ARKANSAS SENATE

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 originally introduced:

Delete everything after the enacting clause and substitute the following:

"SECTION 1. Arkansas Code Title 5, Chapter 37, is amended to add an additional subchapter to read as follows:

Subchapter 6 — Health Care Fraud

5-37-601. Definitions.

As used in this subchapter:

(1) "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 may be made to the person who provided the health care item or service;

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

(3) "Single health plan" includes without limitation the Arkansas Medicaid program;

5-37-602. Health care fraud in the first degree.

(a) A person commits health care fraud in the first degree if the person, on one (1) or more occasions, commits the crime of health care fraud in the fifth degree and the payment or portion of the payment wrongfully received, as the case may be, from a single health plan, in a period of not more than one (1) year, exceeds one million dollars ($1,000,000) in the aggregate.

(b) Health care fraud in the first degree is a Class A felony.

5-37-603. Health care fraud in the second degree.

(a) A person commits health care fraud in the second degree if the person, on one (1) or more occasions, commits the offense of health care fraud in the fifth degree and 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 fifty thousand dollars ($50,000) in the aggregate.

(b) Health care fraud in the second degree is a Class B felony.

5-37-604. Health care fraud in the third degree.

(a) A person commits health care fraud in the third degree if the person, on one (1) or more occasions, commits the offense of health care fraud in the fifth degree and 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 ten thousand dollars ($10,000) in the aggregate.

(b) Health care fraud in the third degree is a Class C felony.

5-37-605. Health care fraud in the fourth degree.

(a) A person commits health care fraud in the fourth degree if the person, on one (1) or more occasions, commits the offense of health care fraud in the fifth degree and 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 three thousand dollars ($3,000) in the aggregate.

(b) Health care fraud in the fourth degree is a Class D felony.

5-37-606. Health care fraud in the fifth degree.

(a) A person commits health care fraud in the fifth degree if with a purpose to defraud a health plan, he or she 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, 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) Health care fraud in the fifth degree is a Class A misdemeanor.

5-37-607. Health care fraud; affirmative defense.

In a prosecution under this subchapter, it is an affirmative defense 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, without personal benefit, executed the orders of his or her employer or of a superior employee generally authorized to direct his or her activities.

SECTION 2. Arkansas Code Title 20, Chapter 77, is amended to add an additional subchapter to read as follows:

Subchapter 21 — Office of Medicaid Inspector General

20-77-2101. Purpose.

The purpose of this subchapter is to:

(1) Consolidate staff and other Medicaid fraud detection, prevention, and recovery functions from the relevant governmental entities into a single office;

(2) Create a more efficient and accountable structure;

(3) Reorganize and streamline the state's process for detecting and combating Medicaid fraud and abuse; and

(4) Maximize the recoupment of improper Medicaid payments.

20-77-2102. Definition.

As used in this subchapter, "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.

20-77-2103. Office of Medicaid Inspector General — Created.

The Office of Medicaid Inspector General is created within the office of the Governor.

20-77-2104. Medicaid Inspector General — Appointment — Qualifications.

(a)(1) The Medicaid Inspector General shall be appointed by the Governor, with the advice and consent of the Senate.

(2) The inspector shall serve at the pleasure of the Governor.

(b) The inspector shall report directly to the Governor.

(c) The Medicaid Inspector General shall be the director of the Office of Medicaid Inspector General.

(d) The inspector shall have not less than ten (10) years of professional experience in one (1) or more of the following areas of expertise:

(1) Prosecution for fraud;

(2) Fraud investigation;

(3) Auditing; or

(4) Comparable alternate experience in health care, if the health care experience involves some consideration of fraud.

20-77-2105. Office of Medicaid Inspector General — Powers and duties.

The Office of Medicaid Inspector General shall:

(1) Prevent, detect, and investigate fraud and abuse within the medical assistance program;

(2) Refer appropriate cases for criminal prosecution;

(3) Recover improperly expended medical assistance funds;

(4) Audit medical assistance program functions; and

(5) Establish a medical assistance program fraud and abuse prevention.

