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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 637

Session of 2011

INTRODUCED BY DAVIS, DeLUCA, BARRAR, CARROLL, D. COSTA, FABRIZIO, HORNAMAN, JOSEPHS, W. KELLER, KOTIK, MANN, MATZIE, MUNDY, M. O'BRIEN, PASHINSKI, SANTARSIERO, M. SMITH AND STURLA, FEBRUARY 14, 2011

REFERRED TO COMMITTEE ON JUDICIARY, FEBRUARY 14, 2011

AN ACT

1 Amending Title 18 (Crimes and Offenses) of the Pennsylvania
2 Consolidated Statutes, providing for health care program
3 fraud.

4 The General Assembly of the Commonwealth of Pennsylvania
5 hereby enacts as follows:

6 Section 1. Title 18 of the Pennsylvania Consolidated
7 Statutes is amended by adding a section to read:

8 § 7332. Health care program fraud.

9 (a) Prohibitions.--A person shall not:

10 (1) Knowingly make, cause to be made or aid and abet in
11 the making of a false statement or false representation of a
12 material fact, by commission or omission, in a claim
13 submitted to the agency or its fiscal agent or a managed care
14 plan for payment.

15 (2) Knowingly make, cause to be made or aid and abet in
16 the making of a claim for items or services that are not
17 authorized to be reimbursed by the Medicaid or other health

care program.

(3) Knowingly charge, solicit, accept or receive anything of value, other than an authorized copayment from a Medicaid or other health care program recipient, from a source in addition to the amount payable for an item or service provided to a Medicaid or other health care program recipient under the Medicaid or other health care program or knowingly fail to credit the agency or its fiscal agent for a payment received from a third-party source.

(4) Knowingly make or cause to be made a false statement or false representation of a material fact, by commission or omission, in a document containing items of income and expense that is or may be used by the agency to determine a general or specific rate of payment for an item or service provided by a provider.

(5) Knowingly solicit, offer, pay or receive remuneration, including a kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of an item or service for which payment may be made, in whole or in part, under the Medicaid or other health care program, or in return for obtaining, purchasing, leasing, ordering or arranging for or recommending, obtaining, purchasing, leasing or ordering a good, facility, item or service, for which payment may be made, in whole or in part, under the Medicaid or other health care program.

(6) Knowingly submit false or misleading information or statements to the Medicaid or other health care program for the purpose of being accepted as a Medicaid or health care

provider.

(7) Knowingly use or attempt to use a Medicaid or health care provider's identification number or a Medicaid or recipient's identification number to make, cause to be made or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid or other health care program.

(b) Penalties.--A person who violates this subsection and receives or attempts to receive something with a value of:

(1) $10,000 or less commits a felony of the third degree.

(2) More than $10,000, but less than $50,000, commits a felony of the second degree.

(3) $50,000 or more commits a felony of the first degree.

(c) Aggregation.--The value of separate funds, goods or services that a person received or attempted to receive under a scheme or course of conduct may be aggregated in determining the degree of the offense.

(d) Fine.--In addition to the sentence authorized by law, a person who is convicted of a violation of this section shall pay a fine in an amount equal to five times the pecuniary gain unlawfully received or the loss incurred by the Medicaid or other health care program or managed care organization, whichever is greater.

(e) Effect of repayment.--The repayment of Medicaid or health care program payments wrongfully obtained, or the offer or endeavor to repay Medicaid or health care program funds wrongfully obtained, does not constitute a defense to, or a ground for dismissal of, criminal charges brought under this

1 section.

2 (f) Records.--Records in the custody of the agency or its
3 fiscal agent which relate to Medicaid or health care program
4 provider fraud are business records within the meaning of 42
5 Pa.C.S. § 6108 (relating to business records).

6 (g) Claims with false statements.--Proof that a claim was
7 submitted to the agency or its fiscal agent which contained a
8 false statement or a false representation of a material fact, by
9 commission or omission, unless satisfactorily explained, gives
10 rise to an inference that the person whose signature appears as
11 the provider's authorizing signature on the claim form, or whose
12 signature appears on an agency's electronic claim submission
13 agreement submitted for claims made to the fiscal agent by
14 electronic means, had knowledge of the false statement or false
15 representation. This subsection applies whether the signature
16 appears on the claim form or the electronic claim submission
17 agreement by means of handwriting, typewriting, facsimile
18 signature stamp, computer impulse, initials or otherwise.

19 (h) Other claims with false statements.--Proof of submission
20 to the agency or its fiscal agent of a document containing items
21 of income and expense, which document is used or that may be
22 used by the agency or its fiscal agent to determine a general or
23 specific rate of payment and which document contains a false
24 statement or a false representation of a material fact, by
25 commission or omission, unless satisfactorily explained, gives
26 rise to the inference that the person who signed the
27 certification of the document had knowledge of the false
28 statement or representation. This subsection applies whether the
29 signature appears on the document by means of handwriting,
30 typewriting, facsimile signature stamp, electronic transmission,

initials or otherwise.

(i) Immunity.--A person who provides the Commonwealth, a Commonwealth agency, a political subdivision or an agency of a political subdivision with information about fraud or suspected fraud by a Medicaid or health care program provider, including a managed care organization, is immune from civil liability for providing the information unless the person acted fraudulently or in bad faith.

(j) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Adult basic program." The program created under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act.

"Agency." An executive agency of the Commonwealth that administers, manages or finances a health care services program on behalf of the residents of this Commonwealth.

"Children's Health Insurance Program." The children's health care program established under Article XXIII of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Fiscal agent." An individual, firm, corporation, partnership, organization or other legal entity that has contracted with the agency to receive, process and adjudicate claims under the Medicaid or other agency program.

"Health care program." A health care program administered, managed or financed through an executive agency of the Commonwealth, including the Medicaid program, the Children's Health Insurance Program and the adultBasic Program.

"Item or service." Includes:

(1) a particular item, device, medical supply or service claimed to have been provided to a recipient and listed in an itemized claim for payment; or

(2) in the case of a claim based on costs, an entry in the cost report, books of account or other documents supporting the claim.

"Knowingly." Describes an act done voluntarily and intentionally and not because of mistake or accident. The term includes the term "willful" or "willfully" which means that an act was committed voluntarily and purposely, with the specific intent to do something that the law forbids, and that the act was committed with bad purpose, either to disobey or disregard the law.

"Managed care plan." A company or health insurance entity licensed under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, to issue an individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under this section or the following:

(1) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(2) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(4) Article XXIV of The Insurance Company Law of 1921.

1 "Medicaid" or "Medical assistance." The program of medical
2 assistance established under the act of June 13, 1967 (P.L.31,
3 No.21), known as the Public Welfare Code.
4 Section 2. This act shall take effect in 60 days.