HOUSE OF REPRESENTATIVES
TWENTY-SIXTH LEGISLATURE, 2012
STATE OF HAWAII

H.C.R. NO. 159

HOUSE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HUMAN SERVICES TO CONDUCT A STUDY ON THE STATE'S COMPLIANCE WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH EMPHASIS ON MEDICAID PROGRAM INTEGRITY.

WHEREAS, the Legislature finds that fraud, abuse of systems, and waste cost state Medicaid programs an estimated $18,000,000,000 per year on a national level; and

WHEREAS, the Center for Program Integrity within the Centers for Medicare and Medicaid Services said the problems with improper payments arise from incorrect coding, medically unnecessary services, incorrect implementation of rules through improper billing practices, along with intentional deception involving billing for services that were never provided; and

WHEREAS, the United States Government Accountability Office on March 9, 2011, issued the report, "Medicare and Medicaid Fraud, Waste, and Abuse", which indicated that improper payments, including over and under payments, put social service programs at risk; and

WHEREAS, as a result of the 2011 report, the United States Government Accountability Office declared both Medicare and Medicaid as "high-risk" programs that can be compromised by fraud, waste, and abuse; and

WHEREAS, the United States Government Accountability Office stressed the need to implement strategies to reduce fraud, waste, and abuse, as well as strategies to reduce improper payments; and

H.C.R. NO. 159

WHEREAS, Hawaii's Medicaid program reported an average monthly enrollment of approximately 272,218 members at the end of fiscal year 2010-2011; and

WHEREAS, the Med-QUEST Division shifted from a fee-for-service delivery system into a robust managed-care system of health care delivery with approximately one percent of Medicaid clients remaining in the limited fee-for-service program; and

WHEREAS, Hawaii has contracted with managed care health plans for its Medicaid populations which include both QUEST health plans and QUEST Expanded Access health plans with the Department of Human Services retaining federally-mandated accountability and oversight of these managed care plans; and

WHEREAS, the problems of fraud, abuse, and waste within Medicaid programs has led to higher costs for each state during a critical time of actuarial rate analysis and the setting of managed care health plan contracts; and

WHEREAS, the federal Patient Protection and Affordable Care Act required each state to submit state plan amendments by December 31, 2010, to detail how they will establish their recovery audit contractor programs to increase post-payment reviews to identify payment errors and recoup overpayments; and

WHEREAS, the recovery audit contractor programs will review Medicaid provider claims to identify and recover overpayments and identify underpayments made for services provided under Medicaid state plans and Medicaid waivers; and

WHEREAS, in an effort to reduce Medicaid fraud, abuse, and waste and ultimately improper payments, the Government Accountability Office has identified these five strategies:

(1) Strengthening provider enrollment standards and procedures, which includes designating providers by levels of risk and providing more stringent review of high-risk providers;

(2) Improving pre-payment review of claims, which includes a Patient Protection and Affordable Care Act requirement that states add automated pre-payment controls within all payment systems;

(3) Focusing post-payment claims reviews on the most vulnerable areas and adding new recovery audit contractors, including recovery audit contractor programs to increase post-payment reviews to identify payment errors and recoup overpayments;

(4) Improving oversight of contractors which includes oversight of prescription drugs and high-risk providers such as home health agencies and durable medical suppliers; and

(5) Developing a robust process for addressing identified vulnerabilities; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-sixth Legislature of the State of Hawaii, Regular Session of 2012, the Senate concurring, that the Department of Human Services is requested to conduct a study on the State's compliance with the federal Patient Protection and Affordable Care Act in regards to Medicaid program integrity within the managed care health plans, fee-for-service program, and the Children's Health Insurance Program, and to include timelines and plans for compliance with the Patient Protection and Affordable Care Act for fiscal years 2010-2011, 2011-2012, 2012-2013, and 2013-2014; and

BE IT FURTHER RESOLVED that the report is requested to include the Department of Human Services' compliance status with the following sections of the Patient Protection and Affordable Care Act:

(1) Medicare, Medicaid, and Children's Health Insurance Program integrity provisions: Provider screening with initial enrollment and routine reviews; searches within the Social Security Administration's Death Master File; increased documentation on referrals to programs at high risk of waste and abuse; enhanced penalties; implementation of recovery audit contractor programs; and pre-payment reviews of claims versus post-payment reviews;

H.C.R. NO. 159

(2) Additional Medicaid Program Integrity Provisions: Termination of providers from Medicaid (if terminated under Medicare, the Medicaid state plan, or Children's Health Insurance Program); termination of excluded providers identified via established federal databanks, i.e, Office of Inspector General List of Excluded Individuals/Entities; processes to maintain a central repository of program integrity targets along with processes to track providers who are under investigation; overpayments including prevention and recoupment; mandatory use of the national coding initiative; registration of billing agents, etc.; implementation of expanded data elements under the Medicaid Management Information System to detect fraud and abuse with corrective action plans; and additional edits and audits, including predictive modeling and analytic technologies; and

(3) Additional program integrity provisions: Means to prohibit false statements and representations; and

BE IT FURTHER RESOLVED that the report is requested to include the Department of Human Services Med-QUEST Division's plans and processes to assure adequate federally-mandated oversight of the contracted managed care health plans' integrity programs and verification of the beneficiary receipt of services claimed by managed care health plans via explanation of benefits forms or another approved method; and

BE IT FURTHER RESOLVED that the report is requested to include analysis of actual cost-savings or projected cost savings per program for the stated fiscal years, as well as actual recouped dollar amounts and fines collected by the Department of Human Services' internal program integrity section, successful referrals and recoupments from the Medicaid Fraud Control Unit of the Attorney General's office, as well as all reported recoupments from both the QUEST and the QUEST Expanded Access health plans, fee-for-service, or Children's Health Insurance Program for fiscal years 2011 through 2014; and

H.C.R. NO. 159

BE IT FURTHER RESOLVED that the Director of Human Services is requested to report the final status of implementation and compliance with the Patient Protection and Affordable Care Act, along with any suggested legislation, to the Legislature no later than 20 days before the convening of the Regular Session of 2015; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Human Services, Director of Health, and Attorney General.

OFFERED BY: _____

MAR 14 2012