20-77-2106. Medicaid Inspector General — Duties.

The Medicaid Inspector General shall:

(1) Hire deputies, directors, assistants, and other officers and employees needed for the performance of his or her duties and prescribe the duties of deputies, directors, assistants, and other officers and fix the compensation of deputies, directors, assistants, and other officers within the amounts appropriated;

(2) Conduct and supervise activities to prevent, detect, and investigate medical assistance program fraud and abuse; and

(3) Work in a coordinated and cooperative manner with:

(A) The Medicaid Fraud Control Unit of the office of the Attorney General;

(B) United States Attorneys;

(C) Prosecuting attorneys; and

(D) An investigative unit maintained by a health insurer;

(4) Solicit, receive, and investigate complaints related to fraud and abuse within the medical assistance program;

(5) Inform the Governor, the Attorney General, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives

regarding efforts to prevent, detect, investigate, and prosecute fraud and abuse within the medical assistance program;

(6)(A) Pursue civil and administrative enforcement actions against an individual or entity that engages in fraud, abuse, or illegal or improper acts within the medical assistance program, including without limitation:

(i) Referral of information and evidence to regulatory agencies and licensure boards;

(ii) Withholding payment of medical assistance funds in accordance with state laws and rules and federal laws and regulations;

(iii) Imposition of administrative sanctions and penalties in accordance with state laws and rules and federal laws and regulations;

(iv) Exclusion of providers, vendors, and contractors from participation in the medical assistance program;

(v) Initiating and maintaining actions for civil recovery and, where authorized by law, seizure of property or other assets connected with improper payments;

(vi) Entering into civil settlements; and

(vii) Recovery of improperly expended medical assistance program funds from those who engage in fraud or abuse or illegal or improper acts perpetrated within the medical assistance program.

(B) In investigating civil and administrative enforcement actions under subdivision (a)(6)(A) of this section, the inspector shall consider the quality and availability of medical care and services and the best interest of both the medical assistance program and recipients;

(7) Make available to appropriate law enforcement officials information and evidence relating to suspected criminal acts that has been obtained in the course of the inspector's duties;

(8)(A) Refer suspected fraud or criminal activity to the Medicaid Fraud Control Unit of the office of the Attorney General.

(B) After a referral and with ten (10) days' written notice to the Medicaid Fraud Control Unit of the office of the Attorney General, the inspector may provide relevant information about suspected fraud or criminal activity to another federal or state law enforcement agency that the inspector deems appropriate under the circumstances;

(9) Subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony;

(10) Require and compel the production of books, papers, records and documents as he or she deems relevant or material to an investigation, examination, or review undertaken under this section;

(11)(A) Examine and copy or remove documents or records related to the medical assistance program or necessary for the inspector to perform his or her duties if the documents are prepared, maintained, or held by or available to a state agency or local governmental entity the patients or clients of which are served by the medical assistance program, or the entity is otherwise responsible for the control of fraud and abuse within the medical assistance program.

(B) A document or record examined and copied or removed by the inspector under subdivision (11)(A) of this section is confidential.

(C) The removal of a record under subdivision (11)(A) of this section is limited to circumstances in which a copy of the record is

insufficient for an appropriate legal or investigative purpose.

(D) For a removal under subdivision (11)(A) of this section, the inspector shall copy the record and ensure the expedited return of the original, or of a copy if the original is required for an appropriate legal or investigative purpose, so that the information is expedited and the original or copy is readily accessible for the care and treatment needs of the patient;

(12)(A) Recommend and implement policies relating to the prevention and detection of fraud and abuse.

