effective hiring and training practices that conform to current laws, regulations, and performance standards; (2) revise its memorandum of understanding (MOU) with the Medicaid agency to reflect current law and practice; (3) develop and implement policies and procedures that conform to current laws, regulations, and performance standards; (4) establish regular communication with Federal agencies; (5) develop and implement procedures to ensure Unit staff investigate cases within the grant authority; and (6) establish fiscal controls. OIG assisted the Unit with developing the corrective action plan, which was finalized in November 2015. By January 2017, OIG considered all of the recommendations to have been implemented by the Unit's corrective actions.

In addition to implementing the recommendations from OIG's previous onsite review, the Unit made other changes to its operations. These changes included hiring and integrating new auditors into the investigative teams and further building the Unit's relationships with key stakeholders. In January 2017, a new MFCU director was put in place, and, in March 2018, the Unit relocated its office to a larger and improved space, a process which took 14 months. The new office contains additional storage, which alleviated the Unit's previous need for offsite storage.

Methodology

We conducted our onsite review in March 2019. The review team consisted of OIG evaluators, OIG agents, a grant oversight analyst, and a director from another State MFCU. Our review covered the 3-year period of FYs 2016–18. The primary purpose of the review was to follow up on issues that OIG identified through its ongoing administration and oversight activities. Our pre-onsite analysis identified low case outcomes as an area of concern. We determined that the Hawaii MFCU had low case outcomes by comparing its criminal convictions, civil settlements and judgments, and total recoveries to those of other similarly sized MFCUs during our review period.[21] Our analysis showed that the Hawaii MFCU's case outcomes were among the lowest compared to other similarly sized MFCUs during FYs 2016–18, and its criminal convictions declined from the previous 3-year period. See Appendix B for a detailed methodology. We focused our data collection and analysis on identifying factors contributing to low case outcomes and ways to help the Unit improve its case outcomes. We also analyzed the Unit's operations and adherence to

[21] We identified 13 similarly sized MFCUs based on their staff size, which ranged from 11 to 17 employees (the Hawaii MFCU had between 14 and 16 employees during FYs 2016–18). Although comparing a MFCU's case outcomes with those of similarly sized MFCUs provides some context, we recognize that other factors besides a MFCU's staff size can affect case outcomes.

the 12 performance standards and applicable Federal laws, regulations, and policy transmittals.

We based our review on an analysis of data from seven sources: (1) Unit documentation, such as policies and procedures; (2) structured interviews with key stakeholders; (3) structured interviews with Unit managers and selected staff; (4) a review of a random sample of case files open at some point during the review period; (5) referrals received by the Unit; (6) observation of Unit operations; and (7) documentation associated with the Unit's fiscal controls. We also compared the Unit's results to those of other similarly sized MFCUs. In examining the Unit's operations and performance, we applied the published performance standards listed in Appendix A, but we did not assess every performance indicator for each of the 12 standards.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but are subject to the same internal quality controls as other OIG evaluations, including internal and external peer review.

FINDINGS

We found that, despite the Hawaii MFCU having implemented a corrective action plan to improve its operations following OIG's previous onsite review, the MFCU's case outcomes were low during FYs 2016–18.[22, 23] This review focused on identifying factors that contributed to the Unit's low case outcomes. We identified three areas in which the Unit should improve and for which we are issuing recommendations. We also assessed the Unit's adherence to the 12 MFCU performance standards. See Appendix A for our full assessment of the Unit's adherence to the performance standards, including observations of Unit operations and practices.

The MFCU received few fraud referrals from the Medicaid Program Integrity Unit and other stakeholders, which contributed to low case outcomes; the Unit initiated outreach efforts in FY 2017 to increase referrals

During FYs 2016–18, the Hawaii MFCU received 22 fraud referrals. Of these, 17 referrals came initially from the State's MCOs and were forwarded to the MFCU by MQD, and the remaining 5 referrals came from other sources, such as private citizens. The number of referrals that the Unit received from MQD was low compared to the number of referrals that similarly sized MFCUs received from their State Medicaid program integrity units, which ranged from 1 to 157 referrals during FYs 2016–18. During the previous 3-year period (FYs 2013–15), the Hawaii MFCU received nine fraud referrals from MQD. Appendix C identifies the Hawaii MFCU's referrals, by source, during FYs 2016–18.

The low number of fraud referrals during our review period limited the number of cases that the Unit could investigate and prosecute, which ultimately affected the Unit's case outcomes. Similar to other States, MQD, as the agency housing the Medicaid program integrity function, should be the predominant source of fraud referrals to the MFCU. These referrals may be generated directly by MQD or originate with the MCOs.

In a 2014 report on program integrity oversight of the Hawaii Medicaid program, the Centers for Medicare & Medicaid Services (CMS) found that MQD had limited staff dedicated to essential program integrity functions. CMS found that MQD was not routinely conducting preliminary investigations or referring suspected cases of fraud to the MFCU and

[22] OIG provides information on MFCU operations and outcomes, but does not direct or encourage MFCUs to investigate or prosecute a specific volume or number of cases. All cases investigated by the MFCU should be based upon credible allegations, and MFCU prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

[23] In FY 2019 (after our period of review), the Hawaii MFCU reported four fraud convictions, one of which resulted in a $3.8 million recovery, which represented a substantial increase in the amount of monetary recoveries from previous years.

faced challenges performing other program integrity functions, such as data mining.[24] At the time of the CMS review, the program integrity unit within MQD had only three full-time staff (one investigator and two nurse reviewers). We found that MQD had the same number of staff for this unit in FY 2018, which may have contributed to the low number of referrals that the MFCU received during our review period.

