Stricken language would be deleted from and underlined language would be added to present law.

1 State of Arkansas *As Engrossed: S3/25/13 H4/9/13*
2 89th General Assembly

A Bill

3 Regular Session, 2013 SENATE BILL 914

4

5 By: Senator D. Sanders
6 By: Representative Westerman

7

8 For An Act To Be Entitled

9 AN ACT TO ESTABLISH THE OFFICE OF THE MEDICAID
10 INSPECTOR GENERAL; AND TO DEVELOP AND TEST NEW
11 METHODS OF MEDICAID CLAIMS AND UTILIZATION *REVIEW; TO*
12 *DECLARE AN EMERGENCY;* AND FOR OTHER PURPOSES.

13

14

15 Subtitle

16 *TO ESTABLISH THE OFFICE OF THE MEDICAID*
17 *INSPECTOR GENERAL AND TO DECLARE AN*
18 *EMERGENCY.*

19

20

21 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

22

23 *SECTION 1. Arkansas Code Title 5, Chapter 37, Subchapter 2, is amended*
24 *to add an additional section to read as follows:*

25

26 <u>*5-37-217. Healthcare fraud.*</u>
27 <u>*(a) A person commits healthcare fraud if with a purpose to defraud a*</u>
28 <u>*health plan:*</u>
29 <u>*(1) The person knowingly provides materially false information*</u>
30 <u>*or omits material information for the purpose of requesting payment from a*</u>
31 <u>*single health plan for a health care item or service; and*</u>
32 <u>*(2) As a result of the materially false information or omission*</u>
33 <u>*of material information, a person receives payment in an amount that the*</u>
34 <u>*person is not entitled to under the circumstances.*</u>
35 <u>*(b)(1) Health care fraud in the fifth degree is a Class A misdemeanor.*</u>
36 <u>*(2) However, if on one (1) or more occasion, the payment or*</u>

1 *portion of the payment wrongfully received from a single health plan in a*
2 *period of not more than one (1) year exceeds:*
3 *(A) Ten thousand dollars ($10,000) in the aggregate,*
4 *health care fraud is a Class D felony;*
5 *(B) Twenty-five thousand dollars ($25,000) in the*
6 *aggregate, health care fraud is a Class C felony;*
7 *(C) Fifty thousand dollars ($50,000) in the aggregate,*
8 *health care fraud is a Class B felony;*
9 *(D) One million dollars ($1,000,000) in the aggregate,*
10 *health care fraud is a Class A felony.*
11 *(c) It is an affirmative defense to prosecution under this section*
12 *that the defendant was a clerk, bookkeeper, or other employee other than an*
13 *employee charged with the active management and control in an executive*
14 *capacity of the affairs of the corporation who executed the orders of his or*
15 *her employer or of a superior employee generally authorized to direct his or*
16 *her activities.*
17
18 *SECTION 2. Arkansas Code Title 20, Chapter 77, is amended to add an*
19 *additional subchapter to read as follows:*
20 *Subchapter 21 – Office of Medicaid Inspector General*
21
22 *20-77-2101. Purpose.*
23 *The purpose of this subchapter is to:*
24 *(1) Consolidate staff and other Medicaid fraud detection,*
25 *prevention, and recovery functions from the relevant governmental entities*
26 *into a single office;*
27 *(2) Create a more efficient and accountable structure;*
28 *(3) Reorganize and streamline the state's process for detecting*
29 *and combating Medicaid fraud and abuse; and*
30 *(4) Maximize the recovery of improper Medicaid payments.*
31
32 *20-77-2102. Definitions.*
33 *As used in this subchapter:*
34 *(1)(A) "Abuse" means provider practices that are inconsistent*
35 *with sound fiscal, business, or medical practices and result in an*
36 *unnecessary cost to the Medicaid program or in reimbursement for services*

