Hall of the House of Representatives

89th General Assembly - Regular Session, 2013

Amendment Form

Subtitle of Senate Bill No. 914

TO ESTABLISH THE OFFICE OF THE MEDICAID INSPECTOR GENERAL; AND TO DEVELOP AND TEST NEW METHODS OF MEDICAID CLAIMS AND UTILIZATION REVIEW.

Amendment No. 1 to Senate Bill No. 914

Amend Senate Bill No. 914 as engrossed, S3/25/13 (version: 03/25/2013 9:22:47 AM):

Page 1, line 11, delete “REVIEW;” AND SUBSTITUTE “REVIEW; TO DECLARE AN EMERGENCY;”

AND

Delete the subtitle in its entirety and substitute:
"TO ESTABLISH THE OFFICE OF THE MEDICAID
INSPECTOR GENERAL AND TO DECLARE AN
EMERGENCY."

AND

Page 1, line 10, delete “DEVELOP, AND” and substitute “DEVELOP, RECOMMEND, AND”

AND

Page 1, line 17, delete “DEVELOP, AND” and substitute “DEVELOP, RECOMMEND, AND”

AND

Page 1, delete lines 24 through 36 and substitute:
"SECTION 1. Arkansas Code Title 5, Chapter 37, Subchapter 2, is amended to add an additional section to read as follows:

5-37-217. Healthcare fraud.

(a) A person commits healthcare fraud if with a purpose to defraud a health plan:

(1) The person knowingly provides materially false information or omits material information for the purpose of requesting payment from a single health plan for a health care item or service; and

(2) As a result of the materially false information or omission of material information, a person receives payment in an amount that the person is not entitled to under the circumstances.

(b)(1) Health care fraud in the fifth degree is a Class A misdemeanor.

(2) However, if on one (1) or more occasion, the payment or portion of the payment wrongfully received from a single health plan in a period of not more than one (1) year exceeds:

(A) Ten thousand dollars ($10,000) in the aggregate, health care fraud is a Class D felony;

(B) Twenty-five thousand dollars ($25,000) in the aggregate, health care fraud is a Class C felony;

(C) Fifty thousand dollars ($50,000) in the aggregate, health care fraud is a Class B felony;

(D) One million dollars ($1,000,000) in the aggregate, health care fraud is a Class A felony.

(c) It is an affirmative defense to prosecution under this section that the defendant was a clerk, bookkeeper, or other employee other than an employee charged with the active management and control in an executive capacity of the affairs of the corporation who executed the orders of his or her employer or of a superior employee generally authorized to direct his or her activities."

AND

Page 2, delete lines 1 through 36

AND

Page 3, delete lines 1 through 16

AND

Page 3, line 30, delete "recoupment" and substitute "recovery"

AND

Page 3, delete lines 32 through 36 and substitute:

"20-77-2102. Definitions.

As used in this subchapter:

(1)(A) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

(B) "Abuse" includes recipient practices that result in an unnecessary cost to the Medicaid program;

(2)(A) "Fraud" means a purposeful deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or another person.

(B) "Fraud" includes any act that constitutes fraud under applicable federal or state law;

(3) "Health plan" means a publicly or privately funded health insurance or managed care plan or contract under which a health care item or service is provided and through which payment is made to the person who provided the health care item or service;

(4) "Investigation" means investigations of fraud, abuse, or illegal acts perpetrated within the medical assistance program by providers or recipients of medical assistance care, services, and supplies;

(5) "Person" means an individual or entity other than a recipient of a health care item or service;

(6) "Recovery" means any action or attempt by the inspector to recoup or collect Medicaid payments already made to a provider with respect to a claim by:

(A) Reducing other payments currently owed to the provider;

(B) Withholding or setting off the amount against current or future payments to the provider;

(C) Demanding payment back from a provider for a claim already paid; or

(D) Reducing or affecting in any other manner the future claim payments to the provider.

(7) "Single health plan" includes without limitation the Arkansas Medicaid Program; and

(8) "Waste" means that taxpayers are not receiving reasonable value for money in connection with a government-funded activity due to an inappropriate act or omission involving mismanagement, inappropriate actions, and inadequate oversight by the person with control over or access to government resources."

