SB 323

Measure Title:	RELATING TO HEALTH INSURANCE.
Report Title:	Medicaid; CHIP; Technology; Fraud; Waste; Abuse
Description:	Requires the State to implement certain cost-savings programs and technologies in the medicaid and children's health insurance programs to reduce fraud, waste, and abuse.
Companion:	
Package:	None
Current Referral:	HMS, WAM
Introducer(s):	GALUTERIA, CHUN OAKLAND, KIDANI, SOLOMON, WAKAI, Gabbard, Kahele, Ruderman

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

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

January 31, 2013

TO: The Honorable Senator Suzanne Chun Oakland, Chair
Senate Committee on Human Services

FROM: Patricia McManaman, Director

SUBJECT: **S.B. 323 - RELATING TO HEALTH INSURANCE**

Hearing: Thursday, January 31, 2013, 1:15 p.m.
Conference Room 016, State Capitol

PURPOSE: The purpose of the bill is to require the State to implement certain cost-savings programs and technologies in the Medicaid and Children's Health Insurance Program to reduce waste, fraud and abuse.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes this bill. The DHS takes program integrity seriously as well as its responsibility as stewards of tax-payers' monies. However, this bill is unnecessary because activities required of this bill already occur, the cost of changes will exceed any savings, and it will require that staff is redirected from information technology (IT) projects necessary to comply with the Affordable Care Act and/or bring in new federal funding.

As an example of our fraud enforcement efforts, the DHS collected $84 million over the past five years from drug companies in pricing fraud. It should be noted that

none of the technologies proposed by this bill would have identified this fraud. See Attachment E.

Regarding provider verification, the DHS already uses technology to check for provider eligibility including sanctions and current licensure. The DHS does not utilize predictive modeling and analytics technology in its fee-for-service (FFS) program. Implementing such an IT solution for our FFS program would be like purchasing a supersonic jumbo jet to airmail five letters. Our FFS program serves less than 40 individuals awaiting organ transplant, 90 individuals with medically needy spend-down, and a few individuals with retrospective eligibility only. In Hawaii, Medicaid is almost entirely managed care. Approximately 285,000 beneficiaries are enrolled in managed care health plans, not FFS.

Our contracted managed care health plans each has its own IT system to prevent fraud, waste, and abuse and uses advanced analytics. Attachment A is a brief description provided by each health plan. How much better, if at all better, a new system would be compared to the IT systems currently utilized by the health plans is unclear, so any projected new savings may be minimal. However, the costs of having each of the five health plans purchase and convert to a new system will be extremely expensive, an expense the State will need to pay if contractually required.

The alternative to purchasing five new systems is to buy only one new system and have all claims be paid by a centralized DHS system instead of by the health plans. This would effectively end managed care and return the Medicaid program to FFS. Ending managed care, i.e. QUEST, would be expected to cost an additional $235 million in State funds.

Whether purchasing one new system or five new systems, either option will cost more than any marginal savings realized from the switch.

If the IT solution that meets the requirements of this bill can fulfill the promises included in the bill regarding savings, then one wonders why a business case can't be made by the vendor to the health plans directly. AlohaCare, HMSA, Kaiser, Ohana, and United HealthCare are the health plans that have Medicaid managed care contracts with the DHS. They are paid on a capitation basis and are at full risk. In other words, they have strong financial incentive to eliminate fraud, waste, and abuse. All of these health plans also have other lines of business and leverage the same systems for their Medicaid and non-Medicaid business. They have similar financial incentives to reduce fraud, waste, and abuse on their commercial sides. Attachment B contains the DHS contractual requirements of health plans to address fraud, waste, and abuse.

The DHS is complying with fraud, waste, and abuse provisions in the Patient Protection and Affordable Care Act. Attachment C is the submitted State Plan Amendment on provider enrollment screening and verification, and Attachment D is the State Plan Amendment for a Recovery Audit Contractor. Fraud, waste, and abuse activities identify and prevent occurrences, but to a larger extent they act as deterrents. A federal review on the cost of fraud detection and amount of fraud identified found that for $100 million spent on fraud detection, only $20 million in fraud was actually detected: http://www.bloomberg.com/news/2012-06-14/medicaid-fraud-audits-cost-five-times-amount-u-s-found.html.

This bill would require that the DHS redirect IT resources from on-going projects to implement the requirements of this bill, potentially resulting in federal non-compliance and the loss of millions in federal funding. DHS staff is already overextended working on IT projects that have time limited substantial federal funding opportunities. For example, the DHS is implementing a $90 million (including 90% federal funding) state-of-the-art eligibility system, to

make eligibility determinations for Medicaid and advanced premium tax credit determinations for the Connector. This new system is required to go live October 1, 2013, but intensive work will continue while the increased federal funding is available through 2015. In addition, the DHS is working to leverage federal funding to advance health information technology and health information exchange, including implementation of the Medicaid electronic health record incentive program. This optional program is expected to provide tens of millions (at 100% federal funding) in incentive payments to Hawaii healthcare providers.

In summary, if the promise of savings from reducing fraud, waste, and abuse without any cost to implementation and administration sounds too good to be true, it probably is. The net effect of this bill would be to serve the interests of a mainland IT vendor looking to do business in Hawaii, not the interests of Hawaii tax-payers, providers, or beneficiaries.