1 *that are not medically necessary or that fail to meet professionally*
2 *recognized standards for health care*.
3 *(B) "Abuse" includes recipient practices that result in an*
4 *unnecessary cost to the Medicaid program;*
5 *(2)(A) "Fraud" means a purposeful deception or misrepresentation*
6 *made by a person with the knowledge that the deception could result in some*
7 *unauthorized benefit to the person or another person.*
8 *(B) "Fraud" includes any act that constitutes fraud under*
9 *applicable federal or state law;*
10 *(3) "Health plan" means a publicly or privately funded health*
11 *insurance or managed care plan or contract under which a health care item or*
12 *service is provided and through which payment is made to the person who*
13 *provided the health care item or service;*
14 *(4) "Investigation" means investigations of fraud, abuse, or*
15 *illegal acts perpetrated within the medical assistance program by providers*
16 *or recipients of medical assistance care, services, and supplies;*
17 *(5) "Person" means an individual or entity other than a*
18 *recipient of a health care item or service;*
19 *(6) "Recovery" means any action or attempt by the inspector to*
20 *recoup or collect Medicaid payments already made to a provider with respect*
21 *to a claim by:*
22 *(A) Reducing other payments currently owed to the*
23 *provider;*
24 *(B) Withholding or setting off the amount against current*
25 *or future payments to the provider;*
26 *(C) Demanding payment back from a provider for a claim*
27 *already paid; or*
28 *(D) Reducing or affecting in any other manner the future*
29 *claim payments to the provider.*
30 *(7) "Single health plan" includes without limitation the*
31 *Arkansas Medicaid Program; and*
32 *(8) "Waste" means that taxpayers are not receiving reasonable*
33 *value for money in connection with a government-funded activity due to an*
34 *inappropriate act or omission involving mismanagement, inappropriate actions,*
35 *and inadequate oversight by the person with control over or access to*
36 *government resources.*

1 *20-77-2103. Office of Medicaid Inspector General — Created.*
2 *The Office of Medicaid Inspector General is created within the office*
3 *of the Governor and is independent from the Department of Human Services.*
4
5 *20-77-2104. Medicaid Inspector General — Appointment — Qualifications.*
6 *(a)(1) The Medicaid Inspector General shall be appointed by the*
7 *Governor, with the advice and consent of the Senate.*
8 *(2) The inspector shall serve at the pleasure of the Governor.*
9 *(b) The inspector shall report directly to the Governor.*
10 *(c) The Medicaid Inspector General shall be the director of the Office*
11 *of Medicaid Inspector General.*
12 *(d) The inspector shall have not less than ten (10) years of*
13 *professional experience in one (1) or more of the following areas of*
14 *expertise:*
15 *(1) Prosecution for fraud;*
16 *(2) Fraud investigation;*
17 *(3) Auditing; or*
18 *(4) Comparable alternate experience in health care, if the*
19 *health care experience involves some consideration of fraud.*
20
21 *20-77-2105. Office of Medicaid Inspector General — Powers and duties.*
22 *The Office of Medicaid Inspector General shall:*
23 *(1) Prevent, detect, and investigate fraud and abuse within the*
24 *medical assistance program;*
25 *(2) Refer appropriate cases for criminal prosecution;*
26 *(3) Recover improperly expended medical assistance funds;*
27 *(4) Audit medical assistance program functions; and*
28 *(5) Establish a medical assistance program fraud and abuse*
29 *prevention.*
30
31 *20-77-2106. Medicaid Inspector General — Duties.*
32 *The Medicaid Inspector General shall:*
33 *(1) Hire deputies, directors, assistants, and other officers and*
34 *employees needed for the performance of his or her duties and prescribe the*
35 *duties of deputies, directors, assistants, and other officers and fix the*
36 *compensation of deputies, directors, assistants, and other officers within*

1 *the amounts appropriated;*
2 *(2)(A) Conduct and supervise activities to prevent, detect, and*
3 *investigate medical assistance program fraud and abuse.*
4 *(B)(i) The Office of Medicaid Inspector General shall*
5 *review provider records only for the three (3) years before an investigation*
6 *begins.*
7 *(ii) However, if a credible allegation of fraud has*
8 *been made or if the office has reason to believe that fraud has occurred, the*
9 *office may review provider records for the five (5) years before the*
10 *investigation began;*
11 *(3) Work in a coordinated and cooperative manner with:*
12 *(A) Federal, state, and local law enforcement agencies;*
13 *(B) The Medicaid Fraud Control Unit of the office of the*
14 *Attorney General;*
15 *(C) United States attorneys;*
16 *(D) United States Department of Health and Human Services*
17 *Office of the Inspector General;*
18 *(E) The Federal Bureau of Investigation;*
19 *(F) The Drug Enforcement Administration;*
20 *(G) Prosecuting attorneys;*
21 *(H) The Centers for Medicare and Medicaid Services; and*
22 *(I) An investigative unit maintained by a health insurer;*
23 *(4) Solicit, receive, and investigate complaints related to*
24 *fraud and abuse within the medical assistance program;*
25 *(5)(A) Inform the Governor, the Attorney General, the President*
26 *Pro Tempore of the Senate, and the Speaker of the House of Representatives*
27 *regarding efforts to prevent, detect, investigate, and prosecute fraud and*
28 *abuse within the medical assistance program.*
29 *(B) All cases in which fraud is determined to have*
30 *occurred shall be referred to the appropriate law enforcement agency for*
31 *prosecution;*
32 *(6)(A) Pursue civil and administrative enforcement actions*
33 *against an individual or entity that engages in fraud, abuse, or illegal or*
34 *improper acts within the medical assistance program, including without*
35 *limitation:*
36 *(i) Referral of information and evidence to*