AND

Page 4, delete line 4 and substitute "of the Governor and is independent from the Department of Human Services."

AND

Page 5, line 3, delete "(2)" and substitute "(2)(A)"

AND

Page 5, delete line 4 and substitute the following:
"investigate medical assistance program fraud and abuse.

(B)(i) The Office of Medicaid Inspector General shall review provider records only for the three (3) years before an investigation begins.

(ii) However, if a credible allegation of fraud has been made or if the office has reason to believe that fraud has occurred, the office may review provider records for the five (5) years before the investigation began;"

AND

Page 5, delete line 6 through 10 and substitute the following:

"(A) Federal, state, and local law enforcement agencies;
(B) The Medicaid Fraud Control Unit of the office of the Attorney General;
(C) United States attorneys;
(D) United States Department of Health and Human Services Office of the Inspector General;
(E) The Federal Bureau of Investigation;
(F) The Drug Enforcement Administration;
(G) Prosecuting attorneys;
(H) The Centers for Medicare and Medicaid Services; and
(I) An investigative unit maintained by a health insurer;"

AND

Page 5, line 13, delete "(5)" and substitute "(5)(A)"

AND

Page 5, delete line 16 and substitute the following:
"abuse within the medical assistance program.
(B) All cases in which fraud is determined to have occurred shall be referred to the appropriate law enforcement agency for prosecution;"

AND

Page 6, line 16, delete "testimony." and substitute "testimony in connection with an investigation or audit under this subchapter and under rules governing these investigations;"

AND

Page 7, line 8, delete "(13)" and substitute "(13)(A)"

AND

Page 7, line 10, delete "program;" and substitute "program and produce a report detailing the results of its monitoring activity as necessary.
(B) The report shall be submitted to the:
(i) Governor;
(ii) President Pro Tempore of the Senate;
(iii) Speaker of the House of Representatives;
(iv) Legislative Council;
(v) Division of Legislative Audit; and
(vi) Attorney General;"

AND

Page 7, delete lines 18 and 19 substitute:
"(16)(A) Work with the fiscal agent employed to operate the Medicaid Management Information System of the Department of Human Services to optimize the system, including without limitation the ability to add edits

and audits in consultation with the Department of Human Services.

(B) The inspector shall be consulted before an edit or audit is added or discontinued by the Department of Human Services;"

AND

Page 7, line 24, delete "(18)" and substitute "(18)(A)"

AND

Page 7, line 26, delete "program;" and substitute "program.

(B) The office shall regularly communicate with and educate providers about the office's fraud and abuse prevention program and its audit policies and procedures.

(C) The office shall educate providers annually concerning its areas of focus within the medical assistance program, appropriate billing and documentation, and methods for improving compliance with program rules, policies, and procedures;"

AND

Page 7, line 28, delete "disclosure and" and substitute "disclosure consistent with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and"

AND

Page 8, delete lines 7 and 8 and substitute the following:

"(23)(A) Take appropriate authorized actions to ensure that the medical assistance program is the payor of last resort; and

(B) Recommend to the Department of Human Resources that it take appropriate actions authorized under the department's jurisdiction to ensure that the medical assistance program is the payor of last resort;"

AND

Page 8, delete lines 10 and 11 and substitute "year to the Governor;

(25) Identify and order the return of underpayments to providers;

(26) Maintain the confidentiality of all information and documents that are deemed confidential by law;

(27) Implement, facilitate, and maintain federally required directives and contracts required for Medicaid integrity programs;

(28) Implement and maintain a hotline for reporting complaints regarding fraud, waste, and abuse by providers;

(29) Audit, investigate, and access Medicaid encounter data, premium data or other information from an entity contracted with for the purpose of serving Medicaid programs;

(30)(A) Promulgate administrative rules to establish policies and procedures for audits and investigations that are consistent with the duties of the office under this chapter.

