**Department of**

**Health and Social Services**

**CSSB 78(FIN)**

**Sectional Analysis:**

Section 1 Adopts intent language related to the need to redesign the state’s Medicaid program to provide financial sustainability, and sets out goals for redesign of the program.

Section 2 Adopts AS 09.10.075, which establishes time limits in which a person may or may not bring an action under new sections AS 09.58.010-09.58.950, the Alaska Medicaid False Claims Act, and a statute of limitations. An action may be brought within six years of when the act or omission was committed, or three years after the date when the act or omission was known or reasonably should have been known by the attorney general and department, but no action may be brought for a violation more than ten years after the date of violation.

Section 3 Amends AS 09.10.120(a) to include reference to new subsection AS 09.10.075, creating an exception for Medicaid fraud action time limits.

Section 4 Adopts AS 09.58, which establishes Alaska Medicaid False Claim and Reporting Act (AFMCA). This section includes several subsections related to liability for certain acts and omissions, civil actions, rights of participants in such actions, awards allowed, actions that are not allowed, limits state liability, and outlines whistleblower protections. This section identifies the fraudulent or false acts that can be committed by a Medicaid provider, a corporation, partnership or individual, or recipient in effort to defraud the State. This section also outlines provisions by which a recipient or provider may reduce the amount of liability from actual damages.

This section also allows a private citizen to pursue a false claim action in the superior court, outlines the provision by which they may file a suit or an extension of time in which to bring an action, and the responsibilities and time-line in which the attorney general must investigate and respond to the claim. This section also identifies the options available to private persons, should the attorney general dismiss the case due to lack of evidence, including pursuing the suit of their own accord. Throughout the process, this section states that the attorney general holds the rights to intervene, settle, dismiss the case, request investigation assistance from the department and bring civil action in superior court.

This section further allows the attorney general to issue subpoenas to compel records in connection with an investigation, and outlines the courts’ authority to issue an order to comply and punishments if the Medicaid provider or recipient(s) fail or refuse to comply with the courts order. Further, by this section the attorney general may elect to interview and file or amend a new complaint based on conduct, transactions or acts set out in the complaint.

Further, this section provides protections for the private person acting as a whistleblower and limit the liability of the state and outlines time limits for bringing action.

Finally, this section includes department regulatory authority, identifies the limits of punitive damages, and provides definitions related to this section.

Section 5 Amends AS 37.05.146(c) to include a new paragraph (88) adding monetary recoveries from the Alaska Medicaid False Claims Act to the program and non-general fund program receipts definitions.

Section 6 Amends AS 40.25.120, a conforming amendment to include new AS.09.58.010 to existing public records statutes.

Section 7 Amends AS 47.05.010 to include a requirement that DHSS develop a health care delivery model that encourages wellness and disease prevention.

Section 8 Amends AS 47.05.200, Medicaid Audits statute, changes the number of program audits to no less than fifty per year and adding that the state shall attempt to minimize concurrent state or federal audits.

Section 9 Adopts AS 47.05.200 that the Department may assess interest and penalties on overpayments, calculating interest using existing statutory rates.

Section 10 Adopts AS 47.05.235, which applies the duty of enrolled Medicaid providers to conduct one annual review, identify overpayment and report findings to the department within ten business days, and create a repayment agreement with the state.

Section 11 Adopts AS 47.05.250, which authorizes the department to develop regulations to impose civil fines and sets limits on the amount of the fines.

Adopts AS 47.05.260, which authorizes the department, after application to the court and a finding of probable cause, to seize certain real or personal property of a medical assistance provider who has committed or is committing medical assistance fraud, to offset the cost of the alleged fraud. The court may authorize seizure of real or personal property to cover the cost of the alleged fraud.

This section provides a list of possible real or personal properties, including bank accounts, automobiles, boats, airplanes, stocks and bonds, and inventory.

This section, upon issuance of the court order of seizure, prohibits the owners of property from disposing of the property, with a provision of good faith in the event property is sold without written permission of the court.

This section further authorizes the forfeiture of any seized property if the Medicaid provider is eventually convicted of medical assistance fraud. This section provides instructions to the state to sell or return properties, and depositing funds from disposal of seized properties.

This section also allows for the action of forfeiture to be joined with any alternative civil or criminal action for damages.

Section 12Amends AS 47.07.036 by adding new subsections (d) – (f) to outline cost containment and reform measures DHSS must undertake, including seeking demonstration waivers related to innovative service delivery models, applying for other options under the Social Security Act to obtain or increase federal match, and improving telemedicine for Medicaid recipients. This section also requires DHSS to apply for an 1115 waiver for a demonstration project for one or more groups of Medicaid recipients in one or more geographic area. The demonstration project may include managed care organizations, community care organizations, patient-centered medical homes, or other innovative payment models.

Section 13 Amends 47.07.900 (4), Medicaid Administration definitions, by removing the grantee status requirement for outpatient community mental health clinics serving Medicaid patients.

Section 14 Amends AS 47.07.900 (17) by removing the grantee/contractor status requirement from drug and alcohol treatment centers and outpatient community mental health clinics. This change, and the one in the previous section, allows mental health and drug treatment service providers who do not receive grants from the department to become enrolled Medicaid providers and deliver services to Medicaid recipients.

Section 15 Adds a new section to outline court rule amendments as a result of enactment of “section 2, 3, and 4 ” (AMFCA) of this Act.

Section 16 Requires DHSS to collaborate with Alaska Tribal health organizations and the U.S. DHHS to implement new federal policy regarding 100% federal funding for services provided to Medicaid-eligible American Indian and Alaska Native individuals.

Section 17Requires DHSS to implement the primary care case management system authorized under AS 47.07.030(d). The purpose of this new system is to increase Medicaid enrollees’ use of primary and preventive care, while decreasing the use of specialty care and hospital emergency department services.

Section 18 Requires DHSS to develop a plan to strengthen the health information infrastructure, including health data analytics capability, to support transformation of the health system in Alaska.

Section 19 Authorizes DHSS to support one or more private initiatives designed to reduce nonurgent use of emergency departments by Medicaid recipients.

Section 20 Authorizes DHSS to contract with one or more accountable care organizations to demonstrate the use of local, provider-led coordinated care entities that agree to monitor care across multiple care settings, and that will be accountable to DHSS for the overall cost and quality of care. DHSS is authorized to participate in public-private partnerships with other purchasers of health care services, and is required to implement an evaluation plan to measure the success of this demonstration project.

Section 21 Instructs DHSS to immediately amend the Medicaid state plan to be consistent with this Act, and submit the amendments to the federal government for approval.

Section 22 Authorizes DHSS to adopt regulations to implement provisions of this Act.

Section 23 Provides that Section 4 is effective conditional on Section 15 receiving a two-thirds majority vote. The new sections of law creating the civil Medicaid false claims act do not take effect unless the indirect court rule change sections of the bill receive the necessary two-thirds vote.

Section 24 Provides that Section 22 is effective immediately under AS 01.10.070(c).

Section 25 Provides that, except for Section 22, the provisions of this Act take effect on July 1, 2016.