

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

State of Arkansas
89th General Assembly
Regular Session, 2013

A Bill

SENATE BILL 248

By: Senator D. Sanders
By: Representative Westerman

For An Act To Be Entitled

AN ACT TO CREATE THE ARKANSAS MEDICAL ASSISTANCE FRAUD PREVENTION PROGRAM; TO PROVIDE FOR THE ADOPTION OF A MEDICAL ASSISTANCE FRAUD PREVENTION PROGRAM; TO PROVIDE FOR DEFINITIONS; TO PROVIDE FOR IMPLEMENTATION BY THE DEPARTMENT OF HUMAN SERVICES; TO PROVIDE FOR IMPLEMENTATION OF A PILOT PROGRAM; TO PROVIDE FOR PARTICIPATION; TO PROVIDE FOR A WAIVER; TO PROVIDE FOR RELATED MATTERS; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE ARKANSAS MEDICAL ASSISTANCE FRAUD PREVENTION PROGRAM AND TO PROVIDE FOR THE ADOPTION OF A MEDICAL ASSISTANCE FRAUD PREVENTION PROGRAM.

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

SECTION 1. Arkansas Code Title 20, Chapter 77, is amended to add an additional subchapter to read as follows:

Subchapter 21 – Arkansas Medical Assistance Fraud Prevention Program

20-77-2101. Title.

This subchapter shall be known and may be cited as the "Arkansas Medical Assistance Fraud Prevention Program".



20-77-2102. Definitions.As used in this subchapter:

(1) "Care management organization" means an entity that is organized for the purpose of providing or arranging health care that has been granted a certificate of authority by the Insurance Commissioner as a health maintenance organization and that has entered into a contract with the Department of Human Services to provide or arrange health care services, products, or both, on a prepaid, capitated basis to members;

(2)(A) "Claim" a request or demand, whether under a contract or otherwise, for money, property, or services that is made to the Arkansas Medicaid program, or to an officer, employee, fiscal intermediary, grantee or contractor of the Arkansas Medicaid program, or to another person or entity if the request of demand results in payments by the Arkansas Medicaid program, if the Arkansas Medicaid program:

(i) Provides or will provide a portion of the money or property requested or demanded; or

(ii) Will reimburse the contractor, grantee, or other recipient for any portion of the money or property requested or demanded.

(B) "Claim" includes a request or demand that is made orally, in writing, electronically, or magnetically; and

(i) Identifies a product or service provided or purported to have been provided within the State of Arkansas to a recipient as reimbursable under the medical assistance program, without regard to whether the money that is requested or demanded is paid;

(ii) States the income earned or expense incurred by a provider in providing a product or a service and that is used to determine a rate of payment under the medical assistance program; and

(iii) Has been generated at the point of transaction and as a result of a recipient's participating in either biometric or alternative method authentication;

(3) "Health care provider" means a person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Arkansas and that has contracted with a care management organization to provide health care services, products, or both, to a member;

(4) "Medicaid" 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;

(5) "Medical assistance" means payment to a provider of a part or all of the cost of a certain item of medical or remedial care or service rendered by the provider to a recipient, if the items are rendered and received in accordance with Medicaid regulations promulgated by the Secretary Of Health And Human Services, all applicable laws of this state, the state Medicaid plan, and rules of the Department of Human Services that are in effect on the date on which the items are rendered;

(6) "Medical assistance card" means a Medicaid card used by a recipient before the implementation of the smart card program under this subchapter, and which will be replaced by smart cards under this subchapter that shall identify an eligible recipient and his or her account numbers and shall be used by recipients to obtain medical assistance for which payment by the state shall be tendered;

(7) "Member" means a Medicaid or ARKids First A recipient who is currently enrolled in a care management organization plan;

(8) "Multifactor authentication" means a security process in which a user provides multiple means of identification, one (1) of which is a token, such as a smart card, and the other of which is representative of who the user is, such as a fingerprint or a photo;

(9) "ARKids First B" means the State of Arkansas's State Children's Health Insurance Program established pursuant to Title XXI of the federal Social Security Act;

(10) "Pilot program" means the front-end, proactive Arkansas Medical Assistance Fraud Prevention Pilot Program implemented under this subchapter before the state-wide rollout of the Arkansas Medical Assistance Fraud Prevention Program;

(11) "Point of transaction" means the place and time at which a recipient obtains a service or product from a provider, if the service or product, or both is submitted as a claim to be paid by the state Medicaid program under Title XIX of the federal Social Security Act;

(12) "Provider" means a health care provider or provider of

medical assistance;

(13) "Provider of medical assistance" means a person or institution, public or private, including its employees, that participates in the state Medicaid plan and that possesses all licenses, permits, certificates, approvals, registrations, charters, and other forms of permission issued by entities other than the Department of Human Services that are required by law either to render health care services, products, or both or to provide medical assistance for which federal financial participation is available and which meets the further requirements for participation prescribed by the Department of Human Services and which is enrolled in the state Medicaid plan;

(14) "Recipient" means a member or a recipient of medical assistance; and

(15) "Recipient of medical assistance" means a person who is certified eligible for medical assistance under the state Medicaid plan to have medical assistance paid on his or her behalf.

