Senate Bill 63

By: Senators Albers of the 56th, Ligon, Jr. of the 3rd, Bethel of the 54th, Staton of the 18th, Miller of the 49th and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to public assistance, so as to enact the "Georgia 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 Community Health; to provide for implementation of a pilot program; to provide for participation; to provide for cooperation by the Department of Human Services; to provide for statutory construction; to provide for certain matters to be referred to the Attorney General; to provide for a waiver; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to public assistance, is amended by adding a new article to read as follows:

″ARTICLE 10

49-4-200.

This article shall be known and may be cited as the 'Georgia Medical Assistance Fraud Prevention Program.'

49-4-201.

As used in this article, the term:

(1) 'Board' means the Board of Community Health established under Chapter 2 of Title 31.

(2) 'Care management organization' means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter

21 of Title 33, and which has entered into a contract with the Department of Community Health to provide or arrange health care services, products, or both on a prepaid, capitated basis to members.

(3) 'Claim' includes any request or demand, whether under a contract or otherwise, for money, property, or services, which is made to the Georgia Medicaid program, or to any officer, employee, fiscal intermediary, grantee or contractor of the Georgia Medicaid program, or to other persons or entities if it results in payments by the Georgia Medicaid program, if the Georgia Medicaid program provides or will provide any portion of the money or property requested or demanded, or if the Georgia Medicaid program will reimburse the contractor, grantee, or other recipient for any portion of the money or property requested or demanded. A claim includes a request or demand made orally, in writing, electronically, or magnetically and:

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

(B) 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

(C) Has been generated at the point of transaction and as a result of recipients participating in either biometric or alternative method authentication as defined in paragraph (2) of subsection (c) and paragraphs (1) and (2) of subsection (d) of Code Section 49-4-203.

(4) 'Commissioner' means the commissioner of community health.

(5) 'Department' means the Department of Community Health established under Chapter 2 of Title 31.

(6) 'Health care provider' means any person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Georgia that has contracted with a care management organization to provide health care services, products, or both to members.

(7) 'Medicaid' means the joint federal and state program of medical assistance established by Title XIX of the federal Social Security Act, which is administered in this state by the department pursuant to Article 7 of this chapter.

(8) 'Medical assistance' means payment to a provider of a part or all of the cost of certain items of medical or remedial care or service rendered by the provider to a recipient, provided such items are rendered and received in accordance with such provisions of Title XIX of the federal Social Security Act of 1935, as amended, regulations promulgated pursuant thereto by the secretary of health and human services, all

applicable laws of this state, the state plan, and regulations of the department which are in effect on the date on which the items are rendered.

(9) 'Medical assistance card' means Medicaid cards currently used by recipients prior to the implementation of the state-wide rollout pursuant to this article, and which will be replaced by smart cards pursuant to this article, which shall identify eligible recipients and their account numbers, and shall be used by recipients to obtain medical assistance for which payment by the state shall be tendered.

(10) 'Member' means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(11) 'Multifactor authentication' means a security process in which a user provides multiple means of identification, one 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 and photo.

(12) 'PeachCare for Kids' means the State of Georgia's State Children's Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the department pursuant to Article 13 of Chapter 5 of this title.

(13) 'Physician' means a physician licensed to practice medicine in this state pursuant to Chapter 34 of Title 43.

(14) 'Pilot program' means the front-end, proactive medical assistance fraud prevention pilot program implemented pursuant to this article prior to a state-wide rollout of the Georgia Medical Assistance Fraud Prevention Program.

(15) 'Point of transaction' means the act of a recipient obtaining a service, product, or both provided by a provider, which service, product, or both is submitted as a claim to be paid for by the state Medicaid program as established by Title XIX of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 7 of this chapter.

(16) 'Program' means the Georgia Medical Assistance Fraud Prevention Program established and operated pursuant to this article.

(17) 'Provider' means a health care provider or provider of medical assistance.

(18) 'Provider of medical assistance' means a person or institution, public or private, including its employees, which possesses all licenses, permits, certificates, approvals, registrations, charters, and other forms of permission issued by entities other than the department, which forms of permission are required by law either to render health care services, products, or both or to receive medical assistance in which federal financial participation is available and which meets the further requirements for participation prescribed by the department and which is enrolled, in the manner and according to the terms prescribed by the department, to participate in the state plan.