Another factor that we identified as affecting fraud referrals during FYs 2016–18 was a resistance in the community to reporting suspected fraud. In interviews, MFCU staff reported that there is a "cultural resistance" to reporting providers in Hawaii. Staff explained that many communities on the Hawaiian Islands are small and isolated, with limited access to providers, which sometimes makes people less willing to report provider fraud. Staff reported that issues are often addressed within the community, and that there is a tendency to protect community members, including providers, from outsiders (e.g., law enforcement).

Performance Standard 4: A MFCU should take steps to ensure that it receives an adequate volume and quality of referrals.

From interviews, we also found that the MFCU conducted insufficient outreach during the review period to generate and encourage referrals of suspected fraud from the public and other stakeholders (e.g., State licensing boards, local law enforcement agencies) and did not, until recently, meet regularly with MCOs and MQD. We found that the lack of regular meetings constituted a missed opportunity for the MFCU to educate MQD about its role and provide guidance on the information needed in fraud referrals. The MFCU director reported that shortly after assuming her new position in FY 2017, she initiated outreach efforts with the purpose of improving the Unit's relationships with MCOs and MQD—efforts that the previous MFCU director did not undertake. The MFCU director explained that these efforts initially focused on building trust and learning about each other's roles, responsibilities, and internal processes. In interviews, the MFCU and MQD reported that they had recently begun discussing how to improve the process and timeliness of referrals to the MFCU.

[24] CMS, *Medicaid Integrity Program Hawaii Comprehensive Program Integrity Review Final Report*, June 2014. Accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/HIfy13.pdf on March 28, 2019.

The Unit experienced significant turnover of investigators and lacked sufficient fraud cases to adequately train new, inexperienced investigators on Medicaid fraud

During FYs 2017–18, the Unit experienced significant turnover of staff when more than half (four of six) of its investigators retired or resigned from the MFCU. Among those who left were two experienced investigators who played key roles in the MFCU's fraud investigations. We found that the departure of the former staff created a knowledge gap within the MFCU, particularly related to Medicaid fraud investigations, which contributed to the Unit's low case outcomes. The staff turnover, coupled with the small number of fraud referrals received during our review period, limited the Unit's ability to provide new investigators with adequate on-the-job fraud training and opportunities to work alongside experienced Medicaid fraud investigators.

At the time of our onsite review, the Unit had filled all of its vacant investigator positions, but none of the new investigators had prior experience investigating Medicaid fraud, and they had limited knowledge about Medicaid policy and regulation. All of the new investigators were former police officers in the Honolulu Police Department and had extensive investigative experience in other areas of law enforcement, such as homicide and narcotics. During interviews, some of the new investigators reported that although they had received some guidance from the MFCU attorneys and other investigators regarding fraud investigations, they would benefit from fraud-specific training. At the time of our review, three of the five new investigators were each working one fraud case, one investigator was working two fraud cases, and the remaining investigator had no active fraud cases.

The MFCU's agreement with Adult Protective Services for processing patient abuse and neglect complaints led to the Unit screening thousands of complaints unsuitable for investigation, which diverted time and resources from viable cases

Unlike in most other States where APS screens potential cases of patient abuse or neglect before referring them to the MFCU, the Hawaii MFCU's agreement with APS requires APS to forward all complaints to the MFCU without screening them for credibility or need for investigation. During FYs 2016–18, the MFCU reported receiving a total of 5,948 unscreened patient abuse or neglect complaints from APS, averaging nearly 2,000 complaints each year.

5,948

unscreened patient abuse and neglect complaints sent to the MFCU during FYs 2016–18; less than 5 percent resulted in investigations

Given that APS did not screen the complaints before sending them to the MFCU, many of the complaints had inaccurate or incomplete information (e.g., names, birth dates) or were not within the MFCU's jurisdiction. Consequently, Unit investigators reported that, as part of screening the complaints, they often had to collect additional information, which could include interviewing witnesses or consulting with other State and law enforcement agencies, such as the State Department of Health and the Honolulu Police Department. From interviews with APS, we found that

the same information was sometimes collected both by APS, for its own investigation after referring the complaint to the MFCU, and by the MFCU.

MFCU staff explained that once the Unit investigators had concluded the initial collection of information, the MFCU attorneys would determine whether to open an investigation—a role that other MFCUs typically assign to the supervising special agent—providing a significant distraction from the prosecutorial work of the attorneys. Given the large number of complaints received from APS, the Unit spent a considerable amount of time screening complaints that were ultimately determined unsuitable for formal investigation, which diverted both time and resources from the Unit working viable cases with substantial potential for criminal prosecution. We determined that less than 5 percent (297 of 5,948) of the complaints that the Unit received from APS during FYs 2016–18 resulted in the Unit opening an investigation. After our onsite review, the Unit reported improvements with the many unscreened complaints that they received from APS. According to Unit investigators, APS improved the accuracy and completeness of the information that APS included in the complaints.