.

20-77-2103. Arkansas Medical Assistance Fraud Prevention Pilot Program – Creation.

(a) The Department of Human Services shall establish and administer the Arkansas Medical Assistance Fraud Prevention Pilot Program.

(b) The department shall enter into an agreement with a third-party vendor to implement and maintain the Arkansas Medical Assistance Fraud Prevention Pilot Program.

(c)(1) Before a state-wide rollout of the Arkansas Medical Assistance Fraud Prevention Program, the department shall conduct a front-end, proactive medical assistance fraud prevention pilot program.

(2) The department shall determine the scope of the pilot program and shall enter into an agreement with a third-party vendor to develop and execute the pilot program.

(3) The department shall adopt rules to implement the pilot program.

(d)(1) The department shall implement the pilot program for a minimum of three (3) months, not to exceed a total of six (6) months, within seven (7) counties chosen by the department.

(2)(A) The pilot program shall involve enrollment, distribution,

and use of a smart card by a recipient.

(B) If applicable, the smart card shall serve as a replacement for a currently used medical assistance card.

(3) The pilot program shall involve the distribution of fingerprint scanners and card readers at each provider location within the designated counties.

(e) The department shall mandate participation in the pilot program by all providers and recipients in the counties in which the pilot program is conducted.

(f) The department shall implement the pilot program not later than January 1, 2014.

20-75-2104. Arkansas Medical Assistance Fraud Prevention Program – Creation.

(a) The Department of Human Services shall implement the Arkansas Medical Assistance Fraud Prevention Program to address Medicaid fraud, waste, and abuse.

(b) The program shall be designed to:

(1) Authenticate a provider at the point of transaction to prevent phantom billing and other forms of provider fraud;

(2) Authenticate a recipient at the onset and completion of each point of transaction to prevent card sharing and other forms of fraud;

(3) Deny ineligible persons at the point of transaction;

(4) Reduce the total amount of medical assistance expenditures by reducing the average cost per recipient; and

(5) Secure and protect the personal identity and information of recipients.

(c) The program shall include:

(1) Biometric fingerprint readers for authentication of a recipient by a provider;

(2)(A) Biometric fingerprint scanners and card readers for real time, multifactor authentication of a recipient's fingerprint template and smart card.

(B) Biometric fingerprint scanners and card readers shall be kept at the point of transaction with a provider;

(3) An image of the recipient stored on both a smart card and in

a data base;

(4) An information system for recording and reporting authenticated transactions;

(5) An information system that interfaces with the state database to determine eligibility of recipients;

(6) No requirement for preenrollment of recipients;

(7)(A) A secure finger-imaging system that is compliant with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(B) The finger-imaging system shall store a fingerprint template on a central host system for authentication purposes, rather than on the smart card, to allow authentication in the event of a lost, stolen, or forgotten card and to prevent Medicaid fraud associated with card reproduction and card sharing.

(C) The finger-imaging system shall take a fingerprint image and convert the finger print image into a fingerprint template associated with a binary PIN number and store the fingerprint template, rather than a fingerprint image, on the central host system.

(D) The finger-imaging system shall be designed to prevent the fingerprint template from being converted into a fingerprint image;

(8)(A) A smart card for storage of a recipient's state benefit information, insurance information, and other general health information.

(B) A smart card shall include a recipient's prescription history information to assist in prevention of drug overutilization and to mitigate costs and risks associated with prescription drugs.

(C) Sensitive information stored on a smart card shall be separated into multiple parts and shall be encrypted, with one (1) part stored on the host database;

(9) A smart card with the ability to store multiple recipients' information on one (1) card; and

(10) A system that gathers analytical information to be provided to a data-mining company to assist in data-mining processes.

(d) In implementing the program, the department may:

(1) Allow electronic prescribing services and prescription database integration and tracking to prevent medical error through information sharing and to reduce pharmaceutical abuse and lower health care

costs;

(2) Allow the program, including without limitation smart cards, fingerprint scanners, and card readers, to be adapted for use by other state programs administered by the department to reduce costs associated with the necessity of multiple cards per recipient;

(3) Enter and store billing codes, deductible amounts, and bill confirmations;

(4) Use an alternative method of authentication of recipients when biometric fingerprint images cannot be used and as necessary to address specific requirements for a waiver or authorization from the Centers for Medicare and Medicaid Services; and

(5) Implement quick pay incentives for providers when electronic prescribing services, electronic health records, electronic patient records, or computerized patient records used by providers automatically synchronize with recipients' smart cards and electronically submit a claim.

(e)(1) The department shall implement a statewide rollout of the program after completion of a successful pilot program under § 20-77-2103.

