State of Arkansas *As Engrossed: S3/21/17*
91st General Assembly A Bill
Regular Session, 2017 SENATE BILL 564

By: Senator D. Sanders

For An Act To Be Entitled

AN ACT TO CLARIFY THE SCOPE OF HEALTHCARE FRAUD; TO MODIFY THE SENTENCING SCHEME OF HEALTHCARE FRAUD TO BE CONSISTENT WITH OTHER ARKANSAS THEFT AND FRAUD LAWS; TO UPDATE THE MEDICAID FRAUD ACT AND THE MEDICAID FRAUD FALSE CLAIMS ACT; TO CONFORM THE MEDICAID FRAUD ACT WITH THE MEDICAID FRAUD FALSE CLAIMS ACT; TO CONFORM THE MEDICAID FRAUD FALSE CLAIMS ACT TO THE FEDERAL FALSE CLAIMS ACT; AND FOR OTHER PURPOSES.

Subtitle

TO CLARIFY THE SCOPE OF HEALTHCARE FRAUD; AND TO UPDATE THE MEDICAID FRAUD ACT AND THE MEDICAID FRAUD FALSE CLAIMS ACT.

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

SECTION 1. Arkansas Code § 5-37-217 is amended to read as follows:

5-37-217. Healthcare fraud.

(a) As used in this section, "healthcare plan" means a publicly or privately funded program or organization that is formed to provide or pay for healthcare goods or services including without limitation:

(1) Health insurance plans;

(2) Managed care organization plans;

(3) Risk-based provider plans;

(4) Arkansas Medicaid Program;

(5) The Social Security Disability Insurance program; and

(6) Medicare program.

~~(a)~~*(b) A person commits healthcare fraud if, with a purpose to defraud a ~~health~~ healthcare plan, the person provides materially false information or* omits material information in support of:

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

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

(1) An application for membership or eligibility for a healthcare plan;

(2) A claim for payment or reimbursement as a member or provider in a healthcare plan; or

(3) A prior claim for payment or to justify payments previously received from a healthcare plan for healthcare goods or services during the course of an audit or investigation conducted by the Office of Medicaid Inspector General or a healthcare oversight agency with jurisdiction to audit, investigate, or prosecute any form of healthcare fraud.

~~(b)(1) Healthcare fraud is a Class A misdemeanor.~~

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

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

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

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

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

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

~~her activities.~~

(c) Healthcare fraud is a:

(1) Class A misdemeanor if the aggregate amount of the *healthcare fraud in any period of twelve (12) months is less than two thousand five hundred dollars ($2,500);*

(2) Class C felony if the aggregate amount of the healthcare fraud in any period of twelve (12) months is two thousand five hundred dollars ($2,500) or more but less than five thousand dollars ($5,000);

(3) Class B felony if the aggregate amount of the healthcare fraud in any period of twelve (12) months is five thousand dollars ($5,000) or more but less than twenty-five thousand dollars ($25,000); and

(4) Class A felony if the aggregate amount of the healthcare fraud in any period of twelve (12) months is twenty-five thousand dollars ($25,000) or more.

SECTION 2. Arkansas Code § 5-55-102 is amended to read as follows:

5-55-102. Definitions.

As used in this subchapter:

(1) "Arkansas Medicaid Program" means the program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., that provides for payments for medical goods or services on behalf of indigent families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services, including all transactions through the actual delivery of healthcare goods or services to a Medicaid recipient regardless of whether the healthcare goods or services are paid for directly by the Department of Human Services or indirectly through a fiscal agent, contractor, subcontractor, risk-based provider organization, managed care organization, or individual;

(2) "Claim" means any written or electronically submitted request or demand for reimbursement or payment made ~~to the Arkansas Medicaid Program~~ by any Medicaid provider or its fiscal agents for each good or service purported to have been provided to any Medicaid recipient whether or not the State of Arkansas provides any ~~or no~~ portion of the money that is requested or demanded;

(3) "Fiscal ~~agents~~ agent" means any individual, firm,

corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity that~~, through a contractual relationship with the Department of Human Services and, thereby, the State of Arkansas~~ receives, processes, ~~and~~ or pays claims for the delivery of healthcare goods or services to Medicaid recipients under the Arkansas Medicaid Program;

(4) "Managed care organization" means a health insurer, Medicaid provider, or other business entity authorized by state law or through a contract with the state to receive a fixed or capitated rate or fee to manage all or a portion of the delivery of healthcare goods or services to Medicaid recipients;

(5)(A) "Medicaid provider" means a person, business organization, risk-based provider organization, or managed care organization that delivers, purports to deliver, or arranges for the delivery of healthcare goods or services to a Medicaid recipient under the Arkansas Medicaid Program.