1 *regulatory agencies and licensure boards;*
2 *(ii) Withholding payment of medical assistance funds*
3 *in accordance with state laws and rules and federal laws and regulations;*
4 *(iii) Imposition of administrative sanctions and*
5 *penalties in accordance with state laws and rules and federal laws and*
6 *regulations;*
7 *(iv) Exclusion of providers, vendors, and*
8 *contractors from participation in the medical assistance program;*
9 *(v) Initiating and maintaining actions for civil*
10 *recovery and, where authorized by law, seizure of property or other assets*
11 *connected with improper payments;*
12 *(vi) Entering into civil settlements; and*
13 *(vii) Recovery of improperly expended medical*
14 *assistance program funds from those who engage in fraud or abuse or illegal*
15 *or improper acts perpetrated within the medical assistance program.*
16 *(B) In investigating civil and administrative enforcement*
17 *actions under subdivision (a)(6)(A) of this section, the inspector shall*
18 *consider the quality and availability of medical care and services and the*
19 *best interest of both the medical assistance program and recipients;*
20 *(7) Make available to appropriate law enforcement officials*
21 *information and evidence relating to suspected criminal acts that has been*
22 *obtained in the course of the inspector's duties;*
23 *(8)(A) Refer suspected fraud or criminal activity to the*
24 *Medicaid Fraud Control Unit of the office of the Attorney General.*
25 *(B) After a referral and with ten (10) days' written*
26 *notice to the Medicaid Fraud Control Unit of the office of the Attorney*
27 *General, the inspector may provide relevant information about suspected fraud*
28 *or criminal activity to another federal or state law enforcement agency that*
29 *the inspector deems appropriate under the circumstances;*
30 *(9) Subpoena and enforce the attendance of witnesses, administer*
31 *oaths or affirmations, examine witnesses under oath, and take testimony in*
32 *connection with an investigation or audit under this subchapter and under*
33 *rules governing these investigations;*
34 *(10) Require and compel the production of books, papers, records*
35 *and documents as he or she deems relevant or material to an investigation,*
36 *examination, or review undertaken under this section;*

1 *(11)(A) Examine and copy or remove documents or records related*
2 *to the medical assistance program or necessary for the inspector to perform*
3 *his or her duties if the documents are prepared, maintained, or held by or*
4 *available to a state agency or local governmental entity the patients or*
5 *clients of which are served by the medical assistance program, or the entity*
6 *is otherwise responsible for the control of fraud and abuse within the*
7 *medical assistance program.*
8 *(B) A document or record examined and copied or removed by*
9 *the inspector under subdivision (11)(A) of this section is confidential.*
10 *(C) The removal of a record under subdivision (11)(A) of*
11 *this section is limited to circumstances in which a copy of the record is*
12 *insufficient for an appropriate legal or investigative purpose.*
13 *(D) For a removal under subdivision (11)(A) of this*
14 *section, the inspector shall copy the record and ensure the expedited return*
15 *of the original, or of a copy if the original is required for an appropriate*
16 *legal or investigative purpose, so that the information is expedited and the*
17 *original or copy is readily accessible for the care and treatment needs of*
18 *the patient;*
19 *(12)(A) Recommend and implement policies relating to the*
20 *prevention and detection of fraud and abuse.*
21 *(B) The inspector shall obtain the consent of the Attorney*
22 *General before the implementation of a policy under subdivision (12)(A) of*
23 *this section that may affect the operations of the office of the Attorney*
24 *General;*
25 *(13)(A) Monitor the implementation of a recommendation made by*
26 *the office to an agency or other entity with responsibility for*
27 *administration of the medical assistance program and produce a report*
28 *detailing the results of its monitoring activity as necessary.*
29 *(B) The report shall be submitted to the:*
30 *(i) Governor;*
31 *(ii) President Pro Tempore of the Senate;*
32 *(iii) Speaker of the House of Representatives;*
33 *(iv) Legislative Council;*
34 *(v) Division of Legislative Audit; and*
35 *(vi) Attorney General;*
36 *(14) Prepare cases, provide testimony, and support*

