regulation.

(c) The board shall adopt regulations restricting the evaluation, diagnosis, supervision, and treatment of a person as authorized under (b) of this section by establishing standards of care, including standards for training, confidentiality, supervision, practice, and related issues.

* Sec. 16. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.075. Actions related to claims based on medical assistance payment fraud. Except as provided in AS 09.58.070, a person may not bring an action under AS 09.58.010 - 09.58.060, unless the action is commenced by (1) six years after the act or omission was committed, or (2) three years after the date when facts material to the action were known, or reasonably should have been known, by the attorney general or the Department of Health and Social Services, whichever is later, but in no event more than 10 years after the date the violation under AS 09.58.010 occurred.

* Sec. 17. AS 09.10.120(a) is amended to read:

(a) Except as provided in AS 09.10.075, an [AN] action brought in the name of or for the benefit of the state, any political subdivision, or public corporation may be commenced only within six years after [OF] the date of accrual of the cause of action. However, if the action is for relief on the ground of fraud, the limitation commences from the time of discovery by the aggrieved party of the facts constituting the fraud.

* Sec. 18. AS 09 is amended by adding a new chapter to read:

Chapter 58. Alaska Medical Assistance False Claim and Reporting Act.

Sec. 09.58.010. False claims for medical assistance; civil penalty. (a) A medical assistance provider or medical assistance recipient may not

(1) knowingly submit, authorize, or cause to be submitted to an officer or employee of the state a false or fraudulent claim for payment or approval under the medical assistance program;

(2) knowingly make, use, or cause to be made or used, directly or indirectly, a false record or statement to get a false or fraudulent claim for payment paid or approved by the state under the medical assistance program;
(3) conspire to defraud the state by getting a false or fraudulent claim paid or approved under the medical assistance program;

(4) knowingly make, use, or cause to be made or used, a false record or statement to conceal, avoid, increase, or decrease an obligation to pay or transmit money or property to the medical assistance program;

(5) knowingly enter into an agreement, contract, or understanding with an officer or employee of the state for approval or payment of a claim under the medical assistance program knowing that the information in the agreement, contract, or understanding is false or fraudulent.

(b) A beneficiary of an intentional or inadvertent submission of a false or fraudulent claim under the medical assistance program who later discovers the claim is false or fraudulent shall disclose the false or fraudulent claim to the state not later than 60 days after discovering the false claim.

(c) In addition to any criminal penalties under AS 47.05, a medical assistance provider or medical assistance recipient who violates (a) or (b) of this section shall be liable to the state in a civil action for

(1) a civil penalty of not less than $5,500 and not more than $11,000;

(2) three times the amount of actual damages sustained by the state;

(3) full reasonable attorney fees and costs in a case involving a fraudulent claim, agreement, contract, or understanding; and

(4) reasonable attorney fees and costs calculated under applicable court rules in a case that does not involve a fraudulent claim, agreement, contract, or understanding.

(d) Liability for actual damages under (c) of this section may be reduced to not less than twice the amount of actual damages that the state sustains if the court finds that a person liable for an act under (a) or (b) of this section

(1) furnished the attorney general or the Department of Health and Social Services with all information known to the person about the violation not later than 30 days after the date the information was obtained;

(2) fully cooperated with the investigation of the violation under AS 09.58.020;
(3) at the time the person furnished the attorney general with the information about the violation, no criminal prosecution, civil action, investigation, or administrative action had been started in this state with respect to the violation, and the person did not have actual knowledge of the existence of an investigation of the violation.

(e) A corporation, partnership, or other individual is liable under this section for acts of its agents if the agent acted with apparent authority, regardless of whether the agent acted, in whole or in part, to benefit the principal and regardless of whether the principal adopted or ratified the agent's claims, representations, statement, or other action or conduct.

(f) Notwithstanding (e) of this section, a corporation, partnership, or other individual is not liable under this section for acts of its agents if the evidence shows that the agent or apparent agent acted with intent to deceive the principal.

Sec. 09.58.015. Attorney general investigation; civil action. (a) The attorney general or the Department of Health and Social Services may investigate an alleged violation of AS 09.58.010. The attorney general may request assistance from the Department of Health and Social Services in an investigation under this section.

(b) The attorney general may bring a civil action in superior court under AS 09.58.010 - 09.58.060.

Sec. 09.58.020. Private plaintiff; civil action. (a) Notwithstanding AS 09.58.015, a person may bring an action under this section for a violation of AS 09.58.010 in the name of the person and the state.