(B) "Medicaid provider" includes an employee, agent, representative, contractor, or subcontractor of a person, business organization, risk-based provider organization, or managed care organization;

(6) "Medicaid recipient" means any individual in whose behalf any person claimed or received any payment from the Arkansas Medicaid Program or its fiscal agents, whether or not the individual was eligible for benefits under the Arkansas Medicaid Program;

~~(5)~~(7) "Person" means any:

(A) ~~Provider~~ Medicaid provider of goods or services under the Arkansas Medicaid Program or any employee of the Medicaid provider, independent contractor of the Medicaid provider, contractor of the Medicaid provider, or subcontractor of the Medicaid provider, whether the provider be an individual, individual medical vendor, firm, corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity; or

(B) Individual, individual medical vendor, firm, corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity, or any employee of any individual, individual medical vendor, firm, corporation, professional association, partnership, organization, risk-based provider

organization, managed care organization, or other legal entity, not a Medicaid provider under the Arkansas Medicaid Program but that provides goods or services to a Medicaid provider under the Arkansas Medicaid Program for which the Medicaid provider submits claims to the Arkansas Medicaid Program or its fiscal agents; and

~~(6)~~(8)(A) "Records" means all documents that disclose the nature, extent, and level of healthcare goods and services provided to *Medicaid recipients* ~~*including, but not limited to, medical documents and X-rays, developed by any person through the claimed provision of any goods or services to any Medicaid recipient*~~.

(B) "Records" include x-rays, magnetic resonance imaging scans, computed tomography scans, computed axial tomography scans, and other diagnostic imaging commonly used and retained as part of the medical records of a patient.

SECTION 3. Arkansas Code § 5-55-103(a)(2), concerning the classification of Medicaid fraud, is amended to read as follows:

(2) Medicaid fraud is a:

~~*(A) Class B felony if the aggregate amount of payments illegally claimed is two thousand five hundred dollars ($2,500) or more; and*~~

~~*(B) Class C felony if the aggregate amount of payments illegally claimed is less than two thousand five hundred dollars ($2,500) but more than two hundred dollars ($200)*~~

(A) Class C felony if the aggregate amount of payments illegally claimed is two thousand five hundred dollars ($2,500) or more but less than five thousand dollars ($5,000);

(B) Class B felony if the aggregate amount of payments illegally claimed is five thousand dollars ($5,000) or more but less than twenty-five thousand dollars ($25,000); and

(C) Class A felony if the aggregate amount of payments illegally claimed is twenty-five thousand dollars ($25,000) or more.

SECTION *4*. Arkansas Code § 5-55-104(f) and (g), concerning records within the Medicaid Fraud Act, is amended to read as follows:

(f)(1) ~~All persons~~ A Medicaid provider or person providing healthcare goods or services under the Arkansas Medicaid Program ~~are~~ is required to

maintain ~~at their principal place of Medicaid business~~ all records at least for a period of five (5) years from the date of claimed provision of any goods or services to any Medicaid recipient.

(2)(A) The records described in subdivision (f)(1) of this section shall be available for audit during regular business hours at the address listed in the Medicaid provider agreement or where the healthcare goods or *services are provided.*

(B) Closed records for inactive patients or clients may be maintained in offsite storage if:

(i) The records can be produced within three (3) working days of being served with a request for records, subpoena, or other lawful notice from any agency with authority to audit the records; and

(ii) The records are maintained within the state.

(C) A Medicaid provider shall disclose upon request the location of any offsite storage facility to any agency with authority to audit the records.

(3) If the healthcare goods or services are provided in the home of the Medicaid recipient, the records shall be maintained at the principal place of business of the Medicaid provider.

(4) If a Medicaid provider goes out of business, the provider shall give written notification to the Department of Human Services and the Office of Medicaid Inspector General of where and how the records will be stored.

(g)(1) It is unlawful to destroy or alter any record or supporting documentation with a purpose to conceal a false or fraudulent claim made to the Arkansas Medicaid Program or to interfere with an audit, investigation, or prosecution related to a claim made to the Arkansas Medicaid Program.

(2) A violation of subdivision (g)(1) of this section is a Class B felony.

(h)(1) Any person found not to have maintained any records upon conviction is guilty of a Class D felony if the unavailability of records impairs or obstructs the prosecution of a felony.

(2) Otherwise, ~~the unavailability of records~~ a violation of *subdivision (h)(1) of this section is a Class A misdemeanor.*

(i) It is an affirmative defense to a prosecution under this section that the records in question were lost or destroyed in a flood, fire, or

other natural disaster or by a criminal act that did not result from the defendant's conduct.

SECTION *5*. Arkansas Code §§ 5-55-107 and 5-55-108 are amended to read as follows:

5-55-107. Restitution and collection.

(a) In addition to any other fine that may be levied ~~under § 5-4-201~~, any person found guilty of or who pleads guilty or nolo contendere to Medicaid fraud as described in this subchapter is required to make full restitution to:

(1) ~~Make full restitution to the~~ The Department of Human Services, with the restitution to be deposited into the Arkansas Medicaid Program Trust Fund for the loss to the Arkansas Medicaid Program or its fiscal agents; and

(2)~~(A) Pay a mandatory fine in the amount of three (3) times the amount of all payments judicially found to have been illegally received from the Arkansas Medicaid Program or its fiscal agents.~~

~~(B) The mandatory fine shall be credited to the general revenues of the State of Arkansas~~ The office of the Attorney *General or prosecuting attorney for reasonable and necessary expenses incurred during investigation and prosecution*.