CONCLUSION AND RECOMMENDATIONS

OIG identified contributing factors in three areas that affected the Hawaii MFCU's low case outcomes during FYs 2016–18. The Unit received few fraud referrals from the Medicaid Program Integrity Unit and other stakeholders, which limited the number of cases available for the Unit to investigate and prosecute. The Unit also experienced significant turnover of investigators, which created a knowledge gap, particularly for Medicaid fraud investigations. The lack of experienced fraud investigators coupled with the small number of fraud referrals that the MFCU received made it difficult for the Unit to adequately train new investigators who had no previous experience investigating Medicaid fraud. In contrast to the low number of fraud referrals that the Unit received, the Unit was inundated with unscreened and incomplete patient abuse or neglect complaints from APS, most of which did not lead to the Unit opening a case. To assess the many complaints, the Unit had to divert time and resources from viable cases and other efforts, which may have adversely affected the case outcomes of the Unit.

To address the issues identified in this report and further improve Unit operations, we recommend that the Hawaii MFCU:

Develop and implement a plan to increase Medicaid fraud referrals from the Medicaid agency and other stakeholders

Given that the Unit received few fraud referrals from its stakeholders during our 3-year review period, the MFCU should take additional steps to ensure that it receives an adequate number of fraud referrals from its stakeholders. The Unit should continue to build upon its outreach efforts to MQD and MCOs and provide periodic feedback to them on the adequacy of both the volume and quality of referrals. To further increase referrals, the Unit could conduct outreach with other groups, such as professional associations and provider and beneficiary organizations, about the MFCU's role in investigating provider fraud and when and how to report potential fraud. The Unit may also want to review and consider adopting relevant beneficial practices of other MFCUs described in Appendix B of the OIG FY 2019 MFCU Annual Report.[25]

[25] OIG, *At a Glance: Medicaid Fraud Control Units Fiscal Year 2019 Annual Report*. Accessed at https://oig.hhs.gov/oei/reports/oei-09-20-00110.asp on April 7, 2020.

Develop and expedite an in-house Medicaid fraud training program for Unit investigators

Given that the Unit has relatively new investigators with limited fraud experience, the Unit should develop and expedite Medicaid fraud training for its investigators. The Unit's training program could include relevant education and training through webinar programs offered by other organizations, such as the National Health Care Anti-Fraud Association and the Association of Certified Fraud Examiners. The Unit could also coordinate with the National Association of Medicaid Fraud Control Units (NAMFCU) and/or OIG to identify training in Medicaid fraud. Additionally, the Unit should continue to work joint fraud cases with Federal partners; this would provide Unit investigators with relevant training and experience in Medicaid fraud. For additional ways to develop a training program, the MFCU could review and adopt relevant beneficial practices of other MFCUs described in Appendix B of the OIG FY 2019 MFCU Annual Report.[26]

Revise the Unit's agreement with Adult Protective Services to establish minimum criteria for a complaint to be sent to the MFCU

The MFCU should work with APS to establish and apply a standard for deciding when to refer patient abuse and neglect complaints to the MFCU. In applying such a standard, APS would have the tools to screen the complaints (which is common practice for APS and other administrative agencies in other States) to determine whether the complaints meet certain minimum criteria for a referral to be sent to the MFCU. The revised policy should reduce the number of inaccurate and incomplete complaints and reduce duplication between the two agencies, thereby promoting Unit efficiency and case flow. The MFCU should also monitor the flow and quality of the complaints and, as necessary, provide training to APS regarding the complaints.

[26] Ibid.

UNIT COMMENTS AND OIG RESPONSE

The Hawaii MFCU concurred with all three of our recommendations.

First, the MFCU concurred with our recommendation to develop and implement a plan to increase Medicaid fraud referrals from the Medicaid agency and other stakeholders. The MFCU stated that it is meeting with the Medicaid agency and managed care organizations on a monthly basis to share information on cases and for relationship building. The Unit also reported that it has implemented a simultaneous case reporting system with the managed care organizations. Fraud referrals are now being sent to both the Medicaid agency and the Hawaii MFCU, which has resulted in a significant increase in the number of fraud referrals that the Unit receives.

Second, the MFCU concurred with our recommendation to develop and expedite an in-house Medicaid fraud training program for Unit investigators. The MFCU reported that it has provided several webinar trainings for its investigators through the National Health Care Anti-Fraud Association. The MFCU noted that it will continue to seek out training opportunities for their investigators and will partner with OIG and other Federal agencies to work joint fraud cases.

Third, the MFCU concurred with our recommendation to revise the Unit's agreement with APS to establish minimum criteria for a complaint to be sent to the MFCU. The Unit reported that it has met with APS to establish such criteria, which has significantly reduced the number of complaints that the MFCU receives from APS. This has allowed the Unit to spend more time on viable cases, rather than allocating time and resources to screening cases deemed unsuitable for investigation.

For the full text of the Unit's comments, see Appendix E.

