F I S C A L I M P A C T R E P O R T

SPONSOR Papen **ORIGINAL DATE** 1/19/19 **LAST UPDATED** 2/13/19 **HB**

SHORT TITLE Medicaid Services, Fraud & Due Process **SB** 41/aSFC

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$57.0-$300.	$57.0-$300.0	$171.0-$900.0	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Administrative Hearings Office (AHO)
Administrative Office of the Courts (AOC)
New Mexico Attorney General (NMAG)
Human Services Department (HSD)
LFC Files (LFC)

SUMMARY

Synopsis of SFC Amendments

The Senate Finance Committee amendments to Senate Bill 41 specify strikes the requirement that a hearing officer for expedited adjudicatory proceedings have at least five years of experience in commercial litigation. The amendments further specify the hearing officer cannot be related to a person employed by the Human Services Department (HSD), related to a person doing business with HSD, or related to a person employed by an organization that does business with HSD; and the hearing officer cannot be a lobbyist, affiliated with a lobbyist, or have a spouse that is a lobbyist. Additionally, the SFC amendments adjust the dates for award of costs, fees and interest, and add a severability section.

Synopsis of Bill

Senate Bill 41 (SB41) would modify the Medicaid Provider Act regarding the methods by which the Human Services Department (HSD) may proceed against providers who have allegedly committed fraud or from whom the department seeks recoupment of Medicaid overpayments.

Below is a detailed synopsis by section:

Section 1 changes the title of the Act to the "Medicaid Provider and Managed Care Act."
Section 2 adds definitions for the terms "claim," "clean claim," "credible allegation of fraud," "fraud," and "overpayment." The definition for credible allegation of fraud differs from the federal definition found in 42 CFR §455.2.
Section 3 addresses contract remedies and penalties. The bill modifies the section by adding "managed care organization" as a Medicaid provider.
Section 4 addresses retention and production of records. The bill modifies the section by adding "managed care organizations" as a Medicaid providers.
Section 5 creates a new section of the Act. This new section codifies a process for determination and recoupment of overpayments, which would replace the process currently contained in NMAC § 8.351.2.13. Key elements of the section require state licensing and certification requirements for persons auditing provider claims; specify that findings cannot be extrapolated; create a right of the provider to an informal conference with the Human Services Department (HSD); and permits HSD to impose a corrective action plan on a provider prior to a final determination of overpayment.
Section 6 is new and establishes timelines and parameters for an informal conference. The provider may request a conference within 30 days of receiving the tentative notice of overpayment. Once a request is received, HSD has 14 days to schedule the conference. After the conference, the provider has 30 days to provide additional information.
Section 7 is new and establishes timelines and processes for an expedited adjudicatory proceeding, and would use hearing officers at the Administrative Hearings Office (AHO) separate from HSD's existing Fair Hearings Bureau. The provider may request a hearing within 30 days of receiving the tentative notice of overpayment, at which point the chief hearing officer at the AHO has 30 days to appoint a presiding hearing officer. The hearing must occur within 30 days of the appointment of the hearing officer and cannot last more than 10 business days. The hearing officer's findings and conclusions are due within 30 days of the close of the record, are binding on HSD, but may be appealed under NMSA 39-3-1.1.
Section 8 is new and creates qualifications for hearing officers conducting expedited adjudicatory proceedings. They must be licensed attorney with at least three years' experience in health insurance or a healthcare related field, at least five years' experience in commercial litigation, not be currently employed by or representing an MCO or third party administrator, and not be related to anyone employed by an executive agency of the state, or doing business with the state.
Section 9 is new and assesses costs for an expedited adjudicatory proceeding between the parties.
Section 10 is new and creates processes for a provider to challenge a tentative or final determination of overpayment by conducting an independent audit or challenging HSD's findings or the credentials of the persons who participated in HSD's audit or claims review.
Section 11 is new and provides for release of payments suspended during an investigation of credible allegations of fraud, where a provider posts a bond in the amount of the suspended payment. It also permits HSD to conduct prepayment claims review or requiring providers to take certain remedial measures, including remedial training and temporarily engaging a third party to manage the provider's organization.
Section 12 is new and prohibits HSD from terminating a provider who is subject to investigation for credible allegations of fraud, or recoupment of overpayment, and who has taken remedial measures imposed by HSD, as outlined in Section 11. It also imposes a duty on HSD to process and pay clean claims within 10 days, if submitted electronically, and within 30 days, if submitted