~~(b)(1) In addition to any other fine mandated by this subchapter or that may be levied under § 5-4-201, any person found guilty of Medicaid fraud as described in this subchapter may be required to pay a fine into the State Treasury in any amount up to three thousand dollars ($3,000) for each claim judicially found to be fraudulently submitted to the Arkansas Medicaid Program or its fiscal agents.~~

~~(2) A fine under subdivision (b)(1) of this section shall be credited to the general revenues of the State of Arkansas.~~

~~(c) For prosecutions brought under this subchapter, the following provisions apply:~~

~~(1) To enable the court to properly fix the amount of restitution, the prosecuting attorney after appropriate investigation, shall recommend an amount that would make the Arkansas Medicaid Program whole with respect to the money fraudulently received from the Arkansas Medicaid Program, including the expense of investigation and all other measurable~~

~~monetary damages directly related to the offense;~~

~~(2) If the defendant disagrees with the recommendation of the prosecuting attorney, he or she is entitled to introduce evidence in mitigation of the amount recommended; and~~

~~(3) The monetary judgment for restitution, as provided in this subchapter, becomes a judgment against the offender and has the same force and effect as any other civil judgment recorded in this state.~~

~~(d)(1) The Attorney General has concurrent jurisdiction and authority with the prosecuting attorney to collect all fines and amounts of restitution levied pursuant to any criminal violation of this subchapter in the manner provided by § 5-4-204, with interest accruing on any amount of restitution to be made and any fine to be paid from and after default in the payment of the restitution or fine in the manner provided in § 16-65-114.~~

~~(2) However, this subsection is not in any way intended to affect the contempt power of any court.~~

(b)(1) Upon a conviction of Medicaid fraud, the sentencing authority shall make a finding regarding the amount of restitution that a defendant shall pay including without limitation:

(A) The full amount of the monetary loss to the Arkansas Medicaid Program and its fiscal agents;

(B) The amount of reasonable and necessary expenses incurred by the office of the Attorney *General or the prosecuting attorney during* the investigation and prosecution; and

(C) Any other measurable monetary damages directly related to the Medicaid fraud.

(2) Except as provided in subdivision (b)(1) of this section, the sentencing authority shall follow the procedures for determination of the restitution amount under § 5-4-205.

(c)(1) In addition to the judgment and commitment order in a criminal case, a court shall enter a separate restitution order against the defendant convicted of Medicaid fraud regarding restitution consistent with this section and § 5-55-108.

(2) The restitution order is a judgment against the defendant and has the same effect as any other civil judgment recorded in the state.

(3) The restitution order shall:

(A) Require the defendant to:

(i) Comply with § 16-66-221 by filing a schedule of property; and

(ii) Update the schedule of property on an annual basis until the restitution is paid in full;

(B) State that:

(i) Interest shall accrue on the amount of the restitution from the date of the restitution order under § 16-65-114; and

(ii) Restitution may be collected through an interception of the defendant's state income tax return under § 5-4-206 if the defendant fails to comply with the terms and conditions of the restitution order.

(d)(1)(A) The Attorney General may use all available civil remedies under state law to collect on a restitution order under this section.

(B) Civil efforts to collect restitution may proceed jointly with criminal efforts to collect restitution.

(C) This subsection does not limit the contempt power of the court or prevent a court from revoking the probation or suspended sentence of a defendant who has willfully failed to pay restitution ordered under this section.

(2)(A) The Attorney General shall provide a full accounting of any restitution collected using civil remedies to the court.

(B) A defendant shall not be required to pay restitution more than one (1) time.

(3)(A) Restitution ordered for a loss to the Arkansas Medicaid Program shall not be excused by the court.

(B) A conviction under this subchapter shall not be sealed or expunged until all ordered restitution is paid in full.

(e)(1) Restitution ordered for losses to the Arkansas Medicaid Program shall be paid to the Arkansas Medicaid Program Trust Fund and used by the Department of Human Services as required by state law.

(2) Restitution ordered for reasonable and necessary expenses incurred by the office of the Attorney *General or the prosecuting attorney during* investigation and prosecution shall be paid to the office of the Attorney *General or the prosecuting attorney to* be retained and used in future investigations for Medicaid fraud.

5-55-108. ~~Civil penalties — Expenses~~ *Fines.*

(a)~~(1)~~ Any person ~~against which any civil judgment is entered as the result of a civil action brought or threatened to be brought by the State of Arkansas, through the Attorney General, on a complaint alleging the person to have fraudulently received any payment from the Arkansas Medicaid Program or its fiscal agents, is required to pay a civil penalty in the amount of two (2) times the amount of all payments judicially found to have been fraudulently received from the Arkansas Medicaid Program or its fiscal agents.~~ who is found guilty of or who pleads guilty or nolo contendere to Medicaid fraud as described in this subchapter shall pay one (1) of the *following fines:*

(1) If no monetary loss is incurred by the Arkansas Medicaid Program, a fine of not less than one thousand dollars ($1,000) or more than three thousand dollars ($3,000) for each omission or fraudulent act or claim; or

(2) If a monetary loss is incurred by the Arkansas Medicaid Program, a fine of an amount not less than the amount of the monetary loss to the Arkansas Medicaid Program and not more than three (3) times the amount of the monetary loss to the Arkansas Medicaid Program.