(19) 'Recipient' means a member or recipient of medical assistance.

(20) 'Recipient of medical assistance' means a person who has been certified eligible, pursuant to the state plan, to have medical assistance paid on his or her behalf.

(21) 'Service' includes care or treatment of recipients.

(22) 'State plan' means all documentation submitted by the commissioner on behalf of the department to and for approval by the secretary of health and human services, pursuant to Title XIX of the federal Social Security Act, as amended (Act of July 30, 1965, P.L. 89-97, Stat. 343, as amended).

49-4-202.

(a) The department shall establish and administer the Georgia Medical Assistance Fraud Prevention Program. The board shall have the authority to enter into an agreement with a third-party vendor for the purpose of implementing and maintaining the program in accordance with this article.

(b) Prior to a state-wide rollout of the program, the department shall conduct a front-end, proactive medical assistance fraud prevention pilot program. The board shall determine the scope of the pilot program and shall have the authority to enter into an agreement with a third-party vendor for the purpose of developing and executing the pilot program in accordance with this article. Further, the board is authorized to establish such rules and regulations as may be necessary or desirable in order to execute the pilot program.

(c) The department shall implement the pilot program for a minimum period of three months, not to exceed a total of six months, within Glynn, Ware, Pierce, Wayne, Camden and Brantley counties. The pilot program shall involve enrollment, distribution, and use of smart cards by all recipients as replacements for currently used Medicaid assistance cards. The pilot program shall involve the distribution of fingerprint scanners and card readers at each provider location within the designated counties.

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

(e) The department shall implement the pilot program not later than October 1, 2011.

49-4-203.

(a) The department shall implement the Georgia Medical Assistance Fraud Prevention Program to address Medicaid fraud, waste, and abuse.

(b) The program shall be designed to:

(1) Authenticate recipients at the onset and completion of each point of transaction in order to prevent card sharing and other forms of fraud;

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

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

(4) Secure and protect the personal identity and information of recipients; and

(5) Reduce the total amount of medical assistance expenditures by reducing the average cost per recipient.

(c) The program shall include:

(1) Smart cards for storage of recipients' state benefit information, insurance information, and other general health information for the purpose of replacing existing medical assistance cards. The smart cards shall include recipients' prescription history information in order to assist in prevention of drug overutilization and to mitigate costs and risks associated with prescription drugs. Sensitive information to be stored shall be split into multiple parts and encrypted, with one part being stored on the host data base;

(2) Biometric fingerprint scanners and card readers for the purpose of real time, multifactor authentication of recipients' fingerprint templates and smart cards. Biometric fingerprint scanners and card readers shall reside at the point of transaction with providers;

(3) Biometric fingerprint readers for authentication by providers;

(4) A secure finger-imaging system that is compliant with the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. 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 lost, stolen, or forgotten cards and to prevent Medicaid fraud associated with card reproduction and card sharing. The system shall take a fingerprint image and convert it into a binary PIN number, known as a fingerprint template, and store the template, rather than the fingerprint image, on the central host system. The fingerprint template shall not be able to be recreated into an actual fingerprint image;

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

(6) An information system that interfaces with the state data base to determine eligibility of recipients;

(7) A system that gathers analytical information to be provided to data-mining companies in order to assist in data-mining processes;

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

(9) No requirement for preenrollment of recipients; and

(10) An image of the recipient stored on both the smart card and data base.

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

(1) Have an alternative method of authentication of recipients when biometric fingerprint images cannot be used and to address specific mandates needed to obtain a waiver or authorization from the federal Centers for Medicare and Medicaid Services;

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

(3) Allow electronic prescribing services and prescription data base integration and tracking in order to prevent medical error through information sharing and to reduce pharmaceutical abuse and lower health care costs;

(4) 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; and

(5) Allow the program, including, but not limited to, smart cards, fingerprint scanners, and card readers, to be adapted for use by other state programs administered by the department and the Department of Human Services in order to reduce costs associated with the necessity of multiple cards per recipient.