APPENDIX A: Performance Assessment

We identified the Hawaii MFCU's case outcomes and assessed its adherence to the 12 MFCU performance standards, including its compliance with applicable laws, regulations, and policy transmittals. From this review, we identified three areas in which the Unit should improve its adherence to program requirements (presented here and as findings in the report) and made other observations about Unit operations and practices. A complete publication of the performance standards, including performance indicators, may be found at 77 Fed. Reg. 32645 (June 1, 2012), and on OIG's website at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/.

CASE OUTCOMES

Observation

The Hawaii MFCU reported 19 indictments; 12 convictions; and 33 civil settlements and judgments for FYs 2016–18.

Of the 12 convictions, 8 involved provider fraud and 4 involved patient abuse or neglect.

The Unit reported $4.3 million in combined civil and criminal recoveries. The Unit reported total recoveries of approximately $4.3 million during FYs 2016–18, with global civil recoveries representing $4.1 million, nonglobal civil recoveries $66,000, and criminal recoveries $147,000. Global civil cases are False Claims Act cases that involve the U.S. Department of Justice and a group of MFCUs. NAMFCU facilitates the settlement of global cases on behalf of the States. Nonglobal civil cases are conducted by individual MFCUs or with other law enforcement partners, and are not coordinated by the NAMFCU.

STANDARD 1	A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation

From the information we reviewed, the Hawaii MFCU complied with applicable laws, regulations, and policy transmittals. We did not identify any legal or compliance concerns related to Unit operations, which was an improvement from OIG's previous onsite review in 2014. During the prior review, we found that the Unit did not comply with all Federal regulations or adhere to all MFCU performance standards. For example, the Unit investigated cases that were outside of its grant authority. We did not identify any such issues during our 2019 onsite review.

STANDARD 2	A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Observation

The Unit maintained staff levels and office locations in accordance with its approved budget. According to Performance Standard 2(b), the Unit should employ a total number of professional staff that is commensurate with the State's total Medicaid program expenditures and that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect.

Following OIG's last onsite review, the Unit took steps to hire an experienced auditor to comply with Federal regulations. After filling the auditor position, the Unit met the requirement of having an appropriate mix of attorneys, investigators, and auditors. Despite significant turnover of investigators, the Unit employed an adequate number of staff to fulfill its mission and objectives during FYs 2016–18. The Unit also improved its office space when it moved to a new office location in FY 2018 that provided a larger space that was not shared with another State agency.

Finding

The Unit experienced significant turnover of investigators and lacked sufficient fraud cases to adequately train new, inexperienced investigators on Medicaid fraud. See page 9.

STANDARD 3	A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

Observation

The Unit maintained written policies and procedures. The Unit maintained a Policy and Procedures Manual that was available to Unit staff electronically on the shared network drive. Hard copies of the manual were also available on the Unit's reference bookshelf. The Unit created this manual in response to OIG's recommendations following the 2014 onsite review, during which we found that the Unit did not maintain policies or procedures specific to its operations. Each employee acknowledged that they had read and understood the manual by signing off on a manual log. The manual included general guidelines on the roles and responsibilities of Unit staff as well as specific procedures related to investigative processes.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Finding

The MFCU received few fraud referrals from the Medicaid Program Integrity Unit and other stakeholders, which contributed to low case outcomes; the Unit initiated outreach efforts in FY 2017 to increase referrals. See page 7.

Finding

The MFCU's agreement with Adult Protective Services for processing patient abuse and neglect complaints led to the Unit screening thousands of complaints unsuitable for investigation, which diverted time and resources from viable cases. See page 9.

STANDARD 5	A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation

Nearly all Unit case files contained documentation of supervisory approval of the opening and closing of investigations and periodic supervisory reviews. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations; review the progress of cases; and take action as necessary to ensure that each stage of an investigation and prosecution is completed within an appropriate timeframe. Our review found that nearly all of the sampled case files contained documentation of supervisory approval of case openings and closings. An estimated 99 percent of case files had supervisory approval to open the cases for investigation. At the time of our review, an estimated 91 percent of cases were closed, and we

estimated that all of the closed cases had supervisory approval to close. An estimated 58 percent of cases were open longer than 90 days and thus subject to periodic supervisory reviews. Of these cases, an estimated 96 percent of case files had periodic supervisory reviews consistent with MFCU policies. The Unit had significantly improved its supervision of cases since OIG's 2014 onsite review, when we found that an estimated 71 percent of case files lacked documentation of periodic supervisory reviews.

STANDARD 6	A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation

The Unit's caseload included a broad mix of provider types. At the end of FY 2018, the Unit's cases included 36 provider types, including physicians, licensed practitioners, healthcare facilities, and medical service providers.

Observation

The Unit pursued few nonglobal civil fraud cases. Performance Standard 6(e) states that Units should seek to maintain, consistent with their legal authority, a balance of criminal and civil fraud cases. Hawaii enacted a False Claims Act in 2000, which provides the Unit with a basis to pursue its own nonglobal cases.[27] However, only 3 percent of the Unit's cases (10 of 331) during FYs 2016–18 were nonglobal civil fraud cases. Nonglobal cases involve primarily State rather than Federal litigation; are pursued separately by Units or with other law enforcement partners; and are not coordinated by NAMFCU. At the time of our onsite review, 5 of the 10 nonglobal civil cases were still in the investigative stage.