(b) To bring an action under this section, a person shall file a complaint, in camera and under seal, and serve on the attorney general

(1) a copy of the complaint; and

(2) written disclosure of substantially all material evidence and information the person possesses that pertains to the claim.

(c) A complaint filed under this section must remain under seal for at least 60 days and may not be served on the defendant until the court so orders. The attorney general may elect to intervene and proceed with the action within 60 days after the attorney general receives both the complaint and the material evidence and the
information required under (b) of this section. The attorney general may, for good
cause shown, move the court, under seal, for an extension of the time during which the
complaint remains under seal under this subsection.

(d) Before the expiration of the 60-day period or an extension of time granted
under (c) of this section, the attorney general shall conduct an investigation and make
a written determination as to whether substantial evidence exists that a violation of
AS 09.58.010 has occurred. After the investigation and determination are complete,
the attorney general shall provide the person who brought the action and the
Department of Health and Social Services with a copy of the determination unless the
action has been referred to the division of the Department of Law that has
responsibility for criminal cases.

(e) Before the expiration of the 60-day period or an extension obtained under
(c) of this section, the attorney general shall

(1) intervene in the action and proceed with the action on behalf of the
state;

(2) notify the court that the attorney general declines to take over the
action, in which case the person bringing the action has the right to conduct the action;
or

(3) if the attorney general determines that substantial evidence does not
exist that a violation of AS 09.58.010 has occurred, or that the action is barred under
AS 09.58.050, the attorney general shall move the court to dismiss the action.

(f) The named defendant in a complaint filed under this section is not required
to respond to a complaint filed under this section until after the complaint is unsealed
by the court and a copy of the summons and complaint are served on the defendant
under the applicable Alaska Rules of Civil Procedure.

(g) When a person brings an action under this section, only the attorney
general may intervene or bring a related action based on similar facts to the underlying
action.

Sec. 09.58.025. Subpoenas. In conducting an investigation under
AS 09.58.015 or 09.58.020, the attorney general may issue subpoenas to compel the
production of books, papers, correspondence, memoranda, and other records in
connection with an investigation under or the administration of AS 09.58.010 - 09.58.060. If a medical assistance provider or a medical assistance recipient fails or refuses, without just cause, to obey a subpoena issued under this subsection, the superior court may, upon application by the attorney general, issue an order requiring the medical assistance provider or medical assistance recipient to appear before the attorney general to produce evidence.

Sec. 09.58.030. Rights in false or fraudulent claims actions. (a) If the attorney general elects to intervene and proceed with an action under AS 09.58.020, the attorney general has exclusive authority for prosecuting the action and is not bound by an act of the person bringing the action. The person who brought the action has the right to continue as a nominal party to the action, but does not have the right to participate in the action except as a witness or as otherwise directed by the attorney general. If the attorney general elects to intervene under AS 09.58.020, the attorney general may file a new complaint or amend the complaint filed by the person who brought the action under AS 09.58.020(b).

(b) Notwithstanding the objections of the person who brought the action, the attorney general may

   (1) move to dismiss the action at any time under this chapter if the attorney general has notified the person who brought the action of the intent to seek dismissal and the court has provided the person who brought the action with an opportunity to respond to the motion;

   (2) settle the action with the defendant at any time, if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances; upon a showing of good cause, the hearing described in this paragraph shall be held in camera.

   (c) If the attorney general elects not to proceed under AS 09.58.020 with the action, the person who brought the action has the right to proceed and conduct the action. The attorney general may request at any time during the proceedings to be served with copies of all documents related to the action, including pleadings, motions, and discovery. The attorney general shall pay for the reasonable copying charges for documents provided under this subsection. If the person who brought the
action proceeds with the action, the court, without limiting the status and rights of the person who brought the action, shall allow the attorney general to intervene at any time.

(d) Whether or not the attorney general proceeds with the action under this chapter, on a showing by the attorney general that certain actions of discovery by the person bringing the action would interfere with pending investigation or prosecution of a criminal or civil proceeding arising out of the same matter, the court may stay the discovery for not more than 90 days. The court may extend the 90-day period on a further showing, in camera, that the state has pursued the criminal or civil investigation or proceedings with reasonable diligence and that proposed discovery in the civil action under AS 09.58.010 - 09.58.060 may interfere with the ongoing criminal or civil investigation or proceedings.