(B) The inspector shall obtain the consent of the Attorney General before the implementation of a policy under subdivision (12)(A) of this section that may affect the operations of the office of the Attorney General;

(13) Monitor the implementation of a recommendation made by the office to an agency or other entity with responsibility for administration of the medical assistance program;

(14) Prepare cases, provide testimony, and support administrative hearings and other legal proceedings;

(15) Review and audit contracts, cost reports, claims, bills, and other expenditures of medical assistance program funds to determine compliance with applicable state laws and rules and federal laws and regulations and take actions authorized by state laws and rules and federal laws and regulations;

(16) Work with the fiscal agent employed to operate the Medicaid Management Information System to optimize the system;

(17) Work in a coordinated and cooperative manner with relevant agencies in the implementation of information technology relating to the prevention and identification of fraud and abuse in the medical assistance program;

(18) Conduct educational programs for medical assistance program providers, vendors, contractors, and recipients designed to limit fraud and abuse within the medical assistance program;

(19)(A)(i) Develop protocols to facilitate the efficient self-disclosure and collection of overpayments; and

(ii) Monitor collections, including those that are self-disclosed by providers.

(B) A provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action;

(20) Receive and investigate complaints of alleged failures of state and local officials to prevent, detect, and prosecute fraud and abuse in the medical assistance program;

(21) Implement rules relating to the prevention, detection, investigation, and referral of fraud and abuse within the medical assistance program and to the recovery of improperly expended medical assistance program funds;

(22) Conduct, in the context of the investigation of fraud and abuse, on-site inspections of a facility or an office;

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

(24) Annually submit a budget request for the next state fiscal year to the Governor; and

(25) Perform other functions necessary or appropriate to fulfill the duties and responsibilities of the office.

20-77-2107. Cooperation of agency officials and employees.

(a)(1) The Medicaid Inspector General shall request information, assistance, and cooperation from a federal, state, or local governmental department, board, bureau, commission, or other agency or unit of an agency to carry out the duties under this section.

(2) A state or local agency or unit of an agency shall provide information, assistance, and cooperation under this section.

(b) Upon request of a prosecuting attorney, the following entities shall provide information and assistance as the entity deems necessary, appropriate, and available to aid the prosecutor in the investigation of fraud and abuse within the medical assistance program and the recoupment of improperly expended funds:

(1) The Office of Medicaid inspector General;

(2) The Department of Human Services;

(3) The Medicaid Fraud Control Unit of the office of the Attorney General; and

(4) Another state or local government entity.

20-77-2108. Transfer of duties and resources.

The duties, functions, records, personnel, property, unexpended balances of appropriations, allocations, or other funds of the Department of Human Services necessary to the operations of the Office of the Medicaid Inspector General under § 20-77-2105 are transferred to the office.

20-77-2109. Reports required of the Medicaid Inspector General.

(a) The Medicaid Inspector General shall, no later than October 1 of each year, submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Attorney General a report summarizing the activities of the Office of the Medicaid Inspector General during the preceding calendar year.

(b) The report required under subsection (a) of this section shall include without limitation:

(1) The number, subject, and other relevant characteristics of:

(A) Investigations initiated, and completed, including without limitation outcome, region, source of complaint, and whether or not the investigation was conducted jointly with the Attorney General;

(B) Audits initiated and completed, including without limitation outcome, region, the reason for the audit, the total dollar value identified for recovery, and the actual recovery from the audits;

(C) Administrative actions initiated and completed, including without limitation outcome, region, and type;

(D)(i) Referrals for prosecution to the Attorney General and to federal or state law enforcement agencies, and referrals to licensing authorities.

(ii) Information reported under subdivision (b)(D)(i) of this section shall include without limitation the status and region of an administrative action; and

(E) Civil actions initiated by the office related to improper payments, the resulting civil settlements entered, overpayments

identified, and the total dollar value identified and collected; and

(2) A narrative that evaluates the office's performance, describes specific problems with the procedures and agreements required under this section, discusses other matters that may have impaired the office's effectiveness and summarizes the total savings to the state medical assistance program.

(c)(1) In making the report required under subdivision (a) of this section, the inspector shall not disclose information that jeopardizes an ongoing investigation or proceeding.