(e) The department shall implement a state-wide rollout of the program after completion of a successful pilot program. The pilot program shall be considered a success if it meets the minimum criteria defined in subsections (b) and (c) of this Code section and reduces the average monthly cost of recipients within the pilot program area by a minimum of 3 percent. In the event that the pilot program does not meet the minimum criteria to be considered a success, the department shall be authorized to extend and revise the pilot program as necessary and to reevaluate the results. In order to evaluate the average monthly cost of recipients within the pilot program and develop the strategy necessary to target the highest rate of savings to the state plan, four sample sets of figures shall be analyzed for the pilot program, including:

(1) Establishment of Base Figures:

Gather claims data for a first sample set which shall include all claims for the recipients within 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;

(2) Adjusted Base Figures for Increase or Decrease in Cost of Services:

In order to evaluate increases or decreases in the cost of services, a second sample set shall be gathered and adjusted to the base figures of the first sample set. 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 as the population 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.

This sample set shall be analyzed against the prior year's figures and compared to current year figures for the same time frame and area to determine an increase or decrease in cost of services. This sample shall not have 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. The increase or decrease in cost per recipient from this sampling shall be factored into the data set determined pursuant to paragraph (1) of this subsection to derive at an Adjusted Base Figure or average cost per recipient per month;

(3) Comparison of Base Figures to Current Figures:

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. A comparison of the Adjusted Base Figures arrived at by the prior sampling with the actual figures from this third sample set shall be made to determine how much the state saved by provider type. Recipients leaving 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

(4) Recipient Surveying:

A fourth sample set of data shall be obtained by sampling 2 percent of Medicaid recipients in the pilot program area and shall be surveyed prior to the start of the pilot program to acknowledge services used, frequency of services used, and satisfaction of services used. This survey shall be taken again at the completion of the pilot program to rate the level of satisfaction of the pilot program.

(f) The department shall adopt a plan to implement the program state-wide in phases. The plan shall include for each phase:

(1) A description of the policies and procedures concerning the handling of lost, forgotten, or stolen cards or situations in which a fingerprint match cannot be confirmed;

(2) A description of the policies and procedures for enrolling all recipients, regardless of age, for participation in the program;

(3) A description of the policies and procedures for distributing and activating smart cards for all recipients. The policies and procedures shall include a simple step-by-step process instructing recipients in the process of enrollment and initial use of smart cards at their primary care provider and to provide their biometric fingerprint in order to activate their card and associate their fingerprint with their smart card. The biometric fingerprint template shall be stored on a host data base and not on recipient smart cards; and

(4) A description of the policies and procedures for distributing and installing fingerprint scanners and card readers within provider locations. The procedures shall include

shipping the equipment to providers and providing simple step-by-step instructions for installation of the equipment.

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

49-4-204.

The department, in preparation for implementing the pilot program required by this article, shall submit a monthly report regarding the progress of pre-implementation of the pilot program to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and presiding officer of each standing committee of the Senate and House of Representatives having jurisdiction over the state Medicaid program. Upon implementation of the pilot program, a quarterly report shall be submitted by the department. The first quarterly report shall include an evaluation of the success of the pilot program, as required by subsection (e) of Code Section 49-4-203.

49-4-205.

The Department of Human Services shall cooperate and assist the department in the process of adopting and administering both the Georgia Medical Assistance Fraud Prevention Program and the Georgia Medical Assistance Fraud Prevention Pilot Program.

49-4-206.

It is the intention of the department that this article be construed consistent with the federal Social Security Act, and any provision of this article found to be in conflict with the federal Social Security Act shall be deemed to be void and of no effect. It is further the intention of the department, in view of the joint state and federal financial participation in the Georgia state plan, that the department shall be authorized to adopt such regulations as may be necessary to comply with the requirements of the federal Social Security Act.

49-4-207.

The department may refer matters to the Attorney General for handling pursuant to Code Section 49-4-168.2 relating to possible violations of Article 7B of this chapter.

49-4-208.

If, before implementing any provision of this article, the department determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the department shall request the waiver or authorization."

SECTION 2.

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