on paper.
Section 13 is new and provides that any funds recouped from a provider due to an overpayment shall be returned to the general fund to be used for the Medicaid program, unless otherwise provided in state or federal law.
Section 14 is new and provides that a determination of a credible allegation of fraud constitutes a final agency decision and is appealable under NMSA 39-3-1.1. The provision also places the burden on HSD in a judicial review to prove by substantial evidence that (a) it did not abuse its discretion and (b) that the evidence supporting its determination was relevant, credible and material.
Section 15 is new and provides for the recovery of costs and attorney fees by the provider in cases where the provider "substantially prevails," up to $100 thousand. It also provides for recovery of interest by the prevailing provider of 1.5 percent per month on suspended claims.
Section 16 is new and makes the expedited hearing process subject to the Administrative Procedures Act, NMSA 12-8-2 *et seq.*
Section 17 is new and provides for hearing officers to be assigned to expedited proceedings by the "chief hearing officer" of the Administrative Hearings Office.
Section 18 is a temporary provision to update all references in law within the Medicaid Provider Act to reference the Medicaid Provider and Managed Care Act.
Section 19 sets an effective date of January 1, 2020.

FISCAL IMPLICATIONS

The Administrative Hearings Office (AHO) indicates although the bill indicates HSD is to reimburse the costs of the contracted hearing officer, AHO is concerned the funds would not be included in its operating budget and could delay contracting for these services. AHO estimates it would need an additional financial support position to comply with the bill at an estimated cost of $57 thousand.

The Human Services Department (HSD) reports:

1) The bill requires a different level of expertise for hearing officers and requires that they be separate and distinct from the administrative law judges in HSD's Fair Hearings Bureau. Based on the rate for which HSD is currently able to recruit and hire experienced attorneys, the additional cost for each attorney will be approximately $100.0 per attorney and scalable dependent on the number of attorneys required to address each case. Also, the bill does not include an appropriation for the new Hearing Office or staff.
2) To the extent the requirements in this bill are not in alignment with federal law, HSD risks loss of federal funds.
3) SB41 as currently written allows for recoveries by providers not afforded to HSD (see Section 15)
4) Section 13 requires that recoupments be returned to the general fund to be used for the Medicaid program. Any recoupment obtained by HSD would be proportionally returned to the federal government and to the general fund based on the match rate in the original claim. Once the portion is returned to the general fund, it would remain there as there is currently no vehicle in statute to re-appropriate that reverted amount directly back to the Medicaid program.

SIGNIFICANT ISSUES

The Attorney General's Office notes the administrative process outlined in SB41 may affect the Attorney General's Medicaid Fraud Control Unit's (MCFU) ability to effectively prosecute cases.

Section 4 requires both Medicaid providers and Medicaid managed care organizations to retain records for six years and produce them at the department's request. Failure to comply is a violation of Section 3. Thus, the previous provision should also include Medicaid providers, to avoid any potential inconsistency.

The Attorney General's Office writes SB41 provides for an administrative process whereby HSD must make a tentative finding of overpayment, including a credible allegation of fraud, and notify the provider of that finding. While an administrative process is contemplated in the federal regulations governing credible allegations of fraud, it is contemplated after the finding is made, and the state has complied with the federal process. 42 CFR § 455.23 requires that the Department "must" suspend all payments and "must" make a referral to the Medicaid Fraud Control Unit (MFCU) when the Department has made a determination of credible allegation of fraud. SB41 requires that the Department allow for the administrative process prior to making a final determination of credible allegation of fraud, including notifying the provider and allowing the provider the right to respond. Thus, the administrative process must be harmonized with federal regulation to avoid any conflicts.

Additionally, SB41 would allow for the administrative process to proceed simultaneously with any potential criminal investigation or process, which may result in inconsistent outcomes. However, should the full administrative process be allowed to run its course prior to referral to the MFCU for credible allegation of fraud, the delay may make HSD referrals more challenging for the MFCU to investigate and prosecute.

SB41 would allow for a provider to continue to receive Medicaid payments during the pendency of an investigation, and even after a provider has been referred to a MFCU based on a finding of credible allegation of fraud. Federal regulations describes the circumstances under which a state may find "good cause", see 42 CFR § 455.23 (e) and (f). SB41 Section 12 should be amended to include what constitutes "good cause" to ensure it is consistent and does not conflict with federal law.