Thank you for the opportunity to testify on this bill.

Attachment A

Med-QUEST Division Health Plans' Fraud and Abuse Systems

The health plans that are contracted with the Med-QUEST Division to provide services to Medicaid beneficiaries have capabilities to meet the requirements in the following two areas:

(1) integrating "provider data verification and provider screening technology solutions into the claims processing workflow to check current healthcare billing and provider rendering data against a continually maintained provider information database for the purposes of automating reviews and identifying and preventing inappropriate payments to deceased providers, sanctioned providers, licensed expiration / retired providers, and confirmed wrong addresses";

AlohaCare

Prior to the initial setup and as part of the provider recredentialing process, AlohaCare staff search the federal Excluded Parties Lists System (EPLS), Office of Inspector General's (OIG) List of Excluded Individuals/Entities, and Med-QUEST Division's Exclusion List for matches. At least once per calendar year, AlohaCare's Corporate Compliance Department staff downloads the entire file of excluded individuals/entities from the EPLS and OIG websites and compares our provider data to these external data sets. All matches involving a provider are investigated. Provider license status is reviewed on a regular basis between recredentialing cycles to maintain up-to-date information.

During the credential and recredentialing process provider licenses, malpractice, DEA, CSC, work history information is reviewed and verified through a national credentialing verification organization. Any discrepancies and/or issues are investigated.

Any information, such as retirement, death, or change of address, obtained through regular provider office site visits, returned mail, other provider contacts, and member contact that involve a provider are routed to our provider relations and contract/credentialing departments for follow up and maintenance of our provider data.

Hawaii Medical Services Association (HMSA)

Updates are made to the provider module of the claims processing system upon notification or discovery of a change. For a provider death, the date of death is the provider's termination date. For sanctioned providers, the termination date is the date of the sanction. For expired medical license, the date the license expired is the termination date. For provider retirements or other provider initiated terminations, the date provided is the provider termination date. If a wrong address is confirmed and provider contacts to get a corrected address are unsuccessful, the provider will be terminated. All claims processed uses the provider module to determine the participation status of the rendering provider. Claims with services dates on or after the termination date are denied.

Kaiser Permanente

KFHP has integrated provider data verification and provider screening technology solutions into its claims processing workflow. The following information describes KFHP's processes for combating FWA.

Claims Fraud Control

With regard to Kaiser Permanente's contracted providers, billing requirements are addressed in the provider manual and periodic provider-oriented publications. Specific education issues for a provider that has been identified as having incorrect billing practices would be addressed in a provider-specific corrective action plan.

Kaiser Permanente pursues a broad cost containment program with the support of National Information Analytics and Compliance Technology ("iACT") and the Claims Operations and Cost Containment departments through both pre-pay avoidance and post-pay recovery, for example:

- Coordination of benefits for commercial, Medicare, and other payors
- Workers' Compensation and other third-party liability identification
- Timely filing and duplicate review
- Code review — both software and clinical
- Retro-termination identification
- Medical/clinical review audit
- Hospital billing audit
- Credit balance audit
- Claim and prompt-pay fee negotiation
- Fraud and abuse screening
- Data mining and audit for contract and other payment errors

These programs are supported by internal process and systems capabilities as well as the use of third-party vendors. National Compliance Office ("NCO") recommends fraud-specific edits for inclusion in the claims processing system. More than 12 specialized vendors are used for both pre-pay and post-pay identification and recovery. Continuous improvement in performance and capability is managed at the regional level in collaboration with National Claims and NCO. The national departments provide consulting, oversight and analytic resources. Suspect claims are referred to the NSIU for further review and investigation, as appropriate.

Furthermore, the Professional Competency Department (Credentials) tracks provider licensing and credentials.

Excluded Providers

All Kaiser Permanente employees, board members, and contractors are screened as part of the hiring or contracting process, and monthly thereafter, to determine if they are suspended, debarred, excluded, sanctioned, or otherwise deemed ineligible from participation in Medicare, Medicaid, or other federal health care programs and in federal procurement or nonprocurement programs. Kaiser Permanente conducts a search of federal databases that identify ineligible individuals. These databases include the U.S. Office of Inspector General List of Excluded Individuals/Entities (LEIE), the List of Specially Designated Nationals and Blocked Persons (SDN) authorized by Executive Order 13244, and the U.S. General Services Administration (GSA) Excluded Parties List System (EPLS).

When a screened person appears as a potential match or has disclosed status as an ineligible person, an investigation is conducted to confirm the status. If a match is confirmed, Kaiser Permanente determines whether it can contract with, employ, or otherwise do business with that individual or entity and will thereafter take action consistent with applicable regulations. Appropriate action will be determined on a case-by-case basis, considering all of the relevant facts and circumstances (e.g.,

applicable HR policies, bylaws, etc.), and can include action up to and including nonpayment for services rendered, termination of employment, or termination of contract.

‘Ohana Health Plan

The first component of our pre-payment process to prevent Fraud, Waste, and Abuse (FWA) is a form of "business logic" in which incoming claims are routed through WellCare's primary 'pick logic', which acts as a filtering mechanism, and prevents certain claims from entering the payment system. The filter validates three categories on a claim: member, provider and codes. In the member filter, the system attempts to validate the member by using fields such as name, address, subscriber ID and date of birth; if no match is determined, the claim is rejected. This front line defense can identify potential theft of ID issues. If a claim passes through the member logic, it then faces the provider verification process. In the provider filter, internal software verifies the provider name, provider address, NPI and Federal Tax Identification Number. If the logic cannot locate a provider in the system, the claim is flagged for review or denial. If a claim passes through the member and provider filter, fields such as charges, CPT, ICD-9 and modifiers are validated and ultimately approved for payment. If the claim fails to pass through this stage, it is sent for a manual review.

UnitedHealthcare Community Plan

1. A deceased report is pulled monthly from the Medicare (MCS) website and if provider is identified, system is updated (i.e. claims will no longer process for dates of service on/after date of death). This process is done on a national level by UnitedHealth Networks for the entire country, for all health plan programs. Locally, if the provider network (including credentialing) staff becomes aware that a provider has passed away (e.g. reported by staff, found in the obituaries, etc.), the system will be updated so that claims will not process for dates of service on or after dates of service).

2. UnitedHealthcare monitors excluded and sanctioned provider information maintained on the Department of Health and Human Services Office of Inspector General (DHHS OIG) List of Excluded Entities and Individuals (LEIE) database and the Medicaid exclusions published by the Hawaii DHS Med-QUEST Division. The report(s) pulled identify providers that have been flagged as excluded/sanctioned and is sent to the provider network team for handling and updating provider and claims systems (e.g. to cease authorizations, claims processing, etc.).

3. The provider credentialing team also checks OIG & SAM (formerly EPLS) databases for provider exclusions from government programs as well as the check the State Exclusion list during initial and recredentialing of providers. The provider credentialing team checks the aforementioned government databases and lists on a monthly basis to identify any new excluded/sanctioned providers. Any providers who have been flagged as excluded/sanctioned during the credentialing/recredentialing process and from the monthly review are updated in our systems by the provider network team which will cease authorizations and claims payments for the provider(s).

4. Claim reviews are done to verify that provider information, including addresses, matches what has been loaded into our provider database(s) from the provider network team (e.g. provider contract). If a provider is identified (e.g. provider address mismatch between what is on the claim form and what was loaded from the provider’s contract) a report is generated and sent to the local provider service team for investigation, review and resolution.

5. When provider licenses expire (different provider types are on different license renewal schedules with the State of Hawaii), the provider credentialing team uses files from the State of Hawaii

(purchased files) and identifies any providers who have not renewed their license. The provider services team outreaches to the impacted providers to confirm status (e.g. non-renewal confirmation or provider cannot be located). The system is updated with the result(s) and appropriate action is taken (e.g. provider's credentials and contract is terminated). Providers who have neglected to renew their license are subject to automatic suspension and possible termination of credentials. Claims will not process against a suspended or terminated provider.

6. During periodic provider education trainings, the providers are educated on their roles and responsibilities as a provider in the QExA/QUEST programs. One of their responsibilities is to maintain their credentialed status with UnitedHealthcare. Providers are also trained on maintaining accurate and current information with UnitedHealthcare including practice status and demographic information, such as address changes.

(2) implementing "state-of-the-art" predictive modeling and analytics technologies in a pre-payment position within the healthcare claim workflow to provide a more comprehensive and accurate view across all providers, beneficiaries and geographies within the Medicaid and CHIP programs in order to:

- **Identify and analyze those billing or utilization patterns that represent a high risk of fraudulent activity;**
- **Be integrated into the existing Medicaid and CHIP claims workflow;**
- **Undertake and automate such analysis before payment is made to minimize disruptions to the workflow and speed claim resolution;**
- **Prioritize identified transactions for additional review before payment is made based on likelihood of potential waste, fraud or abuse;**
- **Capture outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies based on historical data and algorithms within the system; and**
- **Prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent or abusive until the claims have been automatically verified as valid.**

AlohaCare

Prepayment:

AlohaCare's information system contains multiple edits to ensure that claims data is complete and validated against acceptable values and reference tables. Submitted claims are subjected to edits such as National Correct Coding logic, duplicate claim, invalid service code, invalid service code for date of service, invalid modifier, invalid place of service, non-covered service, member not eligible at date of service, timely filing and service invalid for gender.

AlohaCare Claim Leads and/or Claims Analysts review pre-remit reports to identify payment exceptions. All QUEST claims over $10,000 are reviewed by the Claims Analyst and Claims Lead or Claims Manager prior to payment. All QUEST claims over $5,000 is reviewed by the Claims Lead either prior to payment or post payment.

Postpayment:

AlohaCare's Claim and Finance staff performs a monthly post-payment audit for payment accuracy. We delegate specific anti-fraud and recovery services to OptumInsight, which includes access to their special investigative unit (SIU). OptumInsight reviews AlohaCare's claims data on a semi-annual basis and reports any possible aberrant billing patterns to Corporate Compliance Department Referrals for investigation.

For investigations of potential fraud and abuse involving a provider, where the findings are that the provider is not billing appropriately but does not rise to the level of fraud and abuse, outreach and education (and where needed, more formal training) is conducted and documented by the Provider Network Department.

Pharmacy Department staff review members who are high users of (and prescribing provider's practice patterns for) controlled drugs; requests for refill-too-soon, maximum daily dose and point-of-sale edits; and medication use by members in our DM Program to ascertain appropriate use vs. non-compliance.

Hawaii Medical Services Association (HMSA)

To address the above bullets, our Utilization Management Program and our claims system editing program, National Correct Coding Initiative (CCI edits and bundling) are used.

As part of the Utilization Management Program, service utilization is reviewed on a regular basis. When inappropriate utilization is suspected, further research is done to determine if the service provided was appropriate and medically necessary. If through this process inappropriate utilization is confirmed, the claim system can be updated to require a pre-certification, pend the claim for medical review by a medical director to confirm medical necessity or the claims system can be updated to reject that service.

Our claims system uses an editing program, CCI edits and bundling, during the claim adjudication process. CCI edits and bundling promotes national correct coding methodologies and is designed to prevent improper payment when incorrect code combinations are submitted on a claim. When an edit is fired, it will cause the claim to pend for review or deny prior to claim payment.

Kaiser Permanente

KFHP has a robust data mining and monitoring analytic program designed to analyze all member plan types, including Medicaid and CHIP. The information below provides an overview of these activities.

Data Mining for Detection and Prevention

Kaiser Permanente is committed to detecting FWA of its organizational assets. Detection includes, but is not limited to, implementing effective internal monitoring, auditing, and data mining. As part of NCO's iACT team, the data analytics team conducts data mining and analysis specifically designed to detect FWA. A core function is to conduct dynamic data mining studies designed to identify anomalous patterns that may be indicative of FWA, such as:

- Overpayments
    - Observation days
    - Billing errors
    - Medical necessity

- Theft of medication
    - Inventory
    - Prescription pads
    - Refills
- Overpayments/bogus payments
    - To third parties (coordination of benefits)
    - To vendors
- Contract provider upcoding
    - Bundling
    - Unbundling
- Identity theft
    - Medical services
    - Financial gains

In addition, managers are responsible for establishing appropriate internal controls to detect and monitor FWA associated with organizational assets in their custody or under their control.

Pharmacy Audit Program

Kaiser Permanente has automated data mining tools developed by iACT to identify and analyze unusual revenue, drug purchasing trends, and prescribing and dispensing patterns. These tools allow audit staff to proactively seek out FWA patterns, protect the health of our members, and ensure compliance with regulatory requirements.

Relating to prioritize identified transactions for additional review before payment is made based on likelihood of potential waste, fraud or abuse, please see the KFHP's reply item no. 1 above under the section on "Claims Fraud Control."

'Ohana Health Plan

Claims that have passed through WellCare's "pick logic" enter into their proprietary "Xycles" system, WellCare's main frame claims system. In this stage, additional edits and safeguards are built in to protect payment integrity. Those edits include interrogation of claims and billed charges according to configuration logic that applies proper adjudication rules according to provider and plan contracts. These rules validate that adjudication is proper for pricing, benefits, fee schedules and final payments.

In addition to "pick logic" and "xycles", WellCare uses "Integrated Claims Management," (ICM) which is an iHealth product, as part of its claims process. ICM uses enhanced claim editing tools to define and implement medical claim payment policies. Edits include but are not limited to AMA, CMS, FDA and State Medicaid guidelines that include high dollar claims, unbundled procedures, modifiers, CCI edits, duplicates, maximum units, multiple surgeries, and bilateral procedures.

UnitedHealthcare Community Plan

1. UnitedHealthcare Community Plan integrates a powerful "state-of-the-art" prospective fraud, waste and abuse detection tool into the existing claims workflow called Prospective Review 2.0 ("P2"). In order to minimize disruptions to the workflow and speed claim resolution, P2 allows us to identify and analyze billing patterns that represent a high risk of fraudulent activity before payments are made. P2 incorporates two complementary components ("Challenger" and

"Predictive") that evaluate and identify suspect claims on the basis of one or a combination of factors such as unlikely diagnosis and procedure code combinations. Both components assume that most providers are billing correctly and look for claims that are outliers by creating data driven peer groups. This is done by grouping providers whose service mix is similar (based on billed CPT codes). When claims are identified through P2 they are sent for review. For claims that are identified and verified as "suspect", we then send the provider a request for medical records to support the review process. Outcome information from the reviewed claims is captured to allow for refinement and enhancement of P2 leading to better filtering of claims. Over time, this increases the number of automatic verification and validation of claims.

2. The Hawaii Compliance Committee reviews all "P2" provider suspected instances of fraud, waste and abuse on a regular. Each case is reviewed thoroughly reviewed and investigated. In appropriate cases, the matter is reported to the State and law enforcement in accordance with federal and state requirements (and as set forth in State of Hawaii DHS-MQD approved P&Ps).

3. Note: our "P1" fraud, waste and abuse process is provider-centric (vs. P2 which is claims centric and is across all providers, members, and geographies). P1 focuses on specific providers identified as suspect (through a variety of sources, including data mining and analysis). Suspect providers are reviewed on and on-going basis to ascertain if fraud, waste and/or abuse is occurring.