(2) The inspector may disclose information in the report required under subdivision (a) of this section if the information does not jeopardize an ongoing investigation or proceeding and the inspector fully apprises the designated recipients of the scope and quality of the office's activities.

(d) Quarterly by April 1, July 1, October 1, and January 1 of each year, the inspector shall submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Attorney General an accountability statement providing a statistical profile of the referrals made to the Medicaid Fraud Control Unit of the office of the Attorney General, audits, investigations, and recoveries.

20-77-2110. Department of Human Services consultation with Office of the Medicaid Inspector General.

(a) The Department of Human Services shall consult with the Office of the Medicaid Inspector General regarding an activity undertaken by a fiscal intermediary or fiscal agent regarding an investigation of suspected fraud and abuse.

(b) The department, in consultation with the office, shall:

(1) Develop, test, and implement new methods to strengthen the capability of the Medicaid Payment Information System to detect and control fraud and improve expenditure accountability; and

(2)(A) Enter into further agreements with a fiscal agent, an information technology agent, or both to develop, test, and implement the new methods under subdivision (b)(1) of this section.

(B) An agreement under subdivision (b)(2)(A) of this section shall be made with an agent that has demonstrated expertise in the areas addressed by the agreement.

(3)(A) Develop, test, and implement an automated process to improve the coordination of benefits between the medical assistance program and other sources of coverage for medical assistance recipients.

(B)(i) An automated process under subdivision (b)(3()A) of this section initially shall examine the savings potential to the medical assistance program through retrospective review of claims paid.

(ii) The examination under subdivision (b)(3)(B)(i) of this section shall be completed no later than January 1, 2014.

(iii) If, based upon the initial experience under subdivision (b)(3)(B)(i) of this section, the Medicaid Inspector General deems the automated process to be capable of including or moving to a prospective review, with negligible effect on the turnaround of claims for provider payment or on recipient access to services, the inspector in subsequent tests shall examine the savings potential through prospective, pre-claims payment review;

(4) Take all reasonable and necessary actions to intensify the state's current level of monitoring, analyzing, reporting, and responding to medical assistance program claims data maintained by the state's Medicaid Management Information System fiscal agents.

(5) Make efforts to improve the utilization of data in order to better identify fraud and abuse within the medical assistance program and to identify and implement further program and patient care reforms for the improvement of the program; and

(6) Identify additional data elements that are maintained and otherwise accessible by the state, directly or through any of its contractors, that would, if coordinated with medical assistance data, further increase the effectiveness of data analysis for the management of the medical assistance program.

(7) Provide or arrange in-service training for state and county medical assistance personnel to increase the capability for state and local data analysis to move toward a more cost-effective operation of the medical assistance program; and

(8)(A) No later than January 1, 2014, develop, test, and implement an automated process for the targeted review of claims, services, populations, or a combination of claims, services, populations.

(B) A review under subdivision (8)(A) of this section is to identify statistical aberrations in the use or billing of the services and to assist in the development and implementation of measures to ensure that service use and billing are appropriate to recipients' needs.

(c)(1) The methods developed under subdivision (b)(1) of this section shall address without limitation the development, testing, and implementation of an automated claims review process that, before payment, shall subject a medical assistance program services claim to review for proper coding and another review as may be necessary.

(2) Services subject to review shall be based on:

(A) The expected cost-effectiveness of reviewing the service;

(B) The capabilities of the automated system for conducting the review; and

(C) The potential to implement the review with negligible effect on the turnaround of claims for provider payment or on recipient access to necessary services.

(3) A review under subdivision (c)(2) of this section shall be designed to provide for the efficient and effective operation of the medical assistance program claims payment system by performing functions including without limitation:

(A) Capturing coding errors, misjudgments, incorrect, or multiple billing for the same service; and

(B) Possible excesses in billing or service use, whether intentional or unintentional;

(d)(1) No later than December 1, 2013, the Director of the Department of Human Services shall prepare and submit an interim report to the Governor and the cochairs of the Legislative Council on the implementation of the initiatives under this section.

