ACT 240

H.B. NO. 1207

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 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 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 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 the timelines and plans for compliance with the federal Patient Protection and Affordable Care Act of 2010 for fiscal years 2013-2014, 2014-2015, and 2015-2016.

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

(1) Implementation of provider enrollment, screening verification, and termination programs;
(2) Implementation of recovery audit contractor programs;
(3) Implementation of processes to provide managed care oversight of the department's mandated fraud and abuse programs;
(4) Implementation of means to prohibit false statements and representations, including the department's processes of verification of the beneficiary receipt of services claimed by managed care health plans via explanation of benefits forms or other approved methods;
(5) The projected cost savings per program per fiscal year;
(6) Activities taken by the department's internal program integrity section to prevent and reduce fraud, waste, and abuse, including overpayments recovered and number of fraud reports received by the

department from the QUEST and QUEST Expanded Access health plans, fee-for-service program, and the children's health insurance program each cited fiscal year; and

(7) Number of referrals to the department of the attorney general's medicaid fraud control unit.

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 on July 1, 2014.

(Approved June 27, 2013.)