40.200 Provider Network

40.210.1 General Provisions

The health plan shall not include in its network any providers or providers whose owners or managing employees have been excluded from participation by the U. S. Department of Health and Human Services, Office of Inspector General (OIG), Section 1128 or Section 1128A of the Social Security Act, or have been excluded by the DHS from participating in the Hawaii Medicaid program and all other state Medicaid programs. The health plan shall be responsible for checking with the MQD for those providers excluded from any Federal or State program at least annually and shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded. The health plan shall be responsible for routinely checking Federal exclusion lists to include but not limited to the List of Excluded Individuals and Entities (LEIE) maintained by the OIG. The health plan shall immediately terminate any provider(s) or affiliated provider(s) whose owners or managing employees are found to be excluded. The health plan shall report provider application denials or termination to the DHS where individuals were on the exclusions list, including denial of credentialing for fraud-related concerns as they occur.

The health plan shall immediately comply if the DHS requires that it remove a provider from its network if: (1) the provider fails to meet or violates any State or Federal laws, rules, and regulations; or (2) the provider's performance is deemed

inadequate by the State based upon accepted community or professional standards.

50.420 Member Education

The health plan shall educate its members on the importance of good health and how to achieve and maintain good health. Educational efforts shall emphasize the following but are not limited to: the availability and benefits of preventive health care; the importance and schedules for screenings for cancer, high blood pressure and diabetes; the importance of early prenatal care; and, the importance of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services including timely immunizations. The health plan shall also provide educational programs and activities that outline the risks associated with the use of alcohol, tobacco and other substances.

The health plan shall educate its members on the concepts of managed care and the procedures that members need to follow such as informing the health plan and the DHS of any changes in member status, the use of the PCP as the primary source of medical care and the scope of services provided through the health plan. This includes education in the areas of member rights and responsibilities, availability and role of CC/CM services and how to access these services, the grievance and appeal process, identifying fraud and abuse by a provider and how the member can report fraud and abuse, and the circumstances/situations under which a member may be billed for services or assessed charges or fees including information

that a member cannot be terminated from the program for non-payment of non-covered services and no-show fees.

As part of these educational programs, the health plan may use classes, individual or group sessions, videotapes, written material and media campaigns. All instructional materials shall be provided in a manner and format that is easily understood.

The DHS shall review and approve materials prior to the health plan distributing them or otherwise using them in educational programs. The health plan shall submit its member education materials including training plan and curricula for review and approval by the due date identified in Section 51.700, Readiness Review.

51.300 Fraud & Abuse

51.310 General Requirements

The health plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. In addition, as part of these internal controls and policies and procedures, the health plan shall have ways to verify services were actually provided using random sampling of all members. The health plan shall have a compliance officer and sufficient staffing (as required in Section 51.400) and resources to investigate unusual incidents and develop and implement corrective action plans to assist the health plan in preventing and detecting potential fraud and abuse activities. The health

plan's fraud and abuse activities shall comply with the program integrity requirements outlined in 42 CFR Section 438.608.

All suspected fraud and abuse committed by a member should be reported to the appropriate entity. The health plan shall report eligibility fraud for, medical assistance, financial assistance, or Supplemental Nutrition Assistance Program (SNAP) should be reported to the Investigations Office (INVO) of the Benefit, Employment and Support Services Division (BESSD). The reporting shall be done either through written notification or a telephone call to INVO Hotline. Fraudulently obtaining controlled substances, other medical services, or collusion between provider and member to obtain services would be reported to MQD.

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

51.320 Reporting and Investigating Suspected Provider Fraud and Abuse

Within thirty (30) calendar days of discovering instances of suspected fraud or abuse, the health plan shall report all instances of suspected fraud or abuse to the MQD and the State

of Hawaii, Department of the Attorney General, Medicaid Fraud Control Unit (MFCU). The health plan shall use the report form to be provided by the DHS to report or refer suspected cases of Medicaid fraud or abuse. At a minimum, this form shall require the following information for each case:

- Name;
- ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate dollars involved; and
- Legal and administrative disposition of the case.

As part of its report, the health plan shall include the results of its preliminary investigation. This includes, but is not limited to, providing any evidence it has on the member's services or provider's billing practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately).

Once the health plan has filed its report, it shall not contact the provider who is the subject of the investigation about any matters related to the investigation, enter into or attempt to negotiate any settlement or agreement, or accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation in connection with the incident.

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

51.330 Compliance Plan

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

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

- Require the reporting of suspected and/or confirmed fraud and abuse be done as required in Sections 51.320 and 51.570.1;

- Ensure that all of its officers, directors, managers and employees know and understand the provisions of the health plan's fraud and abuse compliance plan;
- Require the designation of a compliance officer and a compliance committee that are accountable to senior management;
- Ensure and describe effective training and education for the compliance officer and the organization's employees;
- Ensure that providers and members are educated about fraud and abuse identification and reporting, and include information in the provider and member material;
- Ensure effective lines of communication between the compliance officer and the organization's employees;
- Ensure that enforcement of standards through well-publicized disciplinary guidelines;
- Ensure provision of internal monitoring and auditing with provisions for prompt response to potential offenses, and for the development of corrective action initiatives relating to the health plan's fraud and abuse efforts;
- Possess written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
- Ensure that no individual who reports health plan violations or suspected fraud and abuse is retaliated against; and
- Include a monitoring program that is designed to prevent and detect potential or suspected fraud and abuse. This monitoring program shall include but not be limited to:

- Monitoring the billings of its providers to ensure members receive services for which the health plan is billed;
- Requiring the investigation of all reports of suspected fraud and over billings (upcoding, unbundling, billing for services furnished by others, and other overbilling practices);
- Reviewing providers for over-utilization or under-utilization;
- Verifying with members the delivery of services as claimed; and
- Reviewing and trending consumer complaints on providers.

