Senate Bill 572

By: Senators Goggans of the 7th, Stephens of the 27th, Williams of the 19th, Douglas of the 17th, Pearson of the 51st and others

A BILL TO BE ENTITLED

AN ACT

To amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, so as to establish and define a crime of medical assistance managed care fraud; to change certain provisions relating to administrative hearings and appeals; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia, relating to medical assistance generally, is amended by inserting a new Code section 49-4-146.4, to read as follows:

"49-4-146.4.

(a) As used in this Code section, the term:

(1) 'Claim' means:

(A) Any request or demand for money, property, or benefit made to any agency, employee or officer of the department, or to any contractor, subcontractor, agent, or fiscal intermediary of the department, or to any managed care plan operated, funded, or reimbursed by the department, by or on behalf of a provider of medical assistance; or

(B) Any record, file, documentation, data, or information, which is required to be kept or maintained, in whatever form, that is intended or designed to support, justify, or allow the obtaining of payments or benefits, or the retention of payments or benefits previously obtained, if any portion of the payments or benefits is requested or demanded from, or was provided by, a managed care plan operated, funded, or reimbursed by the department.

(2) 'Knowing' or 'knowingly' means that a person, with respect to information, does any of the following:

(A) Has or should have actual knowledge of the information;

(B) Acts in deliberate ignorance of the truth or falsity of the information; or

(C) Acts in reckless disregard of the truth or falsity of the information.

(3) 'Person' includes any natural person, corporation, professional corporation, firm, association, organization, partnership, business, limited liability company, trust, or other legal entity.

(4) 'Statement' or 'representation' means, but is not limited to, an acknowledgment, certification, assertion, ratification, or report of demographic statistics, encounter data, enrollment, financial information, health care services available or rendered, and the qualifications of a person that is rendering, will render, or has rendered health care or ancillary services, which is submitted to any department employee or officer, contractor or agent of the department, any contractor, subcontractor agent, or fiscal intermediary of the department, or any managed care program operated, funded, or reimbursed by the department.

(b) It shall be unlawful for any person to:

(1) Present or cause to be presented a false or fraudulent claim for payment or approval for payment, knowing that all or a portion of the payment for the claim would issue from or be paid with funds provided by the department, or by a managed care program operated, funded, or reimbursed by the department;

(2) Knowingly make, use, or cause to be made or used a false or fraudulent record, datum, or statement to obtain or attempt to obtain payment or approval for payment, knowing that all or a portion of the payment would be paid with funds issued from or provided by the department, or by a managed care program operated, funded, or reimbursed by the department;

(3) Conspire to defraud the state, any department or agency of the state, or any political subdivision thereof by obtaining payment or approval for payment of a false claim knowing that all or a portion of the claim would be paid with funds issued from or provided by the department, or by a managed care program operated, funded, or reimbursed by the department;

(4) Have possession, custody, or control of property or money issued from or provided by the department, or by any contractor, subcontractor agent, or fiscal intermediary of the department, or by a managed care program operated, funded, or reimbursed by the department for the provision of health care or ancillary services, and knowingly deliver or cause to be delivered fewer goods and services or less treatment than the person certifies or asserts were provided, or which are less than contractually required or mandated;

(5) Knowingly make, use, or cause to be made or used a false or fraudulent record or statement in or to a managed care program in order to conceal, avoid, or decrease an obligation to pay, repay, return, submit, or transmit money or property knowing that the money or property is wholly or partially derived from the department or from a managed care program operated, funded, or reimbursed by the department;

(6) Having learned or discovered that a claim previously submitted to the department or to a managed care program operated, funded, or reimbursed by the department was false, knowingly fail to disclose the false claim to the department within a reasonable time after discovery of the false claim;

(7) Submit or cause to be submitted a claim for providing services to a recipient in a managed care program operated, funded, or reimbursed by the department, knowing that the recipient of medical assistance has been or will be denied service or has received or will receive a lesser degree of service than is certified as being or having been provided; or

(8) Knowingly withhold or unreasonably restrict access to items of medical or remedial care or service when payment for the items of medical or remedial care or service has been or will be made by the department or by a managed care program operated, funded, or reimbursed by the department.

(c) In addition to any other penalties provided by law, each person violating any provision of subsection (b) of this Code section shall be guilty of a felony and, upon conviction thereof, shall be punished for each offense by a fine of not more than $10,000.00, by imprisonment for not less than one nor more than ten years, or both. Any fines imposed under this provision shall be paid to the department.

(d) It shall be the duty of the department to identify and investigate violations of this article and to apprehend and arrest any person who violates such laws. For such purposes, the department shall be considered to be a law enforcement unit as that term is used in Chapter 8 of Title 35.″

SECTION 2.