Sec. 09.58.040. Award to false or fraudulent claim plaintiff. (a) If the attorney general proceeds with an action brought by a person for a violation of AS 09.58.010, the person who brought the action shall receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending on the extent to which the person bringing the action contributed to the prosecution of the action. The court order or settlement agreement shall state the percentage and the amount to be received by the person who brought the action. A payment under this subsection to the person who brought the action may only be paid from proceeds received from a judgment or settlement under this section.

(b) If the attorney general does not proceed with an action brought under AS 09.58.020, the person bringing the action to judgment or settlement by court order shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages based on the person's effort to prosecute the action successfully. The amount shall be at least 25 percent but not more than 30 percent of the proceeds of the action or settlement of the claim. A payment under this subsection to the person who brought the action may only be paid from proceeds received from a judgment or settlement received under this section. In addition, if the person bringing the action prevails, the person is entitled to

(1) full reasonable attorney fees and court costs in a case involving a
fraudulent claim, agreement, contract, or understanding; or

(2) reasonable attorney fees and court costs calculated under applicable court rules in a case that does not involve a fraudulent claim, agreement, contract, or understanding.

(c) Whether or not the attorney general participates in the action, if the court finds that the action was brought by a person who planned or initiated the violation alleged in the action brought under AS 09.58.020, the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action that the person would otherwise receive under (a) or (b) of this section, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from the person's role in the violation of AS 09.58.010, the court shall dismiss the person from the civil action and the person may not receive any share of the proceeds of the action or settlement. A dismissal under this subsection does not prejudice the right of the attorney general to continue the action.

(d) In this section, "proceeds of the action or settlement"

(1) includes damages, civil penalties, payment for cost of compliance, and other economic benefits realized by the state as a result of a civil action brought under AS 09.58.010 - 09.58.060;

(2) does not include attorney fees and costs awarded to the state.

Sec. 09.58.050. Certain actions barred. A person may not bring an action under AS 09.58.020 if the action is

(1) based on evidence or information known to the state when the action was brought;

(2) based on allegations or transactions that are the subject of a civil or criminal action or an administrative proceeding in which the state is already a party;

(3) based on the public disclosure of allegations or actions in a criminal or civil action or an administrative hearing, or from the news media, unless the action is brought by the attorney general or the person bringing the action is an original source of the information that was publicly disclosed; in this paragraph, a person is an original source of the information that was publicly disclosed if the
person has independent knowledge, including knowledge based on personal
investigation of the defendant's conduct, of the information on which the allegations
are based, and has voluntarily provided or verified the information on which the
allegations are based or voluntarily provided the information to the attorney general
before filing an action under AS 09.58.020 that is based on the information; or

(4) against the state or current or former state employees.

Sec. 09.58.060. State not liable for attorney fees, costs, and other expenses. The state, its agencies, current or former officers, and current or former employees, are
not liable for attorney fees, costs, and other expenses that a person incurs in bringing
an action under AS 09.58.020.

Sec. 09.58.070. Employee protection for retaliation. (a) An employee of a
medical assistance provider who is discharged, demoted, suspended, threatened,
harassed, or discriminated against in the terms and conditions of employment by the
employee's employer because of lawful acts done by the employee on behalf of the
employee or others in furtherance of an action under AS 09.58.010 - 09.58.100,
including investigation for, initiation of, testimony for or assistance in an action filed
or to be filed under AS 09.58.010 - 09.58.100, is entitled to the same relief authorized
under AS 39.90.120.

(b) Notwithstanding (a) of this section, a state employee who is discharged,
demoted, suspended, threatened, harassed, or discriminated against in the terms and
conditions of employment because of lawful acts done by the employee on behalf of
the employee or a person who brings an action under AS 09.58.020 or in furtherance
of an action under AS 09.58.010 - 09.58.100, including investigation, initiation of,
testimony for or assistance in an action filed or to be filed under AS 09.58.010 -
09.58.100, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska Whistleblower
Act).

(c) A person may not bring an action under this section unless the action is
commenced not later than three years after the date the employee was subject to
retaliation under (a) or (b) of this section.

Sec. 09.58.080. Regulations. The attorney general may adopt regulations
under AS 44.62 as necessary to carry out the purposes of this chapter.
Sec. 09.58.090. Special provisions. (a) This chapter does not apply to any controversy involving damages to the state of less than $5,500 in value.