51.340 Employee Education About False Claims Recovery

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

51.350 Child and Adult Abuse Reporting Requirements

The health plan shall report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

The health plan shall ensure that its network providers report all cases of suspected child abuse to the Child Protective Services Section of the DHS, and all suspected dependent adult abuse to the Adult Protective Services Section of the DHS as required by state and federal statutes.

51.520.6 Provider Suspensions and Termination Report

The health plan shall notify the MQD within three (3) business days of any provider suspensions and terminations, both voluntary and involuntary because of suspected or confirmed fraud or abuse. The immediate notification shall include provider's name, provider's specialty, reason for the action and the effective date of the suspension or termination. In addition, the health plan shall submit a summary *Provider Suspensions and Terminations Reports* that list by name, all provider suspensions or terminations. This report shall include all providers, each provider's specialty, their primary city and island of services, reason(s) for the action taken as well as the effective date of the suspension or termination. If the health plan has taken no action against providers during the quarter this shall be documented in the *Provider Suspensions and Terminations Report*. The health plan shall utilize the report format provided by the DHS.

51.570.1 Fraud and Abuse Summary Reports

The health plan shall submit *Fraud and Abuse Report*s that include, at a minimum, the following information on all alleged fraud and abuse cases:

- A summary of all fraud and abuse referrals made to the State during the quarter, including the total number, the administrative disposition of the case, any disciplinary action imposed both before the filing of the referral and after, the approximate dollars involved for each incident and the total approximate dollars involved for the quarter;
- A summary of the fraud and abuse detection and investigative activities undertaken during the quarter, including but not limited to the training provided, provider monitoring and profiling activities, review of providers' provision of services (under-utilization and over-utilization of services), verification with members that services were delivered, and suspected fraud and abuse cases that were ultimately not fraud or abuse and steps taken to remedy the situation; and
- Trending and analysis as it applies to: utilization management, claims management, post-processing review of claims, and provider profiling.

Reports shall be submitted using the format provided by the DHS.

51.570.2 Provider Education and Training Report

The Health Plans shall submit all provider education and training relating to correct/incorrect coding, proper/improper claims submission. The education/training can be to prevent fraud, waste and abuse or initiated by the Health Plan as a result of

pre-payment or post-payment claims reviews. This report shall identify training/education at an individual provider level or as a group session.

This report shall be provided in the format to be prescribed by the DHS.

51.570.3 Employee Suspension and Termination Report

The Health Plans shall report if a subcontractor or employee resigns, is suspended, terminated or voluntarily withdraws from participation as a result of suspected or confirmed fraud and abuse.

This report shall be provided in the format to be prescribed by the DHS.

STATE OF PLANN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **HAWAII**

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.46 Provider Screening and Enrollment

Citation
1902(a)(39);
1902(a)(77);
1902(kk);
P.L. 111-148; and
P.L. 111-152

The Medicaid agency give the following assurances:

42 CFR 455
Subpart E

PROVIDER SCREENING

☒ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

Ordering and referring providers for Medicaid beneficiaries within the provider network of a risk-based managed care organization (MCO) are subject to the compliance of the MCO screening and credentialing process. The State shall rely upon the screening performed by Medicare, other State Medicaid agencies, Children Health Insurance Programs of other States or MCOs contracted by the State for Fee-For-Service (FFS) ordering and referring providers.

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS

☒ Assures enrolled providers will be screened in accordance with 42 CFR. 455.400 et seq.

☒ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412

VERIFCATION OF PROVIDER LICENSES

☒ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and such providers licenses have not expired or have no current limitations.

The State receives a file of licensed providers in good standing from the Department of Commerce & Consumer Affairs from which claims payment is approved or encounter information accepted.

STATE OF PLANN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **HAWAII**

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

42 CFR 455.414

REVALIDATION OF ENROLLMENT

☒ Assures that providers will be revalidated regardless of provider type at least every 5 years.

The State shall rely upon revalidation credentialing performed by Medicare, other State Medicaid agencies, Children Health Insurance Programs of other States or MCOs contracted by the State for Fee-For-Service (FFS) ordering and referring providers. The State shall assure revalidation of Fee-For-Service (FFS) providers not otherwise credentialed.

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT

☒ Assure that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT

☒ Assure that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

☒ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will be appeal rights available under procedures established by State law or regulation.

42 CFR 455.432

SITE VISITS

☒ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

STATE OF PLANN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **HAWAII**

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS

☒ Assures that providers, as condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do under State law, or by the level of screening based on risk fraud, waste abuse for that category of provider.