~~(2) Any penalty shall be paid into the State Treasury and credited to the General Revenue Fund.~~

~~(3) The judgment upon which the civil penalty is based shall be paid as restitution to the Department of Human Services.~~

~~(b)(1) Any person against which any civil judgment is entered as the result of a civil action brought or threatened to be brought by the State of Arkansas, through the Attorney General, on a complaint alleging the person to have fraudulently submitted any claim to the Arkansas Medicaid Program or its fiscal agents, may be required to pay a civil penalty into the State Treasury in any amount up to two thousand dollars ($2,000) for each claim judicially found to have been fraudulently submitted to the Arkansas Medicaid Program or its fiscal agents.~~

~~(2) The entirety of the civil penalty shall be credited to the fund.~~

~~(c)(1) Any person against which any civil judgment is entered as the result of a civil action brought or threatened to be brought by the State of Arkansas, through the Attorney General, on a complaint alleging any~~

~~fraudulent receipt of payment from or false claim submitted to the Arkansas Medicaid Program or its fiscal agents, may be required to pay into the State Treasury all reasonable expenses that the court determines have been necessarily incurred by the Attorney General in the enforcement of this subchapter.~~

~~(2) The entirety of the amount under subdivision (c)(1) of this section shall be credited to the fund.~~

(b)(1) The fines described in subdivision (a)(2) of this section may be waived by the prosecuting attorney.

(2) If the fines are waived, the trier of fact may impose fines under 5-4-201.

(c) All fines assessed under subsection (a) of this section shall be credited to the general revenues of the State of Arkansas.

SECTION *6*. Arkansas Code § 5-55-111 is amended to read as follows:

5-55-111. Criminal acts constituting Medicaid fraud.

A person commits Medicaid fraud when he or she:

(1) Purposely makes or causes to be made any omission or false statement or representation of a material fact in any claim, request for payment, or application for any benefit or payment under the Arkansas Medicaid Program;

(2) At any time purposely makes or causes to be made any omission or false statement or representation of a material fact for use in determining rights to a benefit or payment under the Arkansas Medicaid Program;

(3) Having knowledge of the occurrence of any event affecting his or her initial or continued right to any benefit or payment under the Arkansas Medicaid Program, or the initial or continued right to any benefit or payment under the Arkansas Medicaid Program of any other individual in whose behalf he or she has applied for or is receiving the benefit or payment under the Arkansas Medicaid Program, purposely conceals or fails to disclose the event with an intent fraudulently to secure the benefit or payment under the Arkansas Medicaid Program either in a greater amount or quantity than is due or when no benefit or payment under the Arkansas Medicaid Program is authorized;

(4) Having made or submitted a claim, request for payment, or

application to receive any benefit or payment under the Arkansas Medicaid Program for the use and benefit of another person and having received it, purposely converts the benefit or payment under the Arkansas Medicaid Program or any part of the benefit or payment under the Arkansas Medicaid Program to a use other than for the use and benefit of the other person;

(5) Purposely presents or causes to be presented a claim for a physician's service for which payment may be made under a program under the Arkansas Medicaid Program while knowing that the individual who furnished the service was not licensed as a physician;

(6) Purposely solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(A) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the Arkansas Medicaid Program; or

(B) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the Arkansas Medicaid Program;

(7)(A) Purposely offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce that person to:

(i) Refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the Arkansas Medicaid Program; or

(ii) Purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the Arkansas Medicaid Program.

(B) Subdivisions (7)(A)(i) and (ii) of this section do not apply to:

(i) A discount or other reduction in price obtained by a provider of services or other entity under the Arkansas Medicaid Program if the reduction in price is properly disclosed and appropriately reflected

in the costs claimed or charges made by the provider or entity under the Arkansas Medicaid Program;

(ii) Any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the provision of covered items or services;

(iii) Any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under the Arkansas Medicaid Program if:

(a) The person has a written contract with each individual or entity that specifies the amount to be paid to the person and the amount may be a fixed amount or a fixed percentage of the value of the purchases made by each individual or entity under the contract; and

(b) In the case of an entity that is a provider of services as defined in § 20-9-101, the person discloses in such form and manner as the Director of the Department of Human Services requires to the entity and, upon request, to the director the amount received from each vendor with respect to purchases made by or on behalf of the entity; or

(iv) Any payment practice specified by the director promulgated pursuant to applicable federal or state law;

(8) Purposely makes or causes to be made, or induces or seeks to induce ~~the making of~~, any omission or false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or ~~entity~~ Medicaid provider in order that the institution, facility, or ~~entity~~ Medicaid provider may qualify ~~either upon initial certification or upon recertification as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for individuals with intellectual disabilities, home health agency, or other entity, including an eligible organization under applicable federal law for which certification is required, or with respect to information required pursuant to applicable federal and state law, rules, regulations, and provider agreements~~ to obtain or maintain any licensure or certification when the licensure or certification is required to be enrolled or eligible to deliver any healthcare goods or services to Medicaid recipients by state law, federal law, or the rules of the Arkansas Medicaid Program;