1 *administrative hearings and other legal proceedings;*
2 *(15) Review and audit contracts, cost reports, claims, bills,*
3 *and other expenditures of medical assistance program funds to determine*
4 *compliance with applicable state laws and rules and federal laws and*
5 *regulations and take actions authorized by state laws and rules and federal*
6 *laws and regulations;*
7 *(16)(A) Work with the fiscal agent employed to operate the*
8 *Medicaid Management Information System of the Department of Human Services to*
9 *optimize the system, including without limitation the ability to add edits*
10 *and audits in consultation with the Department of Human Services.*
11 *(B) The inspector shall be consulted before an edit or*
12 *audit is added or discontinued by the Department of Human Services;*
13 *(17) Work in a coordinated and cooperative manner with relevant*
14 *agencies in the implementation of information technology relating to the*
15 *prevention and identification of fraud and abuse in the medical assistance*
16 *program;*
17 *(18)(A) Conduct educational programs for medical assistance*
18 *program providers, vendors, contractors, and recipients designed to limit*
19 *fraud and abuse within the medical assistance program.*
20 *(B) The office shall regularly communicate with and educate*
21 *providers about the office's fraud and abuse prevention program and its audit*
22 *policies and procedures.*
23 *(C) The office shall educate providers annually concerning its*
24 *areas of focus within the medical assistance program, appropriate billing and*
25 *documentation, and methods for improving compliance with program rules,*
26 *policies, and procedures;*
27 *(19)(A)(i) Develop protocols to facilitate the efficient self-*
28 *disclosure consistent with the Patient Protection and Affordable Care Act,*
29 *Pub. L. No. 111-148, and collection of overpayments; and*
30 *(ii) Monitor collections, including those that are*
31 *self-disclosed by providers.*
32 *(B) A provider's good faith self-disclosure of*
33 *overpayments may be considered as a mitigating factor in the determination of*
34 *an administrative enforcement action;*
35 *(20) Receive and investigate complaints of alleged failures of*
36 *state and local officials to prevent, detect, and prosecute fraud and abuse*

1 *in the medical assistance program;*
2 *(21) Implement rules relating to the prevention, detection,*
3 *investigation, and referral of fraud and abuse within the medical assistance*
4 *program and to the recovery of improperly expended medical assistance program*
5 *funds;*
6 *(22) Conduct, in the context of the investigation of fraud and*
7 *abuse, on-site inspections of a facility or an office;*
8 *(23)(A) Take appropriate authorized actions to ensure that the*
9 *medical assistance program is the payor of last resort; and*
10 *(B) Recommend to the Department of Human Resources that it*
11 *take appropriate actions authorized under the department's jurisdiction to*
12 *ensure that the medical assistance program is the payor of last resort;*
13 *(24) Annually submit a budget request for the next state fiscal*
14 *year to the Governor;*
15 *(25) Identify and order the return of underpayments to*
16 *providers;*
17 *(26) Maintain the confidentiality of all information and*
18 *documents that are deemed confidential by law;*
19 *(27) Implement, facilitate, and maintain federally required*
20 *directives and contracts required for Medicaid integrity programs;*
21 *(28) Implement and maintain a hotline for reporting complaints*
22 *regarding fraud, waste, and abuse by providers;*
23 *(29) Audit, investigate, and access Medicaid encounter data,*
24 *premium data or other information from an entity contracted with for the*
25 *purpose of serving Medicaid programs;*
26 *(30)(A) Promulgate administrative rules to establish policies*
27 *and procedures for audits and investigations that are consistent with the*
28 *duties of the office under this chapter.*
29 *(B) The rules shall be posted on the office's website;*
30 *(31) Identify conflicts between the Medicaid state plan,*
31 *department rules, Medicaid provider manuals, Medicaid notices, or other*
32 *guidance and recommend that the department reconcile inconsistencies;*
33 *(32) When conducting an audit, investigation, or review under*
34 *this subchapter, classify violations as either:*
35 *(A) Errors that do not rise to the level of fraud or*
36 *abuse; or*

1 *(B) Fraud or abuse;*
2 *(33)(A) If a credible allegation of fraud has been made, review*
3 *provider records that have been the subject of a previous audit or review for*
4 *the purpose of fraud investigation and referral.*
5 *(B) However the Medicaid Inspector General shall not*
6 *duplicate an audit of a contract, cost report, claim, bill, or expenditure of*
7 *a medical assistance program fund that has been the subject of a previous*
8 *audit or review by or on behalf of the office of Medicaid Inspector General,*
9 *the Medicaid Fraud Control Unit, or other federal agency with authority over*
10 *the medical assistance program providing the audit or review were performed*
11 *in accordance with Government Auditing Standards;*
12 *(34)(A) Utilize a quality improvement organization as part of*
13 *the assessment of quality of services.*
14 *(B) The quality improvement organization shall refer all*
15 *identified improper payments due to technical deficiencies, abuse, waste, or*
16 *fraud to Medicaid Inspector General for further investigation and appropriate*
17 *action, including without limitation recovery; and*
18 *(35) Perform other functions necessary or appropriate to fulfill*
19 *the duties and responsibilities of the office.*
20
21 *20-77-2107. Cooperation of agency officials and employees.*
22 *(a)(1) The Medicaid Inspector General shall request information,*
23 *assistance, and cooperation from a federal, state, or local governmental*
24 *department, board, bureau, commission, or other agency or unit of an agency*
25 *to carry out the duties under this section.*
26 *(2) A state or local agency or unit of an agency shall provide*
27 *information, assistance, and cooperation under this section.*
28 *(b) Upon request of a prosecuting attorney, the following entities*
29 *shall provide information and assistance as the entity deems necessary,*
30 *appropriate, and available to aid the prosecutor in the investigation of*
31 *fraud and abuse within the medical assistance program and the recovery of*
32 *improperly expended funds:*
33 *(1) The Office of Medicaid Inspector General;*
34 *(2) The Department of Human Services;*
35 *(3) The Medicaid Fraud Control Unit of the office of the*
36 *Attorney General; and*