SB41 also makes the posting of a surety bond a per se good faith exception to a suspension of payments in the context of a finding of credible allegation of fraud. The good faith exceptions are enumerated in federal regulation, and do not include the posting of a surety bond

The Administrative Hearings Office (AHO) notes:

1) Under Section 8 of the bill, the minimal qualifications standards for the hearing officer are so high that the pool of potential people interested and qualified as candidates to serve as a hearing officer would likely be extremely limited. No current hearing officer at AHO has significant knowledge or experience in the healthcare industry, preventing any of them from being designated as the hearing officer in these disputes. Even if AHO had a qualified on staff hearing officer, the prohibition from an executive branch employee to serve as a hearing officer would prevent an AHO hearing officer from adjudicating these cases under Section 8 (A)(5). Unless the language of that provision were changed to

allow an employee of AHO to serve as a hearing officer if the person otherwise meets the minimum qualifications, the hearing officer would have to be a contract hearing officer. A contract hearing officer for that potential volume of work is far more expensive than an on-staff hearing officer. Related to this concern is that the pool of potential hearing officers that are both interested in the work and meet the qualification might be so small that there is not sufficient manpower to meet the statutory deadlines in the bill.

2) The complexity of the litigation surely involving medical expert testimony and litigation attorneys, as well as the possibility of parallel proceedings such as an informal conference and criminal actions, in such a highly specialized and complex area of the law, may be insufficient to ensure that all parties have a full and fair opportunity to be heard by the deadlines imposed by the bill. Discovery, depositions of expert witnesses, and motions practice alone in complex litigation will require more time than allotted under the bill, potentially disadvantaging all parties in the proceeding including the Medicaid provider and HSD.

ADMINISTRATIVE IMPLICATIONS

The Administrative Hearing's Office (AHO) indicates its budget would need to be changed to expressly allow collection of revenue from HSD for payment of the hearing services, and likely require a creation of a non-reverting fund so AHO can maintain employed or contracted hearing officers available at all times given the compressed hearing schedule in the bill and the natural fluctuations in the docket volume that might not coincide with the end and start of a new fiscal year.

The Human Services Department (HSD) indicates the bill calls for the creation of a new administrative hearings body, separate from HSD's Fair Hearings Bureau, and would apply a new set of occupational requirements for HSD's current administrative law judges, and the bill does provide funding for these new requirements.

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TECHNICAL ISSUES

The Attorney General's Office suggests the following amendments be considered to align with the provisions found in 42 CFR § 455.23 (e) and (f) for determining good cause not to suspend payments:

(e) Good cause not to suspend payments. The department may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
(2) Other available remedies implemented by the department more effectively or quickly protect Medicaid funds.
(3) The department determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
(4) Beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:
(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(ii) The individual or entity serves a large number of beneficiaries within a HRSA–designated medically underserved area.
(5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.
(6) The Department determines that payment suspension is not in the best interests of the Medicaid program.
(f) Good cause to suspend payment only in part. The department may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
(1) Beneficiary access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:
(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
(ii) The individual or entity serves a large number of beneficiaries within a HRSA–designated medically underserved area.
(2) The department determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
(3)(i) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
(ii) The department determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
(4) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.
(5) The department determines that payment suspension only in part is in the best interests of the Medicaid program.

The Administrative Hearings Office (AHO) notes the bill's provisions requiring the expedited adjudicatory proceeding to occur pursuant to the Administrative Procedures Act are potentially in conflict with provisions of the Administrative Hearings Office Act, which expressly state that the rules of evidence and procedure do not apply to hearings before AHO.

Also, if AHO is to conduct the hearing types provided for in the bill, it reports it needs to be given subpoena authority to compel production of relevant materials and attendance at the hearing. With subpoena authority, the bill also needs to provide an enforcement mechanism to the parties in the event of non-compliance, such as the ability to stay the proceeding as a party seeks enforcement of the subpoena in the district court.

AHO notes under Section 9(B), there is a reference that the hearing officer shall allow a witness to appear telephonically upon request. AHO suggests adding video teleconference testimony.

HSD notes in Section 15 the definition of "substantially prevails" is not clear, and the provision does not provide a corresponding right of recovery for HSD.

OTHER SUBSTANTIVE ISSUES

The Human Services Department (HSD) reports the following:

Although a state is not required to participate in the Medicaid program, once it chooses to do so it must develop a state plan that complies with the Medicaid Act and regulations promulgated by the federal government. As a participant in the Medicaid program, all states are required by federal regulations to establish program integrity requirements. Failure by the state to properly safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments consistent with federal law and regulation could potentially jeopardize federal matching funds. This bill proposes a number of significant changes in the way the Human Services Department oversees managed care organizations and contracted healthcare providers, particularly with respect to the processes for determining credible allegations of fraud and the identification and recoupment of overpayments.