(b) No punitive damages may be awarded in an action brought under AS 09.58.010 - 09.58.060.

Sec. 09.58.100. Definitions. In this chapter,

(1) "attorney general" includes a designee of the attorney general;

(2) "claim" means a request for payment of health care services or equipment, whether made to a contractor, grantee, or other person, when the state provides, directly or indirectly, a portion of the money, property, or services requested or demanded, or when the state will, directly or indirectly, reimburse the contractor, grantee, or other recipient for a portion of the money, property, or services requested or demanded;

(3) "controversy" means the aggregate of one or more false claims submitted by the same medical assistance provider or medical assistance recipient under this chapter;

(4) "knowingly" means that a person, with or without specific intent to defraud,

(A) has 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;

(5) "medical assistance program" means the federal-state program administered by the Department of Health and Social Services under AS 47.05 and AS 47.07 and regulations adopted under AS 47.05 and AS 47.07;

(6) "medical assistance provider" has the meaning given under AS 47.05.290;

(7) "medical assistance recipient" has the meaning given under AS 47.05.290;

(8) "obligation" means an established duty, whether or not fixed,
an express or implied contractual grantor or grantee or
licensor or licensee relationship;
(B) a fee-based or similar relationship;
(C) a statute or regulation; or
(D) the retention of any overpayment.

Sec. 09.58.110. Short title. This chapter may be cited as the Alaska Medical
Assistance False Claim and Reporting Act.

* Sec. 19. AS 09.58.025, added by sec. 18 of this Act, is amended to read:
Sec. 09.58.025. Subpoenas. In conducting an investigation under
AS 09.58.015 [OR 09.58.020], the attorney general may issue subpoenas to compel
the production of books, papers, correspondence, memoranda, and other records in
connection with an investigation under or the administration of AS 09.58.010 -
09.58.060. If a medical assistance provider or a medical assistance recipient fails or
refuses, without just cause, to obey a subpoena issued under this subsection, the
superior court may, upon application by the attorney general, issue an order requiring
the medical assistance provider or medical assistance recipient to appear before the
attorney general to produce evidence.

* Sec. 20. AS 09.58.070(b), added by sec. 18 of this Act, is amended to read:
(b) Notwithstanding (a) of this section, a state employee who is discharged,
demoted, suspended, threatened, harassed, or discriminated against in the terms and
conditions of employment because of lawful acts done by the employee on behalf of
the employee [OR A PERSON WHO BRINGS AN ACTION UNDER AS 09.58.020]
or in furtherance of an action under AS 09.58.010 - 09.58.060, including investigation,
initiation of, testimony for or assistance in an action filed or to be filed under
AS 09.58.010 - 09.58.060, is entitled to relief under AS 39.90.100 - 39.90.150 (Alaska
Whistleblower Act).

* Sec. 21. AS 17.30.200(a) is amended to read:
(a) The controlled substance prescription database is established in the Board
of Pharmacy. The purpose of the database is to contain data as described in this
section regarding every prescription for a schedule [IA, IIA, IIIA, IVA, OR VA
CONTROLLED SUBSTANCE UNDER STATE LAW OR A SCHEDULE I,] II, III,
(15) records relating to proceedings under AS 09.58 (Alaska Medical
Assistance False Claim and Reporting Act).

* Sec. 38. AS 44.33 is amended by adding a new section to read:

Article 5A. Telemedicine Business Registry.

Sec. 44.33.381. Telemedicine business registry. (a) The department shall
adopt regulations for establishing and maintaining a registry of businesses performing
telemedicine services in the state.

(b) The department shall maintain the registry of businesses performing
telemedicine services in the state. The registry must include the name, address, and
contact information of businesses performing telemedicine services in the state.

(c) In this section,

(1) "department" means the Department of Commerce, Community,
and Economic Development;

(2) "telemedicine services" means the delivery of health care services
using the transfer of medical data through audio, visual, or data communications that
are performed over two or more locations by a provider who is physically separated
from the recipient of the health care services.

* Sec. 39. AS 47.05 is amended by adding a new section to article 1 to read:

Sec. 47.05.105. Enhanced computerized eligibility verification system. (a)
The department shall establish an enhanced computerized income, asset, and identity
eligibility verification system for the purposes of verifying eligibility, eliminating
duplication of public assistance payments, and deterring waste and fraud in public
assistance programs administered by the department under AS 47.05.010. Nothing in
this section prohibits the department from verifying eligibility for public assistance
through additional procedures or authorizes the department or a third-party vendor to
use data to verify eligibility for a federal program if the use of that data is prohibited
by federal law.

