
A BILL FOR AN ACT

RELATING TO HUMAN SERVICES.

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

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

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



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

10 The legislature finds that Hawaii has contracted with
11 managed care health plans for the State's medicaid populations,
12 which include QUEST health plans and QUEST Expanded Access
13 health plans, with the department of human services retaining
14 federally-mandated accountability and oversight of these managed
15 care plans, as mandated by the Balanced Budget Act of 1997,
16 Section 438: Managed Care: Subpart H-Certifications and
17 Program Integrity; Section 438.66: Monitoring Procedures.

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



1 The federal Patient Protection and Affordable Care Act of
2 2010 required each state to submit state plan amendments by
3 December 31, 2010, to detail how it will establish its recovery
4 audit contractor programs to increase post-payment reviews to
5 identify payment errors and recoup overpayments. Recovery audit
6 contractor programs review medicaid provider claims to identify
7 and recover overpayments and identify underpayments made for
8 services provided under medicaid state plans and medicaid
9 waivers.

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

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



1 insurance program, including the timelines and plans for
2 compliance with the federal Patient Protection and Affordable
3 Care Act of 2010 for fiscal years 2013-2014, 2014-2015, and
4 2015-2016.

5 Each report to the legislature shall include, at a minimum,
6 for fiscal years 2013-2014 and 2014-2015, the following
7 information or the department of human services' compliance
8 status with various provisions of the federal Patient Protection
9 and Affordable Care Act of 2010 as they relate to:

- 10 (1) Implementation of provider enrollment, screening
11 verification, and termination programs;
- 12 (2) Implementation of recovery audit contractor programs;
- 13 (3) Implementation of processes to provide managed care
14 oversight of the department's mandated fraud and abuse
15 programs;
- 16 (4) Implementation of means to prohibit false statements
17 and representations, including the department's
18 processes of verification of the beneficiary receipt
19 of services claimed by managed care health plans via
20 explanation of benefits forms or other approved
21 methods;



- 1 (5) The projected cost savings per program per fiscal
2 year;
- 3 (6) Activities taken by the department's internal program
4 integrity section to prevent and reduce fraud, waste,
5 and abuse, including overpayments recovered and number
6 of fraud reports received by the department from the
7 QUEST and QUEST Expanded Access health plans, fee-for-
8 service program, and the children's health insurance
9 program each cited fiscal year; and
- 10 (7) Number of referrals to the department of the attorney
11 general's medicaid fraud control unit.

12 SECTION 3. The department of human services shall submit a
13 report on the final status of implementing and complying with
14 the federal Patient Protection and Affordable Care Act of 2010
15 with respect to program integrity, to the legislature no later
16 than twenty days before the convening of the regular session of
17 2017.

18 SECTION 4. This Act shall take effect on July 1, 2050.



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 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. Takes effect 7/1/2050. (SD1)

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