(B) The rules shall be posted on the office's website;

(31) Identify conflicts between the Medicaid state plan, department rules, Medicaid provider manuals, Medicaid notices, or other guidance and recommend that the department reconcile inconsistencies;

(32) When conducting an audit, investigation, or review under this subchapter, classify violations as either:

(A) Errors that do not rise to the level of fraud or abuse; or

(B) Fraud or abuse;

(33)(A) If a credible allegation of fraud has been made, review provider records that have been the subject of a previous audit or review for the purpose of fraud investigation and referral.

(B) However the Medicaid Inspector General shall not duplicate an audit of a contract, cost report, claim, bill, or expenditure of a medical assistance program fund that has been the subject of a previous audit or review by or on behalf of the office of Medicaid Inspector General, the Medicaid Fraud Control Unit, or other federal agency with authority over the medical assistance program providing the audit or review were performed in accordance with Government Auditing Standards;

(34)(A) Utilize a quality improvement organization as part of the assessment of quality of services.

(B) The quality improvement organization shall refer all identified improper payments due to technical deficiencies, abuse, waste, or fraud to Medicaid Inspector General for further investigation and appropriate action, including without limitation recovery; and

(35) Perform other functions necessary or appropriate to fulfill"

AND

Page 8, line 24, delete "recoupment" and substitute "recovery"

AND

Page 8, line 26, delete "inspector" and substitute "Inspector"

AND

Page 8, delete line 30 and substitute the following:"

"(4) Another state or local government entity.

(c) All tips to the Arkansas Medicaid Fraud and Abuse Hotline that include an allegation of fraud shall be forwarded to the office."

AND

Page 8, line 33, delete "The" and substitute "(a) The"

AND

Page 8, delete line 36 and substitute the following:

"Inspector General under § 20-77-2105 are transferred to the office.

(b) The office shall assume the duties under the Medical Assistance Programs Integrity Law, § 20-77-1301 et seq."

AND

Page 9, line 5, delete “Representatives,” and substitute “Representatives, Division of Legislative Audit, Legislative Council,”

AND

Page 9, delete lines 15 and 16 and substitute the following:
"limitation outcome, region, the reason for the audit, the total state and federal dollar value identified for recovery, the actual state and federal recovery from the audits, and the amount repaid to the Centers for Medicare & Medicaid Services;"

AND

Page 9, line 23, delete "(b)(D)(i)" and substitute "(b)(1)(D)(i)"

AND

Page 9, line 24, delete “action; and” and substitute “action;”

AND

Page 9, line 27, delete “collected; and” and substitute “collected; and
(F) Administrative and education activities conducted to improve compliance with Medicaid program policies and requirements; and”

AND

Page 9, line 28, delete "(2)" and substitute "(2)(A)"

AND

Page 9, line 31, delete "effectiveness and" and substitute "effectiveness, and"

AND

Page 9, delete lines 32 and 33 and substitute the following:
"assistance program.

(B)(i) In addition to total savings, the narrative shall detail net savings in state funds.

(ii) As used in subdivision (b)(2)(B)(i) of this section, "net savings" means amounts recovered by the office less payments made to the Centers for Medicare & Medicaid Services and the costs of state administrative procedures.

(c) The office may subpoena individuals, books, electronic and other records, and documents that are necessary for the completion of reports under this section.

(d)(1) In making the report required under subsection (a) of this"

AND

Page, 10, line 1, delete "subdivision" and substitute "subsection"

AND

Page 10, line 5, delete "(d)" and substitute "(e)"

AND

Page 10, line 7, delete "Representatives," and substitute "Representatives, Division of Legislative Audit, Legislative Council,"

AND

Page 10, delete lines 16 and 17 and substitute "intermediary or fiscal agent pertaining to suspected fraud, waste, or abuse."

AND

Page 10, line 19, delete "test, and implement new" and substitute "test, recommend, and implement"

AND

Page 10, delete line 21 and substitute "fraud, waste, and abuse and improve expenditure accountability;"

AND

Page 10, delete lines 22 through 24 and substitute the following:
"(2)(A) Enter into agreement with a fiscal agent in collaboration with the Office of Medicaid Inspector General's data mining technology to develop, test, and implement the new methods under subdivision (b)(1) of this section."