1 *(4) Another state or local government entity.*
2 *(c) All tips to the Arkansas Medicaid Fraud and Abuse Hotline that*
3 *include an allegation of fraud shall be forwarded to the office.*
4
5 *20-77-2108. Transfer of duties and resources.*
6 *(a) The duties, functions, records, personnel, property, unexpended*
7 *balances of appropriations, allocations, or other funds of the Department of*
8 *Human Services necessary to the operations of the Office of the Medicaid*
9 *Inspector General under § 20-77-2105 are transferred to the office.*
10 *(b) The office shall assume the duties under the Medical Assistance*
11 *Programs Integrity Law, § 20-77-1301 et seq.*
12
13 *20-77-2109. Reports required of the Medicaid Inspector General.*
14 *(a) The Medicaid Inspector General shall, no later than October 1 of*
15 *each year, submit to the Governor, the President Pro Tempore of the Senate,*
16 *the Speaker of the House of Representatives, Division of Legislative Audit,*
17 *Legislative Council, and the Attorney General a report summarizing the*
18 *activities of the Office of the Medicaid Inspector General during the*
19 *preceding calendar year.*
20 *(b) The report required under subsection (a) of this section shall*
21 *include without limitation:*
22 *(1) The number, subject, and other relevant characteristics of:*
23 *(A) Investigations initiated, and completed, including*
24 *without limitation outcome, region, source of complaint, and whether or not*
25 *the investigation was conducted jointly with the Attorney General;*
26 *(B) Audits initiated and completed, including without*
27 *limitation outcome, region, the reason for the audit, the total state and*
28 *federal dollar value identified for recovery, the actual state and federal*
29 *recovery from the audits, and the amount repaid to the Centers for Medicare &*
30 *Medicaid Services;*
31 *(C) Administrative actions initiated and completed,*
32 *including without limitation outcome, region, and type;*
33 *(D)(i) Referrals for prosecution to the Attorney General*
34 *and to federal or state law enforcement agencies, and referrals to licensing*
35 *authorities.*
36 *(ii) Information reported under subdivision*

1 *(b)(1)(D)(i) of this section shall include without limitation the status and*
2 *region of an administrative action;*
3 *(E) Civil actions initiated by the office related to*
4 *improper payments, the resulting civil settlements entered, overpayments*
5 *identified, and the total dollar value identified and collected; and*
6 *(F) Administrative and education activities conducted to*
7 *improve compliance with Medicaid program policies and requirements; and*
8 *(2)(A) A narrative that evaluates the office's performance, describes*
9 *specific problems with the procedures and agreements required under this*
10 *section, discusses other matters that may have impaired the office's*
11 *effectiveness, and summarizes the total savings to the state medical*
12 *assistance program.*
13 *(B)(i) In addition to total savings, the narrative shall*
14 *detail net savings in state funds.*
15 *(ii) As used in subdivision (b)(2)(B)(i) of this*
16 *section, "net savings" means amounts recovered by the office less payments*
17 *made to the Centers for Medicare & Medicaid Services and the costs of state*
18 *administrative procedures.*
19 *(c) The office may subpoena individuals, books, electronic and other*
20 *records, and documents that are necessary for the completion of reports under*
21 *this section.*
22 *(d)(1) In making the report required under subsection (a) of this*
23 *section, the inspector shall not disclose information that jeopardizes an*
24 *ongoing investigation or proceeding.*
25 *(2) The inspector may disclose information in the report*
26 *required under subsection (a) of this section if the information does not*
27 *jeopardize an ongoing investigation or proceeding and the inspector fully*
28 *apprises the designated recipients of the scope and quality of the office's*
29 *activities.*
30 *(e) Quarterly by April 1, July 1, October 1, and January 1 of each*
31 *year, the inspector shall submit to the Governor, the President Pro Tempore*
32 *of the Senate, the Speaker of the House of Representatives, Division of*
33 *Legislative Audit, Legislative Council, and the Attorney General an*
34 *accountability statement providing a statistical profile of the referrals*
35 *made to the Medicaid Fraud Control Unit of the office of the Attorney*
36 *General, audits, investigations, and recoveries.*