(9) Purposely:

(A) Charges, for any service provided to a patient under the Arkansas Medicaid Program, money or other consideration at a rate in excess of the rates established by the state; or

(B) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the Arkansas Medicaid Program, any gift, money, donation, or other consideration other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient:

(i) As a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; or

(ii) As a requirement for the patient's continued stay in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities when the cost of the services provided in the hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities to the patient is paid for in whole or in part under the Arkansas Medicaid Program; ~~or~~

(10) Purposely makes or causes to be made any false statement or representation of a material fact in any application for a benefit or payment in violation of the rules, regulations, and provider agreements issued by the Arkansas Medicaid Program or its fiscal agents;

(11) Knowingly submits false documentation or makes or causes to be made, or induces or seeks to induce any material false statement to the Office of Medicaid Inspector General or the Medicaid Fraud Control Unit within the office of the Attorney General during an audit or in response to a request for information or a subpoena;

(12) Purposely forges the signature of a doctor, nurse, or other medical professional on a prescription, referral for healthcare goods or services, or finding of medical necessity;

(13) Knowingly submits a forged prescription, referral for healthcare goods or services, or finding of medical necessity for:

(A) Payment under the Arkansas Medicaid Program; or

(B) An audit or in response to a request for information or a subpoena to the Office of Medicaid Inspector General or the Medicaid Fraud Control Unit within the office of the Attorney General; or

(14) Purposely places a false entry in a medical chart, medical

record, or any record of services required to made to the Arkansas Medicaid Program that indicates that healthcare goods or services have been provided to a Medicaid recipient knowing that the healthcare goods or services were not provided.

SECTION *7*. Arkansas Code § 5-55-112 is repealed.

~~5-55-112. Disposition of offenders.~~

~~For a prosecution under this subchapter:~~

~~(1) The punishment shall be fixed by the finder of fact, whether a court or a jury; and~~

~~(2) Restitution shall be fixed by the court.~~

SECTION *8*. Arkansas Code § 5-55-114(a), concerning the special deputy prosecutor under the Medicaid Fraud Act, is amended to read as follows:

(a) ~~An attorney employed by the office of the Attorney General may be designated a special deputy prosecutor by the prosecuting attorney having criminal jurisdiction in the matter for the purposes of prosecuting in a court of competent jurisdiction an action brought under this subchapter~~ A prosecuting attorney having jurisdiction over an offense may designate an attorney employed by the office of the Attorney General as a special duty prosecutor to prosecute any charges related to healthcare fraud or any other charges that may arise from the same factual allegations or may be properly joined under state law.

SECTION *9*. Arkansas Code §§ 20-77-901 — 20-77-903 are amended to read as follows:

20-77-901. Definitions.

As used in this subchapter:

(1) "Arkansas Medicaid Program" means the program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., that ~~which~~ provides for payments for medical goods or services on behalf of indigent families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services, including all transactions through the actual delivery of healthcare goods or services to a Medicaid recipient regardless of whether the healthcare goods or services are paid for directly by the

Department of Human Services or indirectly through a fiscal agent, contractor, subcontractor, risk-based provider organization, managed care organization, or individual;

(2)(A) "Claim" ~~includes any request or demand, including any and all documents or information required by federal or state law or by rule, made against medical assistance programs funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. A claim may be made through electronic means if authorized by the Department of Human Services. Each claim may be treated as a separate claim, or several claims may be combined to form one (1) claim;~~ means any request or demand for money or property, regardless of whether under a contract, that:

(i) Is presented to an officer, employee, agent, or fiscal agent of the Arkansas Medicaid Program;

(ii) Is made to a contractor, grantee, or other recipient if:

(a) The money or property is spent or used on behalf of the Arkansas Medicaid Program or to advance the Arkansas Medicaid Program or its interest; and

(b) The Arkansas Medicaid Program:

(1) Provides or has provided any portion of the money or property requested or demanded; or

(2) Is reimbursing the contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(B) "Claim" includes:

(i) Billing documentation;

(ii) All documentation required to be created or maintained by law or rule to justify, support, or document the delivery of healthcare goods or services to a Medicaid recipient;

(iii) All documentation submitted to justify or help establish a unit rate, capitated rate, or other method of determining what to be paid for healthcare goods or services delivered to Medicaid recipients; and

(iv) All transactions in payment for healthcare

goods or services delivered or claimed to have been delivered to Medicaid recipients under the Arkansas Medicaid Program regardless of whether the State of Arkansas has title to the money or property or has transferred responsibility for delivering healthcare services to another legal entity;

(3) "Damages" means the actual loss to the Arkansas Medicaid Program and its fiscal agents, including the total amount of all claims paid as a result of any false claim and the value of healthcare goods or services paid for but not delivered to a Medicaid recipient;

~~(3)~~(4) "Fiscal agent" means any individual, firm, corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity ~~which, through a contractual relationship with the department, the State of Arkansas~~ that receives, processes, ~~and~~ or pays claims for the delivery of healthcare goods and services to Medicaid recipients under the program;

~~(4)~~(5)(A) "Knowing" or "knowingly" means that the person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information.