Several factors contributed to the Unit's few nonglobal civil fraud cases during our review period. In addition to the Unit receiving few fraud referrals, the MFCU director reported that the Unit was focusing primarily on criminal prosecutions, consistent with its law enforcement mission, rather than nonglobal civil judgments and settlements. The MFCU director also reported, similar to other States, receiving few whistleblower complaints under the qui tam provisions of the Hawaii Civil False Claims Act. Further, the Unit reported resource constraints and other practical and legal barriers to pursuing nonglobal civil fraud cases. After our onsite review, the Unit reported that it was exploring avenues for producing more nonglobal civil cases, including screening referrals for potential civil action and opening a civil case when the facts do not support a criminal fraud case.

[27] Hawaii State Statutes §§ 661-21—661-31.

STANDARD 7	A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Observation

The Unit generally maintained case files in an effective manner, but some practices did not allow for efficient access to case information. According to Performance Standard 7(e), the Unit should have an information management system that manages and tracks case information from initiation to resolution. The Unit used an electronic case-file system that records and tracks all case information. Overall, we determined that the case files were adequately maintained, but observed some practices that did not allow for efficient access to case information. For example, we found that Unit staff sometimes entered multiple documents into the electronic case management system containing separate yet repetitive pieces of information. Some documents were not named or lacked a descriptive title. We also found that once some cases were closed, the Unit would scan any remaining paper case files as a single attachment rather than attaching and labeling each document separately. This made it difficult to locate particular documents and other information quickly and to understand investigations in their entirety. Based on our observations, we provided the Unit with technical assistance to further enhance its use of the electronic case management system.

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other healthcare fraud.

Observation

The Unit established communication with Federal law enforcement partners and investigated cases jointly with OIG, but did not investigate cases with the U.S. Attorney's Office. The Unit's collaboration with OIG had improved since the 2014 onsite review. The MFCU established regular communication, held regularly scheduled meetings (at least once a quarter), and maintained a positive working relationship with OIG. During the quarterly meetings, the MFCU and OIG discussed new and potential cases, the sharing of resources, and training opportunities. The Unit investigated five joint cases with OIG during FYs 2016–18.

The U.S. Attorney's Office also reported that its relationship and communication with the MFCU had improved in recent years. Both the Unit and the U.S. Attorney's Office reported an interest in working cases together in the future, but, at the time of our review, the Unit had not presented any cases to the U.S. Attorney's Office for prosecution.

Observation

The Unit reported nearly all convictions and adverse actions to Federal partners within appropriate timeframes. Standard 8(f) states that the Unit should transmit to OIG all pertinent information on convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders, so that convicted individuals could be excluded from Federal healthcare programs. The Unit transmitted all but one conviction to OIG within 30 days of sentencing, with the remaining conviction transmitted 49 days after sentencing. Similarly, the Unit reported all but one of the adverse actions to the National Practitioner Data Bank within 30 days of the final action occurring, which is a Federal requirement.[28] This was an improvement from OIG's 2014 onsite review, when we found that 68 percent of adverse actions were reported to the National Practitioner Data Bank more than 91 days after the final adverse action. The Unit explained that it had improved submission rates to OIG and the National Practitioner Data Bank by delegating all submitting and monitoring duties to its legal assistant.

STANDARD 9

A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation

The Unit did not make recommendations to the State Medicaid agency during our review period. Performance Standard 9 states, in part: "[T]he Unit, when warranted and appropriate, makes statutory recommendations to the State legislature [. . . or] makes other regulatory or administrative recommendations regarding program integrity issues to the State Medicaid agency." The MFCU did not identify any items that warranted a program recommendation during our review period.

STANDARD 10

A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

Observation

The Unit's MOU with the State Medicaid agency reflected current practice, policy, and legal requirements. The 2014 OIG onsite review found that the Unit's MOU with MQD did not reflect current law or practice. During FYs 2016–18, the Unit had a current MOU with MQD that had been amended on July 7, 2015. The MOU reflected current practice, policy, and legal requirements. The MOU was renewed in June 2019.

[28] 45 CFR 60.5. See also SSA § 1128E(g)(1) and 45 CFR 60.3.

STANDARD 11	A Unit exercises proper fiscal control over its resources.

Observation

From our limited review, we did not identify deficiencies in the Unit's fiscal control of its resources. From the responses to a detailed fiscal-controls questionnaire and interviews with fiscal staff, we identified no issues related to the Unit's budget process, accounting system, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.

STANDARD 12	A Unit conducts training that aids in the mission of the Unit.

Finding

The Unit experienced significant turnover of investigators and lacked sufficient fraud cases to adequately train new, inexperienced investigators on Medicaid fraud. See page 9.

Observations

MFCU professional staff generally met the requirements outlined in their annual training plans; however, the MFCU did not always track and verify that requirements had been met. We found that the Unit maintained a training plan for all professional disciplines (i.e., attorneys, investigators, and auditors) during FYs 2016–18. The training plans required professional staff to complete a minimum number of training hours annually. This was an improvement from OIG's 2014 onsite review, which found that the Unit lacked training plans for its professional staff. In reviewing the Unit's training records for FYs 2016–18, we found that the MFCU professional staff generally met their training requirements. However, we identified several instances where Unit investigators and auditors were noncompliant with parts of their training plans.