1
2 *20-77-2110. Department of Human Services consultation with Office of*
3 *the Medicaid Inspector General.*
4 *(a) The Department of Human Services shall consult with the Office of*
5 *the Medicaid Inspector General regarding an activity undertaken by a fiscal*
6 *intermediary or fiscal agent pertaining to suspected fraud, waste, or abuse.*
7 *(b) The department, in consultation with the office, shall:*
8 *(1) Develop, test, recommend, and implement methods to*
9 *strengthen the capability of the Medicaid Payment Information System to*
10 *detect and control fraud, waste, and abuse and improve expenditure*
11 *accountability;*
12 *(2)(A) Enter into agreement with a fiscal agent in collaboration*
13 *with the Office of Medicaid Inspector General's data mining technology to*
14 *develop, test, and implement the new methods under subdivision (b)(1) of this*
15 *section.*
16 *(B) A collaborative agreement with the office under*
17 *subdivision (b)(2)(A) of this section shall be made with an agent that has*
18 *demonstrated expertise in the areas addressed by the agreement;*
19 *(3)(A) Develop, test, recommend, and implement an automated*
20 *process to improve the coordination of benefits between the medical*
21 *assistance program and other sources of coverage for medical assistance*
22 *recipients.*
23 *(B)(i) An automated process under subdivision (b)(3()A) of*
24 *this section initially shall examine the savings potential to the medical*
25 *assistance program through retrospective review of claims paid.*
26 *(ii) The examination under subdivision (b)(3)(B)(i)*
27 *of this section shall be completed no later than January 1, 2014.*
28 *(iii) If, based upon the initial experience under*
29 *subdivision (b)(3)(B)(i) of this section, the Medicaid Inspector General*
30 *deems the automated process to be capable of including or moving to a*
31 *prospective review, with negligible effect on the turnaround of claims for*
32 *provider payment or on recipient access to services, the inspector in*
33 *subsequent tests shall examine the savings potential through prospective,*
34 *pre-claims payment review;*
35 *(4) Take all reasonable and necessary actions to intensify the*
36 *state's current level of monitoring, analyzing, reporting, and responding to*

1 *medical assistance program claims data maintained by the state's Medicaid*
2 *Management Information System fiscal agents and ensure that any data*
3 *abnormalities identified are reported to the office for appropriate action;*
4 *(5) Make efforts to improve the utilization of data in order to*
5 *better assist the office in identifying fraud and abuse within the medical*
6 *assistance program and to identify and implement further program and patient*
7 *care reforms for the improvement of the program;*
8 *(6) Identify additional data elements that are maintained and*
9 *otherwise accessible by the state, directly or through any of its*
10 *contractors, that would, if coordinated with medical assistance data, further*
11 *assist the office in increasing the effectiveness of data analysis for the*
12 *management of the medical assistance program;*
13 *(7) Provide or arrange in-service training for state and county*
14 *medical assistance personnel to increase the capability for state and local*
15 *data analysis to move toward a more cost-effective operation of the medical*
16 *assistance program;*
17 *(8)(A) No later than January 1, 2014, assist the office in*
18 *developing, testing, and implementing an automated process for the targeted*
19 *review of claims, services, populations, or a combination of claims,*
20 *services, populations.*
21 *(B) A review under subdivision (8)(A) of this section is*
22 *to identify statistical aberrations in the use or billing of the services and*
23 *to assist in the development and implementation of measures to ensure that*
24 *service use and billing are appropriate to recipients' needs; and*
25 *(9) Pay providers for underpayments identified through actions*
26 *of the office.*
27 *(c)(1) The methods developed and recommended under subdivision (b)(1)*
28 *of this section shall address without limitation the development, testing,*
29 *and implementation of an automated claims review process that, before*
30 *payment, shall subject a medical assistance program services claim to review*
31 *for proper coding and another review as may be necessary.*
32 *(2) Services subject to review shall be based on:*
33 *(A) The expected cost-effectiveness of reviewing the*
34 *service;*
35 *(B) The capabilities of the automated system for*
36 *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 in conjunction with the office 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.

(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.