(B) "Knowing" or "knowingly" does not require proof of a specific intent to defraud;

~~(5)~~(6) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property;

(7) "Managed care organization" means a health insurer, Medicaid provider, or other business entity authorized by state law or through a contract with the state to receive a fixed or capitated rate or fee to manage all or a portion of the delivery of healthcare goods or services to Medicaid recipients;

(8)(A) "Medicaid provider" means a person, business organization, risk-based provider organization, or managed care organization that delivers, purports to deliver, or arranges for the delivery of healthcare goods or services to a Medicaid recipient under the Arkansas Medicaid Program.

(B) "Medicaid provider" includes an employee, agent, representative, contractor, or subcontractor of a person, business organization, risk-based provider organization, or managed care organization;

(9) "Medicaid recipient" means any individual on whose behalf any person claimed or received any payment or payments from the program or

its fiscal agents, whether or not the individual was eligible for benefits under the program;

(10) "Obligation" means an established duty arising from:

(A) An express or implied contract, grantor-grantee, or licensor-licensee relationship;

(B) A fee-based or similar relationship;

(C) State law or rule;

(D) Federal law or regulation; or

(E) Retention of any overpayment not returned within sixty (60) days from the date of discovery by the provider;

~~(6)~~(11) "Person" means any:

(A) Medicaid provider of goods or services or any employee, independent contractor, or subcontractor of the Medicaid provider, whether that provider be an individual, individual medical vendor, firm, corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity ~~under the program but which provides goods or services to a provider under the program or its fiscal agents~~; or

(B) Individual, individual medical vendor, firm, corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity, or any employee of any individual, individual medical vendor, firm, corporation, professional association, partnership, organization, risk-based provider organization, managed care organization, or other legal entity, not a Medicaid provider under the Arkansas Medicaid Program but that provides goods or services to a Medicaid provider under the Arkansas Medicaid Program for which the Medicaid provider submits claims to the Arkansas Medicaid Program or its fiscal agents; and

~~(7)~~(12)(A) "Records" means all documents in any form~~, including, but not limited to, medical documents and X-rays, prepared by any person for the purported provision of any goods or services to any Medicaid recipient~~ that disclose the nature, extent, and level of healthcare goods and services *provided to Medicaid recipients*.

(B) "Records" include x-rays, magnetic resonance imaging scans, computed tomography scans, computed axial tomography scans, and other diagnostic imaging commonly used and retained as part of the medical records

of a patient.

20-77-902. Liability for certain acts.

A person shall be liable to the State of Arkansas, through the Attorney General, for a civil penalty ~~and restitution~~ of three (3) times the amount of the damages if he or she:

(1) Knowingly makes or causes to be made any false statement or representation of a material fact in any claim, request for payment, or application for any benefit or payment under the Arkansas Medicaid Program;

(2) ~~At any time knowingly~~ Knowingly makes or causes to be made any omission or false statement or representation of a material fact for use in determining rights to a benefit or payment under the Arkansas Medicaid Program;

(3) Having knowledge of the occurrence of any event affecting his or her initial or continued right to any benefit or payment or the initial or continued right to any benefit or payment of any other individual in whose behalf he or she has applied for or is receiving a benefit or payment, knowingly conceals or fails to disclose that event with an intent fraudulently to secure the benefit or payment either in a greater amount or quantity than is due or when no benefit or payment is authorized;

(4) Having made or submitted a claim, request for payment, or application to receive any benefit or payment for the use and benefit of another person and having received it, knowingly converts the benefit or payment or any part thereof to a use other than for the use and benefit of the other person;

(5) Knowingly presents or causes to be presented a claim for a physician's service for which payment may be made under the program and knows that the individual who furnished the service was not licensed as a physician;

(6) Knowingly solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(A) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the program; or

(B) In return for purchasing, leasing, ordering, or

arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the program;

(7)(A) Knowingly offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind to any person to induce the person to:

(i) ~~To refer~~ Refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the program; or

(ii) ~~To purchase~~ Purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under the program.