AND

Page 10, Line 25, delete "An agreement" and substitute "A collaborative agreement with the office"

AND

Page 10, line 27, delete "agreement" and substitute "agreement;"

AND

Page 10, line 28, delete "test, and implement" and substitute "test, recommend, and implement"

AND

Page 11, line 10, delete “agents.” and substitute “agents and ensure that any data abnormalities identified are reported to the office for appropriate action;”

AND

Page 11, line 12, delete “better identify” and substitute “better assist the office in identifying”

AND

Page 11, line 14, delete “and”

AND

Page 11, line 18, delete “increase” and substitute “assist the office in increasing”

AND

Page 11, line 19, delete “program.” and substitute “program;”

AND

Page 11, line 23, delete "and" from the end of the line

AND

Page 11, line 24, delete “2014, develop, test, and” and substitute “2014, assist the office in developing, testing, and implementing”

AND

Page 11, line 25, delete “implement”

AND

Page 11, delete line 30 and substitute the following:
"service use and billing are appropriate to recipients' needs; and

(9) Pay providers for underpayments identified through actions of the office."

AND

Page 11, line 31, delete “developed” and substitute “developed and recommended”

AND

Page 12, line 15, delete “unintentional;” and substitute “unintentional.”

AND

Page 12, delete line 22 and substitute “the goals of this section, including recommendations for expansion.

(e) Applicable medical assistance program rules, provider manuals, and administrative policies, procedures, and guidance will be posted on the Office of Medicaid Inspector General website, or by a link from the website to the department’s website.”

AND

Page 12, line 17, delete “Services” and substitute “Services in conjunction with the office”

AND

Page 12, line 24, delete "20-77-1211" and substitute "20-77-2111"

AND

Page 13, line 4, delete “must” and substitute “shall”

AND

Page 13, delete line 9 and substitute the following:
"receives annually seven hundred fifty thousand dollars ($750,000) or more through the state Medicaid program shall adopt and implement a compliance program."

AND

Page 14, line 19, delete “(5)(A)” and substitute “(5)”

AND

Page 14, line 23, delete "(i)" and substitute "(A)"

AND

Page 14, line 24, delete "(ii)" and substitute "(B)"

AND

Page 14, line 25, delete "(iii)" and substitute "(C)"

AND

Page 14, delete lines 26 through 28 and substitute “permitting noncompliant behavior;”

AND

Page 15, line 9, delete “overpayments” and substitute “overpayments; and”

AND

Page 15, delete line 22 and substitute "section by requesting, no more than one (1) time every year, an updated certification that the provider satisfactorily meets the requirements of this section."

AND

Page 15, delete line 33 and substitute the following:

"(h)(1) The office shall adopt rules to implement this section.

(2) The rules shall be subject to review by the Legislative Council.

20-77-2112. Applicability of the Medicaid Fairness Act.

The Medicaid Fairness Act, § 20-77-1701 et seq., applies to this subchapter."

AND

Page 16, delete line 25 and substitute "is binding upon the director with respect to that provider only.

(3) If the director cannot respond to the request for an advisory opinion, the director shall within thirty (30) days notify the provider that he or she will not be responding to the request for an opinion."

AND

Page 17, delete lines 13 and 14 and substitute "(2) If the director modifies or revokes an advisory opinion, the modification or revocation operates prospectively."

AND

Page 17, line 15, delete "recoupment" and substitute "recovery"

AND

Page 17, delete lines 16 through 18 and substitute "provider's reliance on an advisory opinion that is later modified or revoked is prohibited for the period up until the modification or revocation unless the provider is involved in fraud."

AND

Page 17, delete line 28 and substitute "previously issued advisory opinion is a public record.

SECTION 5. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the oversight and audit of the state's Medicaid program is essential to its continued operation; that the creation of the Office of the Medicaid Inspector General will ensure that

fraud, waste, and abuse are found in a timely manner; and that this act is necessary to ensure that state and federal monies are not misspent. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July, 1, 2013."

The Amendment was read _____

By: Representative Westerman

MAG/CDS - 04-08-2013 14:23:35 _____

MAG027 **Chief Clerk**