20-77-2111. 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

1 *provider's size, complexity, resources, and culture;*
2 *(5) For a compliance program to be effective, it must be*
3 *designed to be compatible with the provider's characteristics;*
4 *(6) Key components that shall be included in each compliance*
5 *program if a provider is to be a medical assistance program participant; and*
6 *(7) A provider should adopt and implement an effective*
7 *compliance program appropriate to the provider.*
8 *(b) A provider of medical assistance program items and services that*
9 *receives annually seven hundred fifty thousand dollars ($750,000) or more*
10 *through the state Medicaid program shall adopt and implement a compliance*
11 *program.*
12 *(c)(1) The Office of the Medicaid Inspector General shall create and*
13 *make available on its website guidelines including a model compliance*
14 *program.*
15 *(2) A model compliance program under subdivision (c)(1) of this*
16 *section shall be applicable to billings to and payments from the medical*
17 *assistance program but need not be confined to billings and payments.*
18 *(3) The model compliance program required under subdivision*
19 *(c)(1) this section may be a component of a more comprehensive compliance*
20 *program by the medical assistance provider if the comprehensive compliance*
21 *program meets the requirements of this section.*
22 *(d) A compliance program shall include without limitation:*
23 *(1) A written policy and procedure that:*
24 *(A) Describes compliance expectations;*
25 *(B) Describes the implementation of the operation of the*
26 *compliance program;*
27 *(C) Provides guidance to employees and others on dealing*
28 *with potential compliance issues;*
29 *(D) Identifies a method for communicating compliance*
30 *issues to appropriate compliance personnel; and*
31 *(E) Describes the method by which potential compliance*
32 *problems are investigated and resolved;*
33 *(2)(A) Designation of an employee vested with responsibility for*
34 *the operation of the compliance program.*
35 *(B) The designated employee's duties may solely relate to*
36 *compliance or may be combined with other duties if compliance*

1 *responsibilities are satisfactorily carried out.*
2 *(C) The designated employee shall report directly to the*
3 *entity's chief executive or other senior administrator and periodically shall*
4 *report directly to the governing body of the provider on the activities of*
5 *the compliance program;*
6 *(3)(A) Training and education of affected employees and persons*
7 *associated with the provider, including executives and governing body*
8 *members, on compliance issues, expectations, and the compliance program*
9 *operation.*
10 *(B) The training under subdivision (d)(3)(A) of this*
11 *section shall occur periodically and shall be made a part of the orientation*
12 *for a new employee, appointee, associate, executive, or governing body*
13 *member;*
14 *(4)(A) Lines of communication to the designated compliance*
15 *employee that are accessible to all employees, persons associated with the*
16 *provider, executives, and governing body members to allow compliance issues*
17 *to be reported.*
18 *(B) The lines of communication under subdivision (d)(4)(A)*
19 *of this section shall include a method for anonymous and confidential good-*
20 *faith reporting of potential compliance issues as they are identified;*
21 *(5) Disciplinary policies to encourage good-faith participation*
22 *in the compliance program by an affected individual, including a policy that*
23 *articulates expectations for reporting compliance issues and assisting in*
24 *their resolution, and outlines sanctions for:*
25 *(A) Failing to report suspected problems;*
26 *(B) Participating in noncompliant behavior; and*
27 *(C) Encouraging, directing, facilitating or*
28 *permitting noncompliant behavior;*
29 *(6) A system for routine identification of compliance risk areas*
30 *specific to the provider type for:*
31 *(A) Self-evaluation of the risk areas, including internal*
32 *audits and as appropriate external audits; and*
33 *(B) Evaluation of potential or actual noncompliance as a*
34 *result of the self-evaluations and audits;*
35 *(7) A system for:*
36 *(A) Responding to compliance issues as they are raised;*

1 (B) Investigating potential compliance problems;
2 (C) Responding to compliance problems as identified in the
3 course of self-evaluations and audits;
4 (D) Correcting problems promptly and thoroughly and
5 implementing procedures, policies, and systems to reduce the potential for
6 recurrence;
7 (E) Identifying and reporting compliance issues to the
8 Department of Human Services or the office; and
9 (F) Refunding overpayments; and
10 (8) A policy of nonintimidation and nonretaliation for good-
11 faith participation in the compliance program, including without limitation:
12 (A) Reporting potential issues;
13 (B) Investigating issues;
14 (C) Self-evaluations;
15 (D) Audits and remedial actions; and
16 (E) Reporting to appropriate officials.
17 (e)(1) Upon enrollment in the medical assistance program, a provider
18 shall certify to the department that the provider satisfactorily meets the
19 requirements of this section.
20 (2) The inspector shall determine whether a provider has a
21 compliance program that satisfactorily meets the requirements of this section
22 by requesting, no more than one (1) time every year, an updated certification
23 that the provider satisfactorily meets the requirements of this section.
24 (f) A compliance program that is accepted by the United States
25 Department of Health and Human Services Office of Inspector General and
26 remains in compliance with the standards of the Office of Medicaid Inspector
27 General is in compliance with this section.
28 (g) If the inspector finds that a provider does not have a
29 satisfactory compliance program within ninety (90) days after the effective
30 date of a rule adopted under this section, the provider is subject to any
31 sanction or penalty permitted by a state law or rule or a federal law or
32 regulation, including revocation of the provider's agreement to participate
33 in the medical assistance program.
34 (h)(1) The office shall adopt rules to implement this section.
35 (2) The rules shall be subject to review by the Legislative
36 Council.