Section 2(D) proposes a definition of "credible allegation of fraud" that is inconsistent with the definition contained in 42 CFR 455.2 by eliminating civil false claims and law enforcement investigations as means of verification. 42 CFR 455.2 is used by both HSD and the Attorney General's Office in determining whether an allegation warrants further investigation.
Sections 5 and 6 describe an informal conference process that a provider may request upon receipt of a preliminary finding of overpayment. HSD would be required to provide a representative knowledgeable about the overpayment claim and a member of the audit team, if any, to such a conference. Section 5.A. would require audits to be conducted by a person approved by the state auditor, and that audited claims of providers and subcontractors are to be reviewed by "a person who is licensed, certified, registered, or otherwise credentialed in New Mexico," as to the areas under review. Section 5.B. would limit extrapolation of audit results to circumstances where the provider's or subcontractor's error rate exceeds 10%, which is double the rate considered valid by the federal Department of HHS.

42 C.F.R. 455.14 provides that *"If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.*" While an administrative process is contemplated by the federal regulations (*See* ex. 42 CFR 455.13), the hearing is contemplated after a finding is made and the state has completed their investigation. This is so that any administrative hearing does not interfere with a criminal investigation. The new administrative processes in Section 5 and 6 of the bill require HSD to make a "preliminary" finding and notify the provider right away even in situations where the suspected overpayment is based in whole or in part on a credible allegation of fraud.

42 CFR §455.23 requires that HSD "must" suspend all payments and "must" make a referral to the Attorney General's Office when HSD has made a determination of a credible allegation of fraud. Requiring HSD to provide an entire administrative process on any preliminary finding, including notifying the provider and allowing them to respond, appears to conflict with federal regulation and would generally make any subsequent prosecution of any fraud referrals from HSD very challenging.

42 CFR §456.3 (a) and (b) require the state Medicaid agency to implement procedures to safeguard against provider overpayments. Sections 5 and 6 of this bill, however, limits the pool of persons able to review claims to individuals who are "licensed, certified, registered, or otherwise credentialed in New Mexico." This is a very expansive requirement and the bill does not address whether New Mexico has such credentialed persons currently available, or whether budget realities will permit hiring them. Presumably, experts retained from out of state would have to undergo some form of accreditation process in New Mexico before they would be

acceptable. There is no corresponding limitation on experts retained by providers. The bill does not provide for an appropriation to cover any additional cost for the state of obtaining such experts.

The limitation on extrapolation of claims in Section 5 is financially and logistically burdensome for the state. This prohibition is also inconsistent with federal guidelines. Overpayments, whether they be attributable to fraud or abuse or created by other overpayment situations, still contain a federal match. The Centers for Medicare and Medicaid Services (CMS) is entitled to its proportionate share of settlement or final judgment amount on overpayments. In view of the enormous logistical problems of Medicaid enforcement, courts have found that statistical sampling is the only feasible method available to determine an overpayment. At present, the federal Department of Health and Human Services (DHHS) permits extrapolation of claims where error rates reach 5 percent. Claim universes in such cases can run into the tens of thousands. Requiring a claim-by-claim review in cases where the error rate was as high as 10 percent could render such a review by HSD practically impossible.
Section 7, 8, 9 and 10 create a new "administrative hearings office," describe a new expedited appeals process, establish minimum qualifications for hearing officers conducting provider hearings which will dramatically reduce the pool of eligible hearing officers, allocate the cost of the hearing officer to HSD and allow a Medicaid provider to challenge the entire process on various and new grounds. These new sections appear to assume the creation or existence of an "administrative hearings office" separate from the HSD Fair Hearings Bureau. The bill does not provide for an appropriation to cover any additional cost for the creation and operation of such an office or the skilled manpower required to operate it. Section 8 establishes minimum qualifications for administrative law judges (ALJs) conducting provider hearings, including being licensed attorneys in good standing, at least three years' experience in health law or a related field and at least five years' experience in commercial litigation. No proposed governance or authority for this new office is provided. It is unclear, under the proposed Sections, what the status of the current Fair Hearings Bureau, or its ALJs, who are not currently subject to the requirements of Section 8, would be under the Act. A potential unintended consequence of a new and separate office is inefficient resource allocation that could result in potentially less or poorer quality services. The expedited process sets specific and shortened timelines for the hearing process, which could be problematic particularly where extensive discovery is involved. The process also makes the findings and conclusions of the hearing officer binding, rather than advisory to the Medicaid Director, effectively making the hearing officer's determination a "final agency decision," appealable under Sec. 39-3-1.1 NMSA. However, decisions in favor of the provider are not appealable by HSD. This is problematic and may not offer the State protection from a recovery by CMS in such cases.

It is unclear if the process described in Section 7-10 of this bill allows for a provider's administrative process to run concurrently with a criