HOUSE OF REPRESENTATIVES
TWENTY-SEVENTH LEGISLATURE, 2013
STATE OF HAWAII

H.B. NO. 1207 H.D. 1

A BILL FOR AN ACT

RELATING TO HUMAN SERVICES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that fraud, abuse, and waste cost state medicaid programs an estimated $18,000,000,000 per year on a national level. The Center for Program Integrity within the Centers for Medicare and Medicaid Services stated that the problems with improper billing payments arise from incorrect coding (errors), medically unnecessary services (waste), incorrect implementation of rules through improper billing practices (abuse), and intentional deception by billing for services that were never provided (fraud).

The United States Government Accountability Office submitted written testimony, "Medicare and Medicaid Fraud, Waste, and Abuse", dated March 9, 2011, which indicated that improper payments, including over-payments and under-payments, put social services programs at risk. The office declared both medicare and medicaid as high-risk programs that can be compromised by fraud, waste, and abuse, and identified five key strategies to help reduce fraud, waste, abuse, and improper payments in medicare and medicaid.

Hawaii's medicaid program experienced an average monthly enrollment of approximately 290,496 members at the close of fiscal year 2012. In 2012, the Med-QUEST division experienced an enrollment increase of five per cent, reflecting a total increase of more than thirty-five per cent since 2008. The Med-QUEST division shifted from a fee-for-service delivery system to a managed care system of health care delivery with approximately one per cent of medicaid clients remaining in the limited fee-for-service program.

The legislature finds that Hawaii has contracted with managed care health plans for the State's 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, as mandated by the Balanced Budget Act of 1997, Section 438: Managed Care: Subpart H-Certifications and Program Integrity; Section 438.66: Monitoring Procedures.

The legislature recognizes that the problems of fraud, abuse, and waste within medicaid programs have led to higher costs for each state during the critical time of actuarial rate analysis and the setting of managed care health plan contracts.

The federal Patient Protection and Affordable Care Act of 2010 required each state to submit state plan amendments by December 31, 2010, to detail how it will establish its recovery audit contractor programs to increase post-payment reviews to identify payment errors and recoup overpayments. Recovery audit contractor programs review medicaid provider claims to identify and recover overpayments and identify underpayments made for services provided under medicaid state plans and medicaid waivers.

The purpose of this Act is to require the department of human services to report on the State's program integrity compliance with the federal Patient Protection and Affordable Care Act of 2010 as it relates to medicaid program integrity within managed care health plans, the fee-for-service program, and the children's health insurance program.

SECTION 2. The department of human services shall submit interim reports to the legislature no later than twenty days prior to the convening of the regular sessions of 2014, 2015, and 2016, on the State's program integrity compliance with the federal Patient Protection and Affordable Care Act of 2010 with respect to medicaid program integrity within the managed care health plans, fee-for-service program, and the children's health

insurance program, including timelines and plans for compliance with the federal Patient Protection and Affordable Care Act of 2010, for fiscal years 2012-2013, 2013-2014, and 2014-2015.

Each report to the legislature shall include the following information for fiscal years 2012-2013, 2013-2014, and 2014-2015:

(1) The department of human services' compliance status with the following federal Patient Protection and Affordable Care Act of 2010 sections as they relate to:

(A) Medicaid program integrity within managed care health plans, the fee-for-service program, and the children's health insurance program provisions:

(i) Provider screening with initial enrollment and routine reviews;

(ii) Searches within the Social Security Administration's Death Master File;

(iii) Increased documentation on referrals to programs at high-risk of waste and abuse;

(iv) Enhanced penalties;

(v) Implementation of recovery audit contractor programs; and

(vi) Implementation of processes for increased pre-payment reviews of claims versus post-payment reviews;

(B) Additional medicaid program integrity provisions, including:

(i) Termination of providers from medicaid (if terminated under medicare or other medicaid state plan or the children's health insurance program;

(ii) Termination of excluded providers identified via established federal databanks, i.e., the Office of Inspector General List of Excluded Individuals/Entities;

(iii) Processes to maintain a central repository of program integrity targets with processes to track providers who are under investigation with possible withholding of payments under specified circumstances;

(iv) Overpayments, including prevention and recoupment;

(v) Mandatory use of the National Correct Coding Initiative;

(vi) Registration of billing agents; and

(vii) Implementation of expanded data elements under Hawaii's medicaid management information system to detect fraud and abuse with corrective action plans, and additional edits and audits, including predictive modeling and analytic technologies, as appropriate; and

(C) Additional program integrity provisions: The means to prohibit false statements and representations;

(2) The department of human services Med-QUEST division's plans and processes to assure adequate federally-mandated oversight of the contracted managed care health plan's integrity programs and verification of the beneficiary receipt of services claimed by managed care health plans via explanation of benefits' forms or other approved methods; and

(3) An analysis of:

(A) Actual cost-savings and projected cost savings per program for each fiscal year;

(B) Actual recouped dollar amounts and fines collected by the department of human services' internal program integrity section;

(C) The number of referrals to the department of the attorney general's medicaid fraud control unit; and

(D) The number of reported investigations and recoupments from both the QUEST and the QUEST Expanded Access health plans, fee-for-service, or the children's health insurance program for each cited fiscal year.

SECTION 3. The department of human services shall submit a report on the final status of implementing and complying with the federal Patient Protection and Affordable Care Act of 2010 with respect to program integrity, to the legislature no later than twenty days before the convening of the regular session of 2017.

SECTION 4. This Act shall take effect upon its approval.

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Report Title:
Department of Human Services Compliance; Affordable Care Act

Description:
Requires Department of Human Services to submit to Legislature interim reports on program integrity prior to 2014, 2015, and 2016 Regular Sessions and a final report prior to 2017 Regular Session on its compliance with the federal Patient Protection and Affordable Care Act of 2010 as it relates to Medicare and Medicaid. (HB1207 HD1)

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