(b) The department shall enter into a competitively bid contract with a third-
party vendor for the purpose of developing a system under this section to prevent
fraud, misrepresentation, and inadequate documentation when determining an
applicant's eligibility for public assistance before the payment of benefits and for
periodically verifying eligibility between eligibility redeterminations and during
eligibility redeterminations and reviews under AS 47.05.110 - 47.05.120. The
department may also contract with a third-party vendor to provide information to
facilitate reviews of recipient eligibility and income verification.

(c) The annual savings to the state resulting from the use of the system under
this section must exceed the cost of implementing the system. A contract under this
section must require the third-party vendor to report annual savings to the state
realized from implementing the system. Payment to the third-party vendor may be
based on a fee for each applicant and may include incentives for achieving a rate of
success established by the department for identifying duplication, waste, and fraud in
public assistance programs.

(d) To avoid a conflict of interest, the department may not award a contract to
provide services for the enrollment of public assistance providers or applicants under
this title to a vendor that is awarded a contract under this section.

* Sec. 40. AS 47.05.200(a) is amended to read:

(a) The department shall annually contract for independent audits of a
statewide sample of all medical assistance providers in order to identify overpayments
and violations of criminal statutes. The audits conducted under this section may not be
conducted by the department or employees of the department. The number of audits
under this section may not be less than 50 each year [., AS A TOTAL FOR THE
MEDICAL ASSISTANCE PROGRAMS UNDER AS 47.07 AND AS 47.08, SHALL
BE 0.75 PERCENT OF ALL ENROLLED PROVIDERS UNDER THE
PROGRAMS, ADJUSTED ANNUALLY ON JULY 1, AS DETERMINED BY THE
DEPARTMENT, EXCEPT THAT THE NUMBER OF AUDITS UNDER THIS
SECTION MAY NOT BE LESS THAN 75]. The audits under this section must
include both on-site audits and desk audits and must be of a variety of provider types.
The department may not award a contract under this subsection to an organization that
does not retain persons with a significant level of expertise and recent professional
practice in the general areas of standard accounting principles and financial auditing
and in the specific areas of medical records review, investigative research, and Alaska
health care criminal law. The contractor, in consultation with the commissioner, shall
select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected. **In identifying providers who are subject to an audit under this chapter, the department shall attempt to minimize concurrent state or federal audits.**

* Sec. 41. AS 47.05.200(b) is amended to read:

(b) Within 90 days after receiving each audit report from an audit conducted under this section, the department shall begin administrative procedures to recoup overpayments identified in the audits and shall allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken, in which case, the commissioner shall hold the administrative procedure in abeyance until a final charging decision by the attorney general has been made. The commissioner shall provide copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges. **The department may assess interest and penalties on any identified overpayment. Interest under this subsection shall be calculated using the statutory rates for postjudgment interest accruing from the date of the issuance of the final agency decision to recoup overpayments identified in the audit. In this subsection, the date of issuance of the final agency decision is the later of the date of**

1. the department’s written notification of the decision and the provider’s appeal rights; or

2. if timely appealed by the provider, a final agency decision under AS 44.64.060.

* Sec. 42. AS 47.05 is amended by adding a new section to read:

**Sec. 47.05.235. Duty to identify and repay self-identified overpayments.** (a) Unless a provider is being audited under AS 47.05.200(a), an enrolled medical assistance provider shall conduct a biennial review or audit of a statistically valid sample of claims submitted to the department for reimbursement. If overpayments are identified, the medical assistance provider shall report the overpayment to the department not later than 10 business days after identification of the overpayment. The
report must also identify how the medical assistance provider intends to repay the department. After the department receives the report, the medical assistance provider and the department shall enter into an agreement establishing a schedule for repayment of the identified overpayment. The agreement may authorize repayment in a lump sum, a payment plan, or by offsetting future billings as approved by the department.

(b) The department may not assess interest or penalties on an overpayment identified and repaid by a medical assistance provider under this section.

*Sec. 43. AS 47.05 is amended by adding new sections to read:

Sec. 47.05.250. Civil penalties. (a) The department may assess a civil penalty against a provider who violates this chapter, AS 47.07, or regulations adopted under this chapter or AS 47.07.

