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Sixty-fifth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1226

Introduced by

Representatives Hogan, P. Anderson, K. Koppelman, Mitskog, Olson, Schneider

Senators Grabinger, Nelson, Sorvaag

A BILL for an Act to create and enact four new sections to chapter 54-12 of the North Dakota Century Code, relating to the creation of a medicaid fraud control unit in the attorney general's office.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Four new sections to chapter 54 of the North Dakota Century Code are created and enacted as follows:

Definitions.

As used in this Act, unless the context otherwise requires:

1. "Abuse" means conduct by an applicant, recipient, provider, or other person involving disregard of and an unreasonable failure to conform with the laws and rules governing the medicaid program if the disregard or failure results or may result in an incorrect determination that an individual is eligible for medical assistance or payment by a medicaid agency of medical assistance payments to which the provider is not entitled.
2. "Applicant" means an individual:
   a. Who submitted an application for determination of medicaid eligibility to a medicaid agency on the individual's own behalf or on behalf of another individual; or
   b. On whose behalf an application has been submitted.
3. "Benefit" means the provision of anything of pecuniary value to or on behalf of a recipient under the medicaid program.
4. "Claim" means a communication, whether in oral, written, electronic, magnetic, or other form, which is used to claim specific services or items as payable or reimbursable under the medicaid program or that states income, expense, or other information that is or may be used to determine entitlement to or the rate of payment

under the medicaid program. The term includes any documents submitted as part of or in support of the claim.

5. "Department" means the department of human services.

6. "Document" means an application, claim, form, report, record, writing, or correspondence, whether in written, electronic, magnetic, or other form.

7. "Fraud" means any conduct or activity prohibited by law or rule involving knowing conduct or omission to perform a duty that results in or may result in medicaid payments or benefits to which the applicant, recipient, or provider is not entitled.

8. "Medicaid" means the medical assistance program established under chapter 50-24.1.

9. "Medicaid agency" means any agency or entity of state, county, or local government which administers any part of the medicaid program, whether under direct statutory authority or under contract with an authorized agency of the state or federal government. The term includes the department, the department of corrections and rehabilitation, local offices of public assistance, and other local and state agencies and those agencies' agents, contractors, and employees, if acting with respect to medicaid eligibility, claims processing or payment, utilization review, case management, provider certification, investigation, or other administration of the medicaid program.

10. "Misappropriation of patient property" means exploitation, deliberate misplacement, or wrongful use or taking of a patient's property, whether temporary or permanent, without authorization by the patient or the patient's designated representative. The term includes conduct with respect to a patient's property which would constitute a criminal offense under chapter 12.1-23.

11. "Patient abuse" means the willful infliction of physical or mental injury of a patient or unreasonable confinement, intimidation, or punishment that results in pain, physical or mental harm, or mental anguish of a patient. The term includes conduct with respect to a patient which would constitute a criminal offense under chapter 12.1-16, 12.1-17, 12.1-18, 12.1-20, or 12.1-22.

12. "Patient neglect" means a failure, through inattentiveness, carelessness, or other omission, to provide to a patient goods and services necessary to avoid physical harm, mental anguish, or mental illness if an omission is not caused by factors beyond the person's control or by good-faith errors in judgment. The term includes conduct

with respect to a patient which would constitute a criminal offense under section 12.1-17-03.

13. "Provider" means a person that enrolled or applied to enroll as a provider of services or items under medicaid.

14. "Recipient" means an individual:

a. Who has been determined by a medicaid agency to be eligible for medicaid benefits, regardless of whether the individual has received any benefits; or

b. Who receives medicaid benefits, regardless of whether determined eligible.

15. "Record" means medical, professional, business, or financial information and documents, whether in written, electronic, magnetic, microfilm, or other form:

a. Pertaining to the provision of treatment, care, services, or items to a recipient;

b. Pertaining to the income and expenses of the provider; or

c. Otherwise relating to or pertaining to a determination of eligibility for or entitlement to payment or reimbursement under the medicaid program.

Medicaid fraud control unit.

The medicaid fraud control unit is established as a division of the attorney general's office. The medicaid fraud control unit, which is under the supervision and control of the attorney general, consists of the agents and employees the attorney general considers necessary and appropriate, including individuals qualified by education, training, experience, and high professional competence in criminal and civil investigative procedures and high professional competence to prosecute crimes. The medicaid fraud control unit is a criminal justice agency within the meaning of section 12-60-16.1. Agents designated by the attorney general have peace officer status and authority, including the authority of search, seizure, and arrest.

Powers and duties of medicaid fraud control unit.

1. The medicaid fraud control unit shall:

a. Investigate and prosecute under applicable criminal laws fraud and abuse by applicants, recipients, providers, or any other person, including cases referred by the department;

b. Review a complaint of patient abuse, patient neglect, and misappropriation of patient property and, if appropriate, investigate and initiate criminal proceedings or refer the complaint to another federal, state, or local agency for action;

c. Refer to the department for collection and, if appropriate, consideration and imposition of appropriate recipient restrictions or provider sanctions cases involving recipient or provider overpayments, fraud, abuse, inappropriate use of services, or other improper activities discovered by the unit in carrying out the unit's activities;

d. Communicate and cooperate with and, subject to applicable confidentiality laws, provide information to other federal, state, and local agencies involved in the investigation and prosecution of health care fraud, abuse, and other improper activities related to the medicaid program;

e. Transmit to other state and federal agencies, in accordance with law reports of convictions, copies of judgments and sentences imposed and other information and documents for purposes of program exclusions or other sanctions or penalties under medicaid, medicare, or other state or federal benefit or assistance programs; and

f. Recommend to state agencies appropriate or necessary adoption or revision of laws, rules, policies, and procedures to prevent fraud, abuse, and other improper activities under the medicaid program and to aid in the investigation and prosecution of fraud, abuse, and other improper activities under the medicaid program.

2. The medicaid fraud control unit may:

a. Initiate criminal prosecutions pursuant to subsection 1 in any court of competent jurisdiction in the state;

b. Upon written request, obtain information and records from applicants, recipients, and providers;

c. Subject to applicable federal confidentiality laws and rules and for purposes related to any investigation or prosecution under subsection 1, obtain from the department, local offices of public assistance, and other local, county, or state government departments or agencies records and other information, including applicant and recipient applications, provider enrollment forms, claims and reports, individual or entity tax returns, or other information provided to or in the possession of the tax commissioner or the state auditor;

d. Refer appropriate cases to other federal, state, or local agencies for investigation, prosecution, or imposition of penalties, restrictions, or sanctions; and

e. Enter agreements with the department and other federal, state, and local agencies in furtherance of the unit's mission.

Cooperation of governmental agencies with medicaid fraud control unit.

All local, county, and state departments and agencies shall cooperate with the medicaid fraud control unit and the unit's agents and employees to effectuate the purposes of the unit.