(2) The report under subdivision (d)(1) of this section shall also include a recommendation for a revision that would further facilitate the goals of this section, including recommendations for expansion.

20-77-1211. Provider compliance program.

(a) The General Assembly finds that:

(1) Medical assistance providers potentially are able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs;

(2) A provider compliance program makes it possible to organize provider resources to resolve payment discrepancies, detect inaccurate billings as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences;

(3) It is in the public interest that providers within the medical assistance program implement compliance programs;

(4) The wide variety of provider types in the medical assistance program necessitates a variety of compliance programs that reflect a provider's size, complexity, resources, and culture;

(5) For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics;

(6) Key components that must be included in each compliance program if a provider is to be a medical assistance program participant; and

(7) A provider should adopt and implement an effective compliance program appropriate to the provider.

(b) A provider of medical assistance program items and services that is subject to this section shall adopt and implement a compliance program.

(c)(1) The Office of the Medicaid Inspector General shall create and make available on its website guidelines including a model compliance program.

(2) A model compliance program under subdivision (c)(1) of this section shall be applicable to billings to and payments from the medical assistance program but need not be confined to billings and payments.

(3) The model compliance program required under subdivision (c)(1) this section may be a component of a more comprehensive compliance program by the medical assistance provider if the comprehensive compliance program meets the requirements of this section.

(d) A compliance program shall include without limitation:

(1) A written policy and procedure that:

(A) Describes compliance expectations;

(B) Describes the implementation of the operation of the compliance program;

(C) Provides guidance to employees and others on dealing with potential compliance issues;

(D) Identifies a method for communicating compliance issues to appropriate compliance personnel; and

(E) Describes the method by which potential compliance problems are investigated and resolved;

(2)(A) Designation of an employee vested with responsibility for the operation of the compliance program.

(B) The designated employee's duties may solely relate to compliance or may be combined with other duties if compliance responsibilities are satisfactorily carried out.

(C) The designated employee shall report directly to the entity's chief executive or other senior administrator and periodically shall report directly to the governing body of the provider on the activities of

the compliance program;

(3)(A) Training and education of affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations, and the compliance program operation.

(B) The training under subdivision (d)(3)(A) of this section shall occur periodically and shall be made a part of the orientation for a new employee, appointee, associate, executive, or governing body member;

(4)(A) Lines of communication to the designated compliance employee that are accessible to all employees, persons associated with the provider, executives, and governing body members to allow compliance issues to be reported.

(B) The lines of communication under subdivision (d)(4)(A) of this section shall include a method for anonymous and confidential good-faith reporting of potential compliance issues as they are identified;

(5)(A) Disciplinary policies to encourage good-faith participation in the compliance program by an affected individual, including a policy that articulates expectations for reporting compliance issues and assisting in their resolution, and outlines sanctions for:

(i) Failing to report suspected problems;

(ii) Participating in noncompliant behavior; and

(iii) Encouraging, directing, facilitating or permitting noncompliant behavior.

(B) A disciplinary policy under subdivision (d)(5)(A) of this section shall be fairly and firmly enforced;

(6) A system for routine identification of compliance risk areas specific to the provider type for:

(A) Self-evaluation of the risk areas, including internal audits and as appropriate external audits; and

(B) Evaluation of potential or actual noncompliance as a result of the self-evaluations and audits;

(7) A system for:

(A) Responding to compliance issues as they are raised;

(B) Investigating potential compliance problems;

(C) Responding to compliance problems as identified in the course of self-evaluations and audits;

(D) Correcting problems promptly and thoroughly and implementing procedures, policies, and systems to reduce the potential for recurrence;

(E) Identifying and reporting compliance issues to the Department of Human Services or the office; and

(F) Refunding overpayments;

(8) A policy of nonintimidation and nonretaliation for good-faith participation in the compliance program, including without limitation:

(A) Reporting potential issues;

(B) Investigating issues;

(C) Self-evaluations;

(D) Audits and remedial actions; and

(E) Reporting to appropriate officials.