(b) The department shall adopt regulations establishing a range of civil penalties that the department may assess against a provider under this section. In establishing the range of civil penalties, the department shall take into account appropriate factors, including the seriousness of the violation, the service provided by the provider, and the severity of the penalty. The regulations may not provide for a civil penalty of less than $100 or more than $25,000 for each violation.

(c) The provisions of this section are in addition to any other remedies available under this chapter, AS 47.07, or regulations adopted under this chapter or AS 47.07.

(d) A provider against whom a civil penalty of less than $2,500 is assessed may appeal the decision assessing the penalty to the commissioner or the commissioner's designee. The commissioner shall, by regulation, establish time limits and procedures for an appeal under this subsection. The decision of the commissioner or the commissioner's designee may be appealed to the office of administrative hearings established under AS 44.64.

(e) A provider against whom a civil penalty of $2,500 or more is assessed may appeal the decision assessing the penalty to the office of administrative hearings established under AS 44.64.

Sec. 47.05.270. Medical assistance reform program. (a) The department
(c) As a condition for receipt of payment assistance under (d) of this section, the department, under regulations adopted by the department, shall [MAY] require a person to

(1) apply for other state or federally sponsored programs that may reduce the amount of the payment assistance; and

(2) submit to the department a copy of the person's application for medical assistance coverage under AS 47.07 and the decision letter the person receives regarding the application.

* Sec. 51. AS 09.58.020, 09.58.030, 09.58.040, 09.58.050, and 09.58.060 are repealed July 1, 2019.

* Sec. 52. AS 08.36.070(a)(10); AS 08.64.101(7); AS 08.68.100(a)(11); AS 08.72.060(c)(3); AS 08.80.030(b)(13); AS 17.30.200(o), 17.30.200(p), 17.30.200(q), 17.30.200(r), and 17.30.200(s) are repealed July 1, 2021.

* Sec. 53. AS 47.07.076(c) is repealed.

* Sec. 54. The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT COURT RULE AMENDMENTS. (a) AS 09.58.010, added by sec. 18 of this Act, has the effect of amending Rules 79 and 82, Alaska Rules of Civil Procedure, by providing that the state is entitled to full reasonable attorney fees and costs if the state prevails in a civil action under AS 09.58.010 - 09.58.060 that involves fraud, or reasonable attorney fees and costs if the state prevails in a civil action under AS 09.58.010 - 09.58.060 that does not involve fraud.

(b) AS 09.58.020, added by sec. 18 of this Act, and repealed by sec. 51 of this Act, has the effect of amending the following court rules in the manner specified from the effective date of sec. 18 of this Act until July 1, 2019:

(1) Rules 4, 5, 7, and 12, Alaska Rules of Civil Procedure, by requiring that a complaint under AS 09.58 be filed in camera and under seal and may not be served on the defendant until unsealed and that a copy of the complaint be served on the attorney general;

(2) Rules 41 and 77, Alaska Rules of Civil Procedure, by authorizing the attorney general to move for dismissal of a complaint filed by another person under AS 09.58.020, added by sec. 18 of this Act and repealed by sec. 51 of this Act, and requiring
CMS ISSUES FINAL OVERPAYMENT REFUND RULE

Executive Summary

On February 11, 2016, the Centers for Medicare & Medicaid Services ("CMS") issued its long-awaited Final Rule ("Final Rule") implementing the overpayment reporting and repayment provisions of the Patient Protection and Affordable Care Act ("PPACA"). The Final Rule clarifies certain provisions set out in the February 14, 2012 Proposed Rule ("Proposed Rule"), modifies certain provisions that were controversial for providers and suppliers and provides additional information regarding the intersection between the overpayment obligations and existing CMS and Office of Inspector General ("OIG") self-disclosure protocols.

As was true for the Proposed Rule, the Final Rule will apply only to Medicare Part A and Part B providers and suppliers. The Final Rule discusses additional guidance for other stakeholders, including Medicare Part C, Part D and Medicaid managed care organizations. The Final Rule becomes effective on March 14, 2016. A copy of the Final Rule is available here.

PPACA

Section 6402 of PPACA outlined the requirement that health care entities report and return overpayments to the Secretary, the State, an intermediary, a carrier or a contractor as appropriate. The entity must report and return the overpayment within 60 days "after the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable." Failure to meet the deadline for returning an overpayment exposes the entity to civil monetary penalties under the Federal False Claims Act ("FCA").