1
2 *20-77-2112. Applicability of the Medicaid Fairness Act.*
3 *The Medicaid Fairness Act, § 20-77-1701 et seq., applies to this*
4 *subchapter.*
5
6 *SECTION 3. Arkansas Code Title 23, Chapter 61, Subchapter 1, is*
7 *amended to add an additional section to read as follows:*
8 *23-61-116. Annual report on health insurance fraud.*
9 *Annually, on or before March 1, the Insurance Commissioner shall submit*
10 *to the Governor, the President Pro Tempore of the Senate, the Speaker of the*
11 *House of Representatives, and the Attorney General a report summarizing the*
12 *State Insurance Department's activities to investigate and combat health*
13 *insurance fraud, including without limitation information regarding:*
14 *(1) Referrals received;*
15 *(2) Investigations initiated;*
16 *(3) Investigations completed; and*
17 *(4) Other material necessary or desirable to evaluate the*
18 *department's efforts under this section.*
19
20 *SECTION 4. Arkansas Code Title 25, Chapter 10, Subchapter 1, is*
21 *amended to add an additional section to read as follows:*
22 *25-10-142. Advisory opinions.*
23 *(a) As used in this section, "advisory opinion" means a written*
24 *statement by the Director of the Department of Human Services or his or her*
25 *designee that explains the applicability to a specified set of facts of a*
26 *pertinent statutory or regulatory provision relating to the provision of*
27 *medical items or services under the medical assistance program administered*
28 *by the Department of Human Services.*
29 *(b)(1) The director may issue an advisory opinion at the request of a*
30 *provider enrolled in the medical assistance program.*
31 *(2) Except as under subsection (h) of this section, the opinion*
32 *is binding upon the director with respect to that provider only.*
33 *(3) If the director cannot respond to the request for an advisory*
34 *opinion, the director shall within thirty (30) days notify the provider that*
35 *he or she will not be responding to the request for an opinion.*
36 *(c) A provider may request an advisory opinion concerning:*

1 *(1) A substantive question or a procedural matter;*
2 *(2) Questions arising before an audit or investigation*
3 *concerning a provider’s claim for payment or reimbursement; and*
4 *(3) A hypothetical or projected service plan.*
5 *(d) The director shall not issue an advisory opinion if the request*
6 *for an advisory opinion relates to a pending question raised by the provider*
7 *in an ongoing or initiated investigation conducted by the Medicaid Inspector*
8 *General, the Attorney General, a criminal investigation, or a civil or*
9 *criminal proceeding, or if the provider has received a written notice from*
10 *the director or the Medicaid Inspector General that advises the provider of*
11 *an imminent investigation, audit, suspended claim, or withholding of payment*
12 *or reimbursement.*
13 *(e) This section does not supersede a federal regulation, law,*
14 *requirement, or guidance.*
15 *(f) The director shall adopt a rule establishing the time within which*
16 *an advisory opinion shall be issued and the criteria for determining the*
17 *eligibility of a request for departmental response.*
18 *(g) An advisory opinion represents an expression of the views of the*
19 *director as to the application of laws, rules, and other precedential*
20 *material to the set of facts specified in the request for advisory opinion.*
21 *(h)(1) A previously issued advisory opinion found by the director to*
22 *be in error may be modified or revoked.*
23 *(2) If the director modifies or revokes an advisory opinion, the*
24 *modification or revocation operates prospectively.*
25 *(3) A recovery of medical assistance overpayments caused by a*
26 *provider’s reliance on an advisory opinion that is later modified or revoked*
27 *is prohibited for the period up until the modification or revocation unless*
28 *the provider is involved in fraud.*
29 *(4) The department promptly shall notify the provider of a*
30 *modification or revocation of an advisory opinion.*
31 *(i) An advisory opinion shall include the following notice: "This*
32 *advisory opinion is limited to the person or persons who requested the*
33 *opinion and it pertains only to the facts and circumstances presented in the*
34 *request."*
35 *(j) An advisory opinion shall cite the pertinent law and rule upon*
36 *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.

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.

/s/D. Sanders