

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
to add an additional section to read as follows:*

24

25

5-37-217. Healthcare fraud.

26

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

27

28

*(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*

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30

*(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.*

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32

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

33

(2) However, if on one (1) or more occasion, the payment or



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

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

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

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

10 (B) Possible excesses in billing or service use, whether
11 intentional or unintentional.

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

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

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

23
24 20-77-2111. Provider compliance program.

25 (a) The General Assembly finds that:

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

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

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

35 (4) The wide variety of provider types in the medical assistance
36 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.

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

3
4 SECTION 5. EMERGENCY CLAUSE. It is found and determined by the
5 General Assembly of the State of Arkansas that the oversight and audit of the
6 state's Medicaid program is essential to its continued operation; that the
7 creation of the Office of the Medicaid Inspector General will ensure that
8 fraud, waste, and abuse are found in a timely manner; and that this act is
9 necessary to ensure that state and federal monies are not misspent.
10 Therefore, an emergency is declared to exist, and this act being necessary
11 for the preservation of the public peace, health, and safety shall become
12 effective on July, 1, 2013.

13
14
15 /s/D. Sanders

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18 **APPROVED: 04/23/2013**
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