The PPACA language above caused significant concern and confusion in the health care industry as providers and suppliers scrambled to interpret when the repayment obligations would apply and the timeline for returning overpayments.

Final Rule

The Final Rule provides valuable guidance in areas that were previously unclear, including:

- When does the 60 days start; that is, when is an overpayment considered "identified"?
- How far back in time must a provider or supplier look in quantifying the overpayment amount; that is, how long is the "lookback" period?
- Is there a time limit to identify the overpayment amount?
- How does this repayment obligation work with other repayment protocols (for example, the OIG Self Disclosure Protocol ("SDP") and the CMS Self-Referral Disclosure Protocol ("SRDP")?)
- Does the Final Rule affect previously reported overpayments?

When does the 60 days start?

The Proposed Rule acknowledged that some "reasonable inquiry" might be required to determine whether an overpayment exists; however, little guidance was provided regarding exactly when an overpayment is "identified." The Final Rule addresses this issue directly, stating that "identified" means a person has, or should have: (i) determined that an overpayment was received; and (ii) quantified the amount of the overpayment. Notably, a person "should have" determined that the person received an overpayment if that person fails to exercise "reasonable diligence" and did, in fact, receive an overpayment. "Reasonable diligence" includes both proactive measures, such as compliance audits, and retroactive measures, such as an investigation conducted when a potential overpayment is identified.

Practically speaking, this means that if an entity learns that an overpayment may have occurred, that entity must return the overpayment either:

1. Not more than 60 days after the amount of the overpayment is determined if the entity acted with reasonable diligence as defined above (that is, timely investigated and quantified the amount of the overpayment); or
2. Not more than 60 days after the entity learned that an overpayment may have occurred if the entity did not act with reasonable diligence.

How long is the "lookback" period?

The Proposed Rule would have established a 10-year lookback period, the maximum permissible under the FCA. This period was the subject of intense commentary, and in response, CMS shortened the lookback period. According to the Final Rule, overpayments must be reported...
and returned if an entity identifies the overpayment within six years of the date the overpayment was received.

This six-year limit does not apply, however, if there is evidence of fraud or similar fault attendant to the overpayment. In that case, the lookback period can extend as far as necessary to determine the extent of the fraud or other wrongful activity. This provision could become important if, for example, an entity learns of a possible overpayment and does not act to investigate. In such circumstances, a regulator could allege that the entity fraudulently retained the overpayment and could look back as far as it wished to determine if that allegation was true.

One potential point of confusion is that CMS indicates in the commentary that the lookback period extends back six years from the date the overpayment is identified. This creates ambiguity because providers may not know in advance the time period necessary to quantify the overpayment.

**Is there a time limit to identify the overpayment amount?**

The Final Rule includes discussion of the work that is required to quantify an overpayment amount, and the variations in the time required to do so, depending on the facts and circumstances of each case. For example, if an overpayment results from inappropriately adding a particular modifier to a particular CPT code, quantifying the amount of the overpayment might require only running a billing system query for that code and modifier, and subtracting the amount that should have been received from the amount that was received. However, if an overpayment results from a more complex situation, for example, a relationship that violates the physician self-referral statute, its investigation could involve contract reviews, identification of referral patterns involving multiple patients and procedures and other time-consuming tasks.

CMS acknowledges these variations and states that a reasonable timeframe for investigation is six months from the date a possible overpayment is flagged, barring “extraordinary circumstances.” Practically applied, this means that an entity has eight months to report and return the overpayment: six months for the investigation to quantify the overpayment amount and two months following that investigation to return the overpayment. In discussing “extraordinary circumstances,” CMS refers to “unusually complex investigations...such as physician self-referral violations[,]...natural disasters or a state of emergency.” Even under extraordinary circumstances, however, an entity must act with reasonable diligence as discussed above.

**How does this repayment obligation work with other repayment protocols?**

As was the case in the Proposed Rule, CMS acknowledges the intersection of this repayment obligation and that imposed by other regulations, including the SDP and the SRDP. CMS notes that providers and suppliers submitting disclosures under those protocols must use the reporting processes described in each protocol. For purposes of the 60-day repayment obligation, however, the Final Rule tolls - or stops the clock on - the 60-day reporting and repayment period for any entity that has submitted a disclosure under either the SDP or the SRDP. With respect to the SRDP, the clock remains stopped for the full duration of time that the entity is negotiating a potential settlement with CMS under the SRDP. Once negotiations have concluded, the clock starts and the entity must comply with the 60-day requirement to return any overpayment.