(B) Subdivision (7)(A) of this section shall not apply to:

(i) A discount or other reduction in price obtained by a provider of services or other entity under the program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under the program;

(ii) Any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the providing of covered items or services;

(iii) Any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under the program, if:

(a) The person has a written contract with each individual or entity which specifies the amount to be paid to the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each individual or entity under the contract; and

(b) In the case of an entity that is a Medicaid provider ~~of services~~ as defined in § 20-9-101, the person discloses, in the form and manner as the Director of the Department of Human Services requires, to the entity and upon request to the director the amount received from each vendor with respect to purchases made by or on behalf of the entity; or

(iv) Any payment practice specified by the director

promulgated pursuant to applicable federal or state law;

(8) Knowingly makes or causes to be made or induces or seeks to induce ~~the making of any false statement or representation of a material fact:~~

~~(A) With respect to the conditions or operation of any institution, facility, or entity in order that the institution, facility, or entity may qualify either upon initial certification or upon recertification as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for individuals with intellectual disabilities, home health agency, or other entity for which certification is required; or~~

~~(B) With respect to information required pursuant to applicable federal and state law, rules, regulations, and provider agreements~~ any omission or false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or Medicaid provider in order that the institution, facility, or Medicaid provider may qualify to obtain or maintain any licensure or certification when the licensure or certification is required to be enrolled or eligible to deliver any healthcare goods or services to Medicaid recipients by state law, federal law, or the rules of the Arkansas Medicaid Program;

(9) Knowingly:

(A) Charges for any service provided to a patient under the program money or other consideration at a rate in excess of the rates established by the state; or

(B) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the program, any gift, money, donation, or other consideration other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient:

(i) ~~as~~ As a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; or

(ii) ~~as~~ As a requirement for the patient's continued stay in the hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities when the cost of the services provided therein to the patient is paid for in whole or in part under the

program;

(10) Knowingly makes or causes to be made any omission or false statement or representation of a material fact in any application for benefits or for payment in violation of the rules, regulations, and provider agreements issued by the program or its fiscal agents; ~~or~~

(11) Knowingly:

(A) Participates, directly or indirectly, in the Arkansas Medicaid Program after having pleaded guilty or nolo contendere to or been found guilty of a charge of Medicaid fraud, theft of public benefits, or abuse of adults as defined in the Arkansas Criminal Code, § 5-1-101 et seq.; or

(B) As a certified health provider enrolled in the Arkansas Medicaid Program pursuant to Title XIX of the Social Security Act or the fiscal agent of such a provider who employs, engages as an independent contractor, engages as a consultant, or otherwise permits the participation in the business activities of such a provider, any person who has pleaded guilty or nolo contendere to or has been found guilty of a charge of Medicaid fraud, theft of public benefits, or abuse of adults as defined in the Arkansas Criminal Code, § 5-1-101 et seq.;

(12) Knowingly submits any false documentation supporting a claim or prior payment to the Office of Medicaid Inspector General or the Medicaid Fraud Control Unit within the office of the Attorney General during an audit or in response to a request for information or a subpoena;

(13) Knowingly makes or causes to be made, or induces or seeks to induce, any material false statement to made to the Office of Medicaid Inspector General or the Medicaid Fraud Control Unit within the office of the Attorney General during an audit or in response to a request for information or a subpoena;

(14) Knowingly forges the signature of a doctor or nurse on a prescription or referral for healthcare goods or services or submits a forged prescription or referral for healthcare goods or services in support of a claim for payment under the Arkansas Medicaid Program;

(15) Knowingly places a false entry in a medical chart or medical record that indicates that healthcare goods or services have been provided to a Medicaid recipient knowing that the healthcare goods or services were not provided;

(16) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the Arkansas Medicaid Program;

(17) Knowingly makes, uses, or causes to be made or used a false record or statement that is material to a false or fraudulent claim to the Arkansas Medicaid Program;

(18) Knowingly:

(A) Makes, uses, or causes to be made or used a false record or statement that is material to an obligation to pay or transmit money or property to the Arkansas Medicaid Program; or

(B) Conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Arkansas Medicaid Program; or

(19) Conspires to commit a violation of this section.

20-77-903. Civil penalties.

(a)~~(1)~~ It shall be unlawful for any person to commit any act proscribed by § 20-77-902, and any person found to have committed any such act or acts shall be deemed liable to the State of Arkansas, through the Attorney General, for ~~full restitution and for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) for each violation, plus three (3) times the amount of all payments judicially found to have been fraudulently received from the Arkansas Medicaid Program or its fiscal agents because of the act of that person, except that if the court finds the following~~:

(1) A civil penalty of not less than five thousand five hundred dollars ($5,500) or more than eleven thousand dollars ($11,000) for each claim; and

(2) Three (3) times the amount of damages that the state sustained because of the act of the person.

(b) The trier of fact may assess not less than two (2) times the amount of damages that the state sustained because of the act of the person if the trier of fact finds the following:

~~(A)~~(1) The person committing the violation of this subchapter furnished officials of the Attorney General's office with all information known to the person about the violation within thirty (30) days after the date on which the defendant first obtained the information; and

~~(B)~~(2) The person fully cooperated with any Attorney General's investigation of the violation, and at the time the person furnished the Attorney General with the information about the violation:

~~(i)~~(A) No criminal prosecution, civil action, or administrative action had commenced under this subchapter with respect to the violation; and

~~(ii)~~(B) The person did not have actual knowledge of the existence of an investigation into the violation.

~~(2) The court may assess not more than two (2) times the amount of damages which the state sustained because of the act of the person.~~

~~(b)~~(c)(1) In addition to any other penalties authorized herein, any person violating this subchapter shall also be liable to the State of Arkansas for the Attorney General's reasonable expenses, including the cost of investigation, attorney's fees, court costs, witness fees, and deposition fees.