42 CFR 455.436

FEDEAL DATABASED CHECKS

☒ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

☒ Assures that the State Medicaid agency requires that National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

☒ Assure that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

☒ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

STATE OF PLANN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **HAWAII**

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

☒ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Attachment D

11 0120

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

FEB 10 2011

Patricia McManaman
Director, Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

Dear Ms. McManaman:

Enclosed is an approved copy of Hawaii State Plan Amendment (SPA) No. 10-011 which establishes a Recovery Audit Contractor (RAC) program to contract with one or more Medicaid contractors for the purpose of identifying underpayments and overpayments with respect to all services for which payment is made to any entity under Hawaii's State Plan or approved waiver. This SPA is effective December 31, 2010.

If you have any questions, please feel free to contact Torris Smith at (415) 744-3599 or Torris.Smith@cms.hhs.gov.

Sincerely,

Gerald Nagle acting for.

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Kenneth Fink, Med-QUEST Administrator
Michele Bowser, CMS Center for Medicaid and State Operations
Mary Rydell, Pacific Area Representative

'11 MAR -2 P4:58
DEPT OF HUMAN SVCS
MED-QUEST DIV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 10-011 2. STATE: HAWAII 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) MEDICAL ASSISTANCE
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE December 31, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 1902 (a)(42)(B) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2011 $ 0.00 b. FFY 2012 $ 0.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 4.5, page 80 and 80a (new)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: To establish the Recovery Audit Contractor (RAC) program to contract with one or more Medicaid contractors for the purpose of identifying underpayments and overpayments and recouping overpayments with respect to all services for which payment is made to any entity under our State plan or approved waiver.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Kenneth S. Fink, MD, MGA, MPH	
14. TITLE: Med-QUEST Division Administrator	
15. DATE SUBMITTED: December 30, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: [illegible]

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: [illegible]

21. TYPED NAME: [illegible]

23. REMARKS: [illegible]

FORM HCFA-179 (07-92)

STATE OF PLANN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation:

Section 1902(a)(41)(B)(i) of the Social Security Act

☒ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

☐ The State is seeking an exception to establishing such program for the following reasons:

Section 1902(a)(42)(B)(ii)(I) of the Social Security Act

☒ The State Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

☒ The State will make payments to the RAC(s) only from amounts recovered.

☒ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Social Security Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

☒ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

☐ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

ATTACHMENT E

Jere Beasley Report [http://www.jerebeasleyreport.com]

Hawaii Does Well In Medicaid Fraud Litigation

Hawaii has collected $84 million over the past five years from drug companies for alleged **Medicaid fraud**. It is among the top states with the highest return on investment for its investigations. The amount the state has collected through **litigation** is 12 times what the state paid to prosecute **Medicaid fraud** cases from 2006 to 2011. This is according to a new report by Public Citizen, a Washington, D.C.-based nonprofit consumer advocacy group.

Of the 27 states that recovered money from drug manufacturers, Hawaii had the fourth-highest return on investment. The state spent $6.7 million on **Medicaid fraud** enforcement in the period and recouped $12.50 for every dollar spent. Sammy Almashat, health researcher with Public Citizen, observed:

These are states that have pursued these cases completely on their own without the help of the federal government. States expended their own resources to try to recover money for their own Medicaid programs. Pursuing and prosecuting pharmaceutical companies for fraud...can be exceedingly cost effective for the states that choose to prosecute. These investigations pay for themselves in the long run.

It was pointed out by Public Citizen that the Hawaii cases involved overcharging the Medicaid program for drugs for the state's neediest population, which is the most common violation. On a federal level, cases also involved off-label promotion of medications, or illegal marketing activities to increase pharmaceutical sales. The $84 million Hawaii collected came from two cases. In 2010, Hawaii reached an $82.6 million **settlement** with a number of different drug companies in one case. In 2007 a Merck subsidiary paid the state $1.1 million in the other case. Almashat had this to say about Hawaii's good work:

Sometimes these overcharges can be pretty astronomical. A small state like Hawaii getting an $82 million **settlement** is pretty significant. Pricing fraud has gone on for years, over decades or longer...which add up to a lot of money for state taxpayers and the Medicaid program. State budgets are constantly facing shortfalls and cuts so these settlements really are, in many cases, crucial for state Medicaid programs to continue to provide care for the states' poor and disabled patients.

Almashat gave an example, unrelated to Hawaii, of a drug company charging Medicaid about $5,000 for 200 pills that should have sold for $80. Based on what we have learned in **litigation**, I could give numerous similar examples of how the companies are overcharging in other states for their drugs. In the December issue, we will report on a number of very good settlements made in AWP cases on behalf of other states. The details on those settlements were being worked out as this issue went to the printer.

Source: staradvertiser.com

Hawaii Senate Bill 323: My name is Bill Baylor VP of Government Business Development with Emdeon of Nashville Tn and I am testifying in support of this bill.

According to Centers for Medicare and Medicaid Services (CMS), Medicare paid more than $430 billion in medical claims for beneficiaries in 2009, but more than 10% of that or $45 billion was due to improper payments resulting from fraud, waste and abuse. Likewise, State Medicaid programs paid over $381 billion in medical claims for 51 million recipients in 2009, with nearly 5% or $18 billion attributed to fraud, waste and abuse.