According to Performance Standard 12(b), the Unit should ensure professional staff's compliance with their training plans and maintain records of the staff's compliance. In reviewing the Unit's training records, we found that the Unit did not have a system for tracking and verifying whether staff met their training requirements. For example, the training documentation that OIG received from the Unit included names of professional staff who attended trainings and the dates and locations of those trainings, but lacked information necessary for assessing compliance (e.g., corresponding hours for each completed training). The lack of a tracking system for completed training hours can limit the Unit's ability to ensure that staff receive all necessary trainings and affect the Unit's overall effectiveness, especially during times of significant staff turnover.

MFCU staff reported challenges with attending some valuable trainings. MFCU staff reported that it was sometimes difficult for staff to attend professional trainings, particularly those provided on the U.S. mainland, because it was cost prohibitive due to the remoteness of Hawaii. For example, roughly two thirds of the MFCU investigators hired during our review period were unable to attend trainings provided by NAMFCU within their first year on the job. Unit management explained that the ability to attend a NAMFCU training is subject to available funding and supervisory approval. NAMFCU trainings, while highly valuable, are often booked well in advance due to their popularity, and some of the Unit's new investigators were placed on a wait-list as a result.[29]

[29] NAMFCU offers MFCU employees several 3-day training courses, including Medicaid 101, an introduction to Medicaid fraud; Medicaid 102A, which focuses on four areas of fraud and is designed for experienced MFCU employees; Medicaid 102B, which focuses on three additional areas of fraud; and Medicaid 103, which focuses on complex fraud schemes within different topic areas and is designed for the most experienced MFCU employees.

APPENDIX B: Detailed Methodology

The onsite review team consisted of OIG evaluators and agents, as well as a director from another State MFCU. Our pre-onsite analysis identified low case outcomes as an area of concern. To assist the Unit in identifying ways to improve its case outcomes, we focused our data collection and analysis primarily on the factors that contributed to low case outcomes during FYs 2016–18.

We analyzed qualitative and quantitative data from a variety of sources, including:

- case outcome data;
- referral data associated with the MFCU;
- other documentation that the MFCU submitted to OIG;
- structured interviews with MFCU staff and key stakeholders;
- onsite review of case files;
- onsite observations; and
- documentation related to the MFCU's fiscal controls.

Data Collection and Analysis

Case outcomes. Prior to the onsite visit, we examined statistical reports and other documentation that the MFCU submitted to OIG. This included MFCU case outcome data pertaining to FYs 2016–18 and the previous 3-year period (FYs 2013–15). We examined five case outcome measures: (1) the number of fraud convictions; (2) the number of convictions of patient abuse or neglect; (3) the amount of monetary recoveries associated with criminal convictions; (4) the number of civil settlements and judgments; and (5) the amount of monetary recoveries associated with civil cases.

For each measure, we performed two types of comparative analysis. We compared outcomes for the Hawaii MFCU during each period of 3 fiscal years to determine whether outcomes changed during FYs 2016–18. We also compared Hawaii's case outcomes for FYs 2016–18 to those of other similarly sized MFCUs.[30] In FY 2018, 13 similarly sized MFCUs had staffs ranging in size from 11 to 17 employees; the Hawaii MFCU had a staff size of 16 employees. Our analysis showed that the Hawaii MFCU's case outcomes were among the lowest compared to other similarly sized MFCUs during FYs 2016–18 and its criminal convictions had declined from the previous 3-year period. The low case outcomes were true for both criminal and nonglobal civil cases. Exhibit B-1 displays the

[30] Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than a MFCU's staff size can affect case outcomes.

Hawaii MFCU's case outcomes during FYs 2016–18 and FYs 2013–15, and the median for case outcomes among other similarly sized Units during FYs 2016–18.[31]

Exhibit B-1: Hawaii MFCU case outcomes during FYs 2016–18 compared to those from the previous 3-year period and those of other similarly sized MFCUs

Type of Case	Outcome	Hawaii MFCU		Similarly Sized MFCUs
		FYs 2013–15	FYs 2016–18	FYs 2016–18 Median
Criminal	Indictments	19	19	37
	Fraud convictions	12	8	20
	Patient abuse or neglect convictions	12	4	4.5
	Criminal recoveries	$147,401	$147,021	$1,214,379
Nonglobal Civil	Settlements and judgments	3	5	7.5
	Recoveries	$261,000	$65,678	$3,431,948
Global Civil	Settlements and judgments	26	28	31
	Recoveries	$5,072,487	$4,063,624	$8,565,833

Source: OIG, *Medicaid Fraud Control Units, Expenditures and Statistics*. Accessed at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp on April 23, 2019.

Referrals of fraud and patient abuse or neglect. We examined data associated with referrals that the MFCU received from a variety of sources. This included the number of referrals that the MFCU reported receiving during FYs 2016–18; the number of referrals from the previous 3-year period; and the number of referrals received by other similarly sized MFCUs during FYs 2016–18. These referral-related data included referrals relating to both general types of cases that the MFCU handles: those regarding fraud and those regarding patient abuse or neglect. We also examined the processes that the MFCU used for monitoring the opening of cases, and we examined the outcomes of cases. We also reviewed the MFCU's MOU with the Hawaii Medicaid program, which is administered by MQD.

Other documentation. We examined the MFCU's policies and procedures and held discussions with MFCU management to gain an understanding of those policies and procedures. We confirmed with the MFCU director that the information we had was current, and we requested any additional data and clarification that we needed to perform this review. We also examined data associated with the MFCU's staff, both to identify the number of MFCU staff and to determine how long each staff member had

[31] In FY 2019 (after our review period), the MFCU reported four fraud convictions, one of which resulted in a $3.8 million recovery, which represented a substantial increase in the amount of monetary recoveries from previous years.

been at the MFCU during the period of FYs 2016–18. Finally, we analyzed data on annual training to evaluate the MFCU staff's adherence to its training plans.

Interviews with the MFCU staff and director. We conducted interviews with 11 MFCU staff, including the MFCU director.[32] These interviews focused on case outcomes—specifically, why they were low during FYs 2016–18 and how to improve them. The interviews were informed by our analysis of the MFCU's case-outcomes data, other documentation, and stakeholder interviews. We asked MFCU staff to provide us with any additional context that could help us understand the MFCU's operations. Subsequent to the onsite review, we followed up with the MFCU director to clarify certain data we collected onsite and to gather further information.

Key stakeholder interviews. In February and March 2019, we interviewed individual stakeholders from nine entities who were familiar with the MFCU's operations. Staff conducting the structured interviews included OIG evaluators and agents and a MFCU director from another State. Stakeholders whom we interviewed included: a supervisor and manager from MQD; a special agent with the State's Department of Public Safety Narcotics Enforcement Division; a manager from APS; the supervising Deputy Attorney General in the Criminal Justice Division of the Department of the Attorney General;[33] representatives from the State's largest MCOs; managers, attorneys, and an investigator with the U.S. Attorney's Office; two agents from the Defense Criminal Investigative Service within the Department of Defense Office of Inspector General; two agents from the Federal Bureau of Investigation; and another OIG agent who worked closely with the MFCU.

We focused these interviews on: (1) the MFCU's relationship and interactions with these entities; (2) any areas in which stakeholders believed the MFCU had opportunities for improvement; and (3) practices that may be beneficial to the MFCU's operations or to other MFCUs. As needed, we followed up with some of the interviewees after the onsite review.

Case-file reviews. We asked the MFCU to provide us with a list of cases that were open at any point during FYs 2016–18, and we asked the Unit to include the current status of the case; whether the case was criminal, civil, or global; and the date on which the case was opened and closed, if applicable. The total number of cases that met these parameters was 464. We then excluded a total of 138 cases from our review. We excluded 133 global cases because they are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a

[32] We did not interview all support staff.

[33] The supervising Deputy Attorney General supervises the MFCU director.

group of State MFCUs. We also excluded five agency assist cases because the Unit does not lead these investigations; instead, the Unit provides assistance to another law enforcement agency in charge of the case.

From the 326 remaining case files, we selected a simple random sample of 84 cases. With the assistance of OIG agents and the MFCU director from another State, we reviewed the MFCU's processes for monitoring the opening, status, and outcomes of these cases.[34] We also reviewed the MFCU's approach to investigating and prosecuting cases that were open at some point during FYs 2016–18.

Onsite observations. While onsite, we examined the MFCU's workspace and operations to identify any instances of nonadherence to performance standards and/or instances of noncompliance with applicable Federal laws, regulations, and OIG policy transmittals. We also evaluated the security of the MFCU's case files and the functionality of the MFCU's electronic system for tracking case files. Our examination of the MFCU's workspace and operations while onsite did not result in any findings.

Review of MFCU financial documentation. We conducted a limited review of the MFCU's control over its fiscal resources. Prior to the onsite review, we analyzed the MFCU's response to an internal-controls questionnaire and conducted a desk review of the MFCU's financial status reports. We followed up with MFCU officials to clarify issues identified in the internal-controls questionnaire. We also selected a purposive sample of 30 items from the current inventory list of 158 items required to be maintained in the MFCU's office and verified those items resided onsite.

[34] To verify—in the absence of documentation—whether the periodic reviews for these files had been conducted, we followed up with the MFCU staff.