(2) Any cost or reimbursement ordered under this subsection shall be paid to the office of the Attorney General to be used for future Medicaid investigations and cases.

~~(c)~~(d) The entirety of any penalty obtained under subsection (a) less reimbursement of investigation and prosecution costs and any reward which may be determined by the court pursuant to this subchapter shall be credited as special revenues of the State of Arkansas and deposited into the Arkansas Medicaid Program Trust Fund for the sole use of the program.

~~(d) For actions under this subchapter, the following shall apply:~~

~~(1) To enable the court to properly fix the amount of restitution, the Attorney General shall, after appropriate investigation, recommend an amount that would make the victim whole with respect to the money fraudulently received from the program or its fiscal agents, the expense of investigation, and all other measurable monetary damages directly related to the cause of action; and~~

~~(2) If the defendant disagrees with the recommendation of the Attorney General, he or she shall be entitled to introduce evidence in mitigation of the amount recommended.~~

~~(e) For actions under this subchapter, whether tried by the court or the jury, the restitution and penalty shall be fixed by the court.~~

(e)(1) A person who engages or has engaged in any act described by §

20-77-902 may be enjoined in a court of competent jurisdiction in an action brought by the Attorney General.

(2) An injunction described by subdivision (e)(1) of this section shall be:

(A) Brought in the name of the state; and

(B) Granted if the a case is clearly shown that the rights of the state are being violated by the person and the state will suffer immediate and irreparable injury, loss, or damage pending a final judgment in the action or that the acts or omissions of the person will tend to render a final judgment ineffectual.

(f) The court may make orders or judgments, including the appointment of a receiver, as necessary to:

(1) Prevent any act described by § 20-77-902 by any person; or

(2) Restore to the Arkansas Medicaid Program any money or property, real or personal, that may have been acquired by means of an act described by § 20-77-902.

SECTION *10*. Arkansas Code § 20-77-904(c)(1), concerning investigation by the Attorney General under the Medicaid Fraud False Claims Act, is amended to read as follows:

(1) Adjudging the person in contempt of court and exercising any civil contempt power available under state law;

SECTION *11*. Arkansas Code § 20-77-907(a), concerning records under the Medicaid Fraud False Claims Act, is amended to read as follows:

(a)(1) ~~All persons~~ A Medicaid provider or person providing healthcare goods or services under the Arkansas Medicaid Program are required to *maintain* ~~*at the person's principal place of Medicaid business*~~ *all records at least for a period of five (5) years from the date of claimed* provision of any goods or services to any Medicaid recipient.

~~(2)(A) Any person found not to have maintained all records shall be guilty of a Class D felony if the unavailability of records impairs or obstructs a civil action pursuant to this subchapter.~~

~~(B) Otherwise, the unavailability of records shall be a Class A misdemeanor.~~

(2)(A) The records described in subdivision (a)(1) of this

section shall be available for audit during regular business hours at the address listed in the Medicaid provider agreement or where the healthcare goods or *services are provided.*

(B) Closed records for inactive patients or clients can be maintained in offsite storage if:

(i) The records can be produced within three (3) working days of being served with a request for records, subpoena, or other lawful notice from any agency with authority to audit the records; and

(ii) The records are maintained within the State of Arkansas.

(C) A Medicaid provider shall disclose upon request the location of any offsite storage facility to any agency with authority to audit the records.

(3) If the healthcare goods or services are provided in the home of the Medicaid recipient, the records shall be maintained at the principal place of business of the Medicaid provider.

(4) If a Medicaid provider goes out of business, the provider shall give written notification to the Department of Human Services and the Office of Medicaid Inspector General of where and how the records will be stored.

SECTION *12.* Arkansas Code § 20-77-908(a) and (b), concerning the false claims jurisdiction and procedure under the Medicaid Fraud False Claims Act, is amended to read as follows:

(a) Any action under this subchapter may be brought in the circuit court of Pulaski County or the county where the defendant, or in the case of multiple defendants, any one (1) defendant resides.

(b) A civil action under this section may not be brought more than five (5) years after the date on which the violation of this subchapter is committed.

SECTION *13.* Arkansas Code § 20-77-2502(3), concerning the definition of "health plan" regarding the Office of Medicaid Inspector General, is amended to read as follows:

(3) ~~"Health plan"~~ "Healthcare plan" means a publicly or privately funded ~~health insurance or managed care plan or contract under~~

~~which a healthcare item or service is provided and through which payment is made to the person who provided the healthcare item or service~~ program or organization that is formed to provide or pay for healthcare goods or services including without limitation:

(A) Health insurance plans;

(B) Managed care organization plans;

(C) Risk-based provider plans;

(D) Arkansas Medicaid Program;

(E) The Social Security Disability Insurance program; and

(F) Medicare program;

SECTION *14*. Arkansas Code § 20-77-2502(7), concerning the definition of "single health plan" regarding the Office of Medicaid Inspector General, is repealed.

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

/s/D. Sanders

APPROVED: 04/05/2017