Said article is further amended in Code Section 49-4-153, relating to administrative hearings and appeals, judicial review, and contested cases involving imposition of remedial or punitive measures against a nursing facility, by striking subsection (b) and inserting in lieu thereof the following:

″(b)(1) Any applicant for medical assistance whose application is denied or is not acted upon with reasonable promptness and any recipient of medical assistance aggrieved by the action or inaction of the Department of Community Health as to any medical or remedial care or service which such recipient alleges should be reimbursed under the

terms of the state plan which was in effect on the date on which such care or service was rendered or is sought to be rendered shall be entitled to a hearing upon his or her request for such in writing and in accordance with the applicable rules and regulations of the department and the Office of State Administrative Hearings. As a result of the written request for hearing, a written recommendation shall be rendered in writing by the administrative law judge assigned to hear the matter. Should a decision be adverse to a party and should a party desire to appeal that decision, the party must file a request in writing to the commissioner or the commissioner´s designated representative within 30 days of his or her receipt of the hearing decision. The commissioner, or the commissioner´s designated representative, has ~~ten~~ 30 days from the receipt of the request for appeal to affirm, modify, or reverse the decision appealed from. A final decision or order adverse to a party, other than the agency, in a contested case shall be in writing or stated in the record. A final decision shall include findings of fact and conclusions of law, separately stated, and the effective date of the decision or order. Findings of fact shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Each agency shall maintain a properly indexed file of all decisions in contested cases, which file shall be open for public inspection except those expressly made confidential or privileged by statute. If the commissioner fails to issue a decision, the initial recommended decision shall become the final administrative decision of the commissioner.

(2)(A) A provider of medical assistance may request a hearing on a decision of the Department of Community Health with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department of Community Health. The Department of Community Health shall, within 15 business days of receiving the request for hearing from the provider, transmit a copy of the provider´s request for hearing to the Office of State Administrative Hearings. The provider´s request for hearing shall identify the issues under appeal and specify the relief requested by the provider. The request for hearing shall be filed no later than 15 business days after the provider of medical assistance receives the decision of the Department of Community Health which is the basis for the appeal.

(B) The Office of State Administrative Hearings shall assign an administrative law judge to hear the dispute within 15 days after receiving the request. The hearing is required to commence no later than 90 days after the assignment of the case to an administrative law judge, and the administrative law judge shall issue a written decision

on the matter no later than 30 days after the close of the record except when it is determined that the complexity of the issues and the length of the record require an extension of these periods and an order is issued by an administrative law judge so providing, but no longer than 30 days. Such time requirements can be extended by written consent of all the parties. Failure of the administrative law judge to comply with the above time deadlines shall not render the case moot.

(C) A request for hearing by a nursing home provider shall stay any recovery or recoupment action.

(D) Should the decision of the administrative law judge be adverse to a party and should a party desire to appeal that decision, the party must file a request therefor, in writing, with the commissioner within ten days of his or her receipt of the hearing decision. Such a request must enumerate all factual and legal errors alleged by the party. The commissioner, or the commissioner´s designated representative, may affirm, modify, or reverse the decision appealed from.

(E) The provisions of this subsection shall not be available with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care or service rendered by such provider if the recipient of medical assistance is enrolled in a care management program operated, funded, or reimbursed by the department and the challenged determination was made by the care management organization.

(3) A person or institution who either has been refused enrollment as a provider in the state plan or has been terminated as a provider by the Department of Community Health shall be entitled to a hearing; provided, however, that no entitlement to a hearing before the department shall lie for refusals or terminations based on the want of any license, permit, certificate, approval, registration, charter, or other form of permission issued by an entity other than the Department of Community Health, which form of permission is required by law either to render care or to receive medical assistance in which federal financial participation is available. The final determination (subject to judicial review, if any) of such an entity denying issuance of such a form of permission shall be binding on and unreviewable by the Department of Community Health. In cases where an entitlement to a hearing before the Department of Community Health, pursuant to this paragraph, lies, the Department of Community Health shall give written notice of either the denial of enrollment or termination from enrollment to the affected person or institution; and such notice shall include the reasons of the Department of Community Health for denial or termination. Should such a person or institution desire to contest the initial decision of the Department of Community Health, he or she must give written notice of his or her appeal to the commissioner of community health within ten days after

the date on which the notice of denial or notice of termination was transmitted to him or her. A hearing shall be scheduled and commenced within 20 days after the date on which the commissioner receives the notice of appeal; and the commissioner or his or her designee or designees shall render a final administrative decision as soon as practicable thereafter.″

SECTION 3.

This Act shall become effective on April 1, 2006, or upon its approval by the Governor, whichever last occurs, or upon its becoming law without such approval.

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.