APPENDIX C: Hawaii MFCU Referrals Received, by Source, FYs 2016–18

Exhibit C-1: Hawaii MFCU referrals received during FYs 2016–18, separated by source and type of criminal case

	FY 2016		FY 2017		FY 2018		3-Year Total		
Referral Source	**Fraud**	**Abuse & Neglect[1]**	**Fraud**	**Abuse & Neglect**	**Fraud**	**Abuse & Neglect**	**Fraud**	**Abuse & Neglect**	**Total**
Adult Protective Services	0	1,737	0	1,909	0	2,302	0	5,948	5,948
Anonymous	0	0	0	0	1	1	1	1	2
HHS—Office of Inspector General (OIG)	0	0	0	0	0	0	0	0	0
Long-Term Care Ombudsman	0	0	0	0	0	0	0	0	0
Managed Care Organizations	0	0	0	0	0	0	0	0	0
Medicaid Agency—MQD	8	0	7	0	2	0	17	0	17
Other Law Enforcement	0	0	0	0	0	0	0	0	0
Private Citizens	0	0	0	0	3	3	3	3	6
Private Health Insurer	0	0	0	0	0	0	0	0	0
Provider	0	0	0	0	0	0	0	0	0
State Agency—Other	0	0	0	0	1	0	1	0	1
Other	0	0	0	0	0	1	0	1	1
Total	**8**	**1,737**	**7**	**1,909**	**7**	**2,307**	**22**	**5,953**	**5,975**

Source: OIG analysis of Unit Annual Statistical Reports FYs 2016–18.

[1] The category "Abuse & Neglect" includes patient fund referrals.

APPENDIX D: Point Estimates and 95-Percent Confidence Intervals of Case-File Reviews

Exhibit D-1: Point estimates and 95-percent confidence intervals of case-file reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Had Supervisory Approval To Open	84	98.8%	94.0%	99.7%
Percentage of All Cases Closed at the Time of Our Review	84	90.5%	83.1%	95.5%
Percentage of All Closed Cases That Had Supervisory Approval To Close	76	100.0%	95.7%	100.0%
Percentage of All Case Files Open Longer Than 90 Days	84	58.3%	48.3%	67.7%
Percentage of All Cases Open Longer Than 90 Days and That Had Periodic Supervisory Reviews At Least Every 90 Days	49	95.9%	87.0%	99.0%

Source: OIG analysis of Hawaii MFCU case files, 2019.

APPENDIX E: UNIT COMMENTS

DAVID Y. IGE
GOVERNOR

CLARE E. CONNORS
ATTORNEY GENERAL

DANA O. VIOLA
FIRST DEPUTY ATTORNEY GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
CRIMINAL JUSTICE DIVISION
MEDICAID FRAUD CONTROL UNIT
707 RICHARDS STREET, SUITE 402
HONOLULU, HAWAII 96813
(808) 586-1058
(808) 586-1077 (fax)

June 12, 2020

Suzanne Murrin
Deputy Inspector General
For Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services

RE: OEI-06-19-00110

Dear Ms. Murrin:

Thank you for your team's efforts in assisting the Hawaii Medicaid Fraud Control Unit (MFCU) in its pursuit to protect Hawaii's most vulnerable citizens and ensure the viability of and access to our state's Medicaid program. As a result of HHS OIG 2019 onsite audit, three recommendations have been brought to our attention.

The first recommendation was that the MFCU develop and implement a plan to increase Medicaid fraud referrals from the Medicaid agency and other stakeholders. The MFCU concurs with the recommendation.

The MFCU has been holding consistent monthly meetings with Med-Quest and the health plans in order to build better relationships amongst our agencies and to share information on cases. The MFCU has also implemented a simultaneous case reporting system with the health plans so that cases no longer languish within the Med-Quest agency.

In the past, the health plans would send their potential fraud cases to Med-Quest for investigation. However, we found that process to be very time consuming and slow. Therefore, we asked the health plans to refer potential cases of fraud to us at the same time they refer a case to Med-Quest. This allows our investigators to begin work on the case to determine whether fraud has occurred, rather than waiting for and relying on Med-Quest to refer the case to us. This change of process alone has resulted in a significant increase in the

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number of fraud referrals to our Unit. In addition, we have provided training and outreach to the health plans, law enforcement, Adult Protective Services and other agencies that we collaborate with to familiarize them with our Unit.

The second recommendation was for the MFCU to develop and expedite an in-house Medicaid fraud training program for Unit investigators. The MFCU concurs with the recommendation and has provided a number of webinar trainings for its investigators through the National Health Care Anti-Fraud Association. The MFCU will continue to seek out training opportunities our investigators and will continue to partner with OIG and Federal partners to work joint fraud cases.

The third recommendation was for the MFCU to revise the Unit's agreement with Adult Protective Services (APS) to establish minimum criteria for a complaint to be sent to the MFCU. The MFCU concurs with the recommendation. We have since met with and worked with APS to establish criteria for a complaint to be sent to our Unit. This has significantly cut down the number of complaints that APS sends to our office allowing us to spend more time on viable cases, rather than allocating time and resources screening cases that do not fall within our jurisdiction.

I hope that his letter serves as an acceptable response to the recommendation of HHS OIG. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Dawn S. Shigezawa, Director
Hawaii MFCU

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ACKNOWLEDGMENTS

Anthony Soto McGrath served as the team leader for this study. Others in the Office of Evaluation and Inspections (OEI) who conducted the study include Anna Brown, Kristen Calille, and Petra Nealy. Medicaid Fraud Policy and Oversight Division staff who participated in the review include Susan Burbach. OEI staff who provided support include Kevin Farber and Frank Rogers.

Office of Investigations staff and a peer reviewer from another State MFCU also participated in this review.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Petra Nealy, Deputy Regional Inspector General, as well as in consultation with Richard Stern, Director of the Medicaid Fraud Control Policy and Oversight Division.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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