- As our nation faces nearly $14 trillion in national debt, it is unacceptable to throw always billions of taxpayers' dollars each year due to fraud, waste and abuse aimed at the critical healthcare programs.
- Emdeon is the nation's largest healthcare data exchange,
    - Processing 6B administrative, financial and clinical transactions annually
    - 90%+ of all providers,
    - 600 system vendors and
    - 1,200 public- and private-sector payers in the country,
    - Including HI Medicaid.
- The Hawaii Department of Human Service Med-QUEST Division should be commended for their existing systems and programs to combat Fraud, Waste & Abuse. However much more work needs to be done to bring it into compliance with CMS final rule 6028.
- However in an era of
    - budget constraints &
    - pending increases projected in Medicaid enrollment under the Affordable Care Act,
    - it has never been more important to utilize multiple, proven safety nets to increase ability to detect and prevent fraud, waste & abuse.
- The Bill before you mirrors many provisions of Section 6028 of the Affordable Care Act that the State will have to comply with by 2014.
    - However, it goes further by:
        - Accelerating the timeline to achieving the savings
        - Changing the funding model to a self-funding contingency based model
        - Providing a risked based claims scoring system in a Pre Pay Mode with a integrated case management system that builds the case and link analysis that connects various transactions and relationships between people and third parties.
        - Cross Payer Database where data is combine from multiple payer sources to provide a complete view of the potential Fraud , waste and abuse
- Eight Characteristics of a Best-in-Class FWA Solution: Fraud, Waste and Abuse management solutions vary in both sophistication and efficacy. However, the most effective programs have many or all of the following characteristics and can:
    - Use data-driven analytics to drive meaningful understanding of patterns, trends and FWA identification in a continuous learning mode
    - Leverage large cross-payer database for more comprehensive FWA analysis, which is especially valuable to regional payers
    - Employ both rules-based and predictive, data-driven analytics for provider profiling
    - Apply clinical code edits with business rules, to reflect and enforce a payer's contracts and payment policies
    - Reduce false positives
    - Employ experienced, highly trained investigators and analysts
    - Facilitate the investigatory workflow by prioritizing outcomes

- Examine both provider-level and claims-level data
- There are at least three very critical new tools to detect & prevent FWA included in this Bill:
  - #1 In-stream Provider Validation: The pre-adjudication in stream claim validation of deceased, retired, expired license, possible allegations of fraud and sanctioned providers, including provider sanction details and related professional background information, serves as an additional net to identify suspect claims and providers.
  - #2 Pre-Pay Predictive modeling with an integrated case management system with link analysis: Using a neural network as the basis for its predictive analytics, Emdeon's solution "learns" as more data is fed into the system. Therefore, the aberrance, subtle nuances, and changes in the data are discovered, and the model changes as the data, as well as the fraud and abuse, changes. This allows for future claim lines and providers to be scored differently, based on the historical data and algorithms existing within the system.
    - **Seeded Analytics with Cross Payer Data:** Emdeon has teamed with FICO, the predictive analytics organization which serves as the backbone of the credit card fraud detection industry, to develop and deploy a solution unparalleled in the healthcare industry. This powerful solution uses a combination of patented profiling technology, predictive models, statistical analysis and rules to achieve a level of detection accuracy that is unmatched. The analytics models are seeded with close to one billion Cross Payer claims from Emdeon. By pairing FICO's analytics models with Emdeon's proprietary analytics and claims experience, the team has created an unparalleled predictive analytics engine that is able to dig deeper into the data to find more potential savings.
    - **Link Analysis:** A link analysis engine finds connections between transactions, people, third parties and discrete fraud events that can reveal previously-hidden fraud schemes. The combined capabilities expand the view of the fraud investigator and enable the identification of more-complicated fraud patterns, criminal fraud rings, and networks of collusive participants that might otherwise appear disconnected from a fraud problem.
  - #3 Recovery Audit Contractor: Audit & Recovery services help customers realize the true value of medical cost savings identified through all its validation and audit services by obtaining the overpayment amount identified through the audit process.
- These tools would also bring related benefits to the current state system and the new system, not the least of which include:
  - Reduce false positives
  - Faster compilation of case data
- And improve the state's current rankings of:
  - 46th in fraud recoveries in 2011 with $2,062,717
  - 49th in fraud convictions with 1
  - And 45th for Medicaid fraud recovery rate for every federal dollar spent with $1.15
- It is important to note that these measures would not impact or delay the delivery of care to patients in any way, as all tools are utilized to assess claim data, which is submitted for payment as it is today…*after* services are rendered.
- National statistics for FWA savings range from ½ - 3% of total spend however the
  - Potential 2013 savings for HI Fee For Service Medicaid range from $4M - $9M per year
  - Potential 2014 savings for HI Fee For Service Medicaid range from $6M - $12 M per year
  - This would also significantly improve the number of fraud investigations and convictions as well a increase the recovery rate for every federal dollar spent

- These measure could help to pre-empt other, more drastic measures elsewhere to deal with budget constraints:
    - Reduction of benefits to beneficiaries
    - Reduction of provider reimbursement schedules…which negatively impact *all* providers, the vast majority of which are acting in good faith and providing quality care to those most in need.
- While there is no single magic bullet to eliminate FWA, adoption of the measures in this Bill will keep The Hawaii Department of Human Service Med-QUEST Division on the leading edge of this fight nationwide

I would be happy to answer any questions you may have.