(e)(1) Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the

requirements of this section.

(2) The inspector shall determine whether a provider has a compliance program that satisfactorily meets the requirements of this section.

(f) A compliance program that is accepted by the United States Department of Health and Human Services Office of Inspector General and remains in compliance with the standards of the Office of Medicaid Inspector General is in compliance with this section.

(g) If the inspector finds that a provider does not have a satisfactory compliance program within ninety (90) days after the effective date of a rule adopted under this section, the provider is subject to any sanction or penalty permitted by a state law or rule or a federal law or regulation, including revocation of the provider's agreement to participate in the medical assistance program.

(h) The department shall adopt rules to implement this section.

SECTION 3. Arkansas Code Title 23, Chapter 61, Subchapter 1, is amended to add an additional section to read as follows:

23-61-116. Annual report on health insurance fraud.

Annually, on or before March 1, the Insurance Commissioner shall submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Attorney General a report summarizing the State Insurance Department's activities to investigate and combat health insurance fraud, including without limitation information regarding:

(1) Referrals received;

(2) Investigations initiated;

(3) Investigations completed; and

(4) Other material necessary or desirable to evaluate the department's efforts under this section.

SECTION 4. Arkansas Code Title 25, Chapter 10, Subchapter 1, is amended to add an additional section to read as follows:

25-10-142. Advisory opinions.

(a) As used in this section, "advisory opinion" means a written statement by the Director of the Department of Human Services or his or her designee that explains the applicability to a specified set of facts of a pertinent statutory or regulatory provision relating to the provision of medical items or services under the medical assistance program administered by the Department of Human Services.

(b)(1) The director may issue an advisory opinion at the request of a provider enrolled in the medical assistance program.

(2) Except as under subsection (h) of this section, the opinion is binding upon the director with respect to that provider only.

(c) A provider may request an advisory opinion concerning:

(1) A substantive question or a procedural matter;

(2) Questions arising before an audit or investigation concerning a provider's claim for payment or reimbursement; and

(3) A hypothetical or projected service plan.

(d) The director shall not issue an advisory opinion if the request for an advisory opinion relates to a pending question raised by the provider in an ongoing or initiated investigation conducted by the Medicaid Inspector General, the Attorney General, a criminal investigation, or a civil or

criminal proceeding, or if the provider has received a written notice from the director or the Medicaid Inspector General that advises the provider of an imminent investigation, audit, suspended claim, or withholding of payment or reimbursement.

(e) This section does not supersede a federal regulation, law, requirement, or guidance.

(f) The director shall adopt a rule establishing the time within which an advisory opinion shall be issued and the criteria for determining the eligibility of a request for departmental response.

(g) An advisory opinion represents an expression of the views of the director as to the application of laws, rules, and other precedential material to the set of facts specified in the request for advisory opinion.

(h)(1) A previously issued advisory opinion found by the director to be in error may be modified or revoked.

(2) If the director modifies an advisory opinion, the advisory opinion operates prospectively.

(3) A recoupment of medical assistance overpayments caused by a provider's reliance on an advisory opinion that is later modified is limited to the actual overpayments made, without interest, penalty, multiple damages, or other sanctions.

(4) The department promptly shall notify the provider of a modification or revocation of an advisory opinion.

(i) An advisory opinion shall include the following notice: "This advisory opinion is limited to the person or persons who requested the opinion and it pertains only to the facts and circumstances presented in the request."

(j) An advisory opinion shall cite the pertinent law and rule upon which the advisory opinion is based.

(k) An advisory opinion or a modification or revocation of a previously issued advisory opinion is a public record."

The Amendment was read the first time, rules suspended and read the second time and _____

By: Senator D. Sanders

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MGF494 **Secretary**