**Does the Final Rule affect previously reported overpayments?**

The Final Rule is not retroactive. Entities that reported or returned overpayments prior to the Final Rule’s effective date are not expected to have complied with the Final Rule. Additionally, entities that entered the SRDP prior to the Final Rule’s effective date are not subject to the six-year lookback period but remain subject to the SRDP’s prior four-year lookback period. Following the effective date of the Final Rule, however, all providers and suppliers reporting and returning overpayments on or after the effective date must comply with the Final Rule’s requirements.

**Conclusion**

The Final Rule brings welcome clarity to several issues that have burdened providers and suppliers since enactment of PPACA. It is obvious that CMS recognized many of the concerns raised in comments to the Proposed Rule. The above issues are the major refinements to come out of the Final Rule but not the only changes. Accordingly, we encourage providers and suppliers to consult with counsel when addressing a potential overpayment issue. If you would like to discuss the Final Rule or other matters around overpayments, please contact:

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GREATER FALSE CLAIMS ACT PENALTIES LOOMING

On May 2, 2016, the U.S. Railroad Retirement Board ("RRB") issued an Interim Final Rule ("Interim Final Rule") significantly increasing its civil monetary penalties under the False Claims Act ("FCA") and the Program Fraud Civil Remedies Act ("PFCRA"). Specifically, the RRB implemented minimum and maximum penalties of $10,781 and $21,563 per claim, respectively, to be effective August 1, 2016. These increases were part of the RRB’s efforts to "correct" penalties under the FCA and PFCRA as required by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the "Act"). A copy of the interim Final Rule is available here.

The RRB’s changes directly impact only claims submitted to the RRB, including but not limited to, Railroad Medicare claims. However, the RRB’s increased penalty amounts are significantly higher than expected and are sending shockwaves through the health care provider community as other federal agencies are required under the Act to implement "corrected" penalty amounts no later than August 1, 2016.

Background

The FCA was rewritten in 1986 to include a minimum penalty of $5,000 per claim and a maximum penalty of $10,000 per claim. Pursuant to the Debt Collection Improvement Act of 1996, these minimum and maximum penalties were increased in 1996 to $5,500 and $11,000, respectively. However, FCA penalties have remained unchanged since that time.

The Act went into effect in November 2015 and requires that FCA and PFCRA penalties be "corrected" to adjust for inflation since their last adjustment and that the penalties be adjusted for inflation each following year. All corrections must go into effect by August 1, 2016.

Significance of the Interim Final Rule

The health care provider community expected that "corrections" to FCA and PFCRA penalties would be calculated from 1996, when the penalties were last updated. This would have resulted in an increase of approximately 140%, with a maximum penalty of about $15,000. The RRB in the Interim Final Rule, however, disregarded the 1996 changes since those increases were subject to a 10% cap. Instead, the RRB calculated its corrections based on the 1986 penalty amounts, which resulted in penalty increases of 216%.

The RRB’s approach taken in the Interim Final Rule is significant because the RRB is the first agency to "correct" its FCA and PFCRA penalties. This sets a precedent for other federal agencies that are also required under the Act to implement corrections prior to August 1, 2016. It is possible, if not probable, that other federal agencies will follow the RRB’s lead and increase FCA penalties based on the 1986 penalty amounts in order to ensure consistency under the FCA. States may also take steps to increase state penalties consistent with these FCA penalty changes since the receipt of Medicaid money is contingent upon states significantly mirroring the federal FCA.

Practical Takeaway

Based on the Interim Final Rule, we now anticipate that health care-related FCA civil penalties, while already significant, may soon become even more weighty under the Act. And even though these penalties may not be applied in every FCA settlement, they will certainly raise the stakes even further for those providers considering the risks associated with litigating FCA matters.

This raises the importance of providers maintaining effective compliance programs to try to preclude situations in which the government may seek to invoke these new FCA penalties. Providers should ensure that their compliance programs have all the effectiveness elements in place based on prior guidance from the Office of Inspector General, including the maintenance of proactive auditing and monitoring functions. Self-reporting can also be an effective strategy when potential FCA risks are identified internally. Proper self-reporting and/or refunding identified overpayments and other compliance risks before they can escalate further should be considered a hallmark of any effective compliance program. This compliance program benefit becomes even more important now as the FCA stakes continue to rise.

If you have any questions, or if you would like additional information about this topic, please contact:

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