(2) The pilot program shall be considered a success if it meets the minimum criteria defined in subsections (b) and (c) of this section and reduces the average monthly cost per recipient within the pilot program area by a minimum of three percent (3%).

(3)(A) If the pilot program does not meet the minimum criteria to be considered a success, the department may extend and revise the pilot program as necessary and reevaluate the results.

(B) To evaluate the average monthly cost of a recipient within the pilot program area and to develop a strategy necessary to achieve the highest rate of savings to the state Medicaid plan, the department shall analyze four (4) sample sets of figures for the pilot program, including:

(i)(a) Establishment of base figures.

(b) The department shall gather claims data for a first sample set that includes all claims for the recipients in the pilot program area and the average cost per recipient by provider type and county from at least the prior year for the exact time period for all areas in the pilot program;

(ii)(a) Adjustment of base figures for increase or decrease in cost of services.

(b) To evaluate an increase or decrease in the cost of services, the department shall gather a second sample set and shall adjust the base figures of the first in relation to the second sample set.

(c) The second sample set of claims data shall represent a rural area and an urban area not participating in the pilot program, with as close as possible demographics similar to those of recipients in the pilot program areas, including specific data relating to sex, age, race, and ethnicity, county similarities, number of providers, and the average cost per recipient.

(d) The department shall analyze the second sample set the preceding year's figures by comparing to current year figures for the same time frame and area to determine an increase or decrease in cost of services.

(e) The second sample set shall not include any major changes from the prior year to the current year that would change the comparison, such as the introduction of managed care in the area.

(f) The increase or decrease in cost per recipient from the second sample set shall be factored into the data set determined under this subsection to derive an adjusted base figure or average cost per recipient per month;

(iii)(a) Comparison of base figures to current figures.

(b) A third sample set of data shall be gathered reflecting the claims data of the recipients and the average cost per recipient on a monthly basis during the pilot program by provider type.

(c) A comparison of the adjusted base figures arrived at by the second sample set to the actual figures from the third sample set shall determine how much the state saved by provider type.

(d) A recipient who leaves the pilot program area to avoid fraud detection will be noted, thus, the third sample set will be adjusted by claims derived outside of the pilot program area; and

(iv)(a) Recipient Surveying.

(b) The department shall obtain a fourth sample set of data by sampling two percent (2%) of Medicaid recipients in the pilot program area and shall survey the recipients before the beginning of the pilot program to determine services used, frequency of services used, and

satisfaction with services used.

(c) The department shall repeat the survey required under subdivision (e)(3)(B)(iv)(b) of this section at the completion of the pilot program to rate the level of satisfaction of the pilot program.

(f)(1) The department shall adopt a plan to implement the program statewide in phases.

(2) The plan shall include for each phase a description of the policies and procedures:

(A) For handling lost, forgotten, or stolen cards or situations in which a fingerprint match cannot be confirmed;

(B)(i) For distributing and activating smart cards for all recipients.

(ii) The policies and procedures shall include a simple step-by-step process that instructs a recipient in the process of enrollment and initial use of smart cards at the recipient's primary care provider and in the process of activating a smart card by providing a fingerprint for association with their smart card.

(iii) The biometric fingerprint template shall be stored on a host database and not on a recipient's smart card; and

(C)(i) For distributing and installing fingerprint scanners and card readers within provider locations.

(ii) The procedures shall include shipping the equipment to providers and providing simple step-by-step instructions for installation of the equipment; and

(D) For enrolling recipients for participation in the program.

(g) The department shall mandate participation in the program by all providers and recipients as the program is rolled out.

20-75-2105. Pilot program reports.

(a) The Department of Human Services, in preparation for implementing the Arkansas Medical Assistance Fraud Prevention Pilot Program required under this subchapter, shall submit a monthly report regarding the progress of preimplementation of the pilot program to the Governor, the Lieutenant Governor, the cochairs of the Legislative Council and the chair of the House Committee on Public Health, Welfare, and Labor, and the chair of the Senate

Committee on Public Health, Welfare, and Labor.

(b)(1) Upon implementation of the pilot program, the department shall submit a quarterly report to the Governor, the Lieutenant Governor, the cochairs of the Legislative Council and the chair of the House Committee on Public Health, Welfare, and Labor, and the chair of the Senate Committee on Public Health, Welfare, and Labor.

(2) The first quarterly report shall include an evaluation of the success of the pilot program.

20-75-2106. Interaction with federal law.

(a) This subchapter is intended to be consistent with the Social Security Act, 42 U.S.C. § 1396 et seq.

(b) If a provision of this subchapter is found to be in conflict with the Social Security Act, the provision is void.

(c) The Department of Human Services shall adopt rules to comply with the requirements of the Social Security Act.

20-75-2107. Referral to Attorney General.

The Department of Human Services shall refer a case of suspected fraud under this subchapter to the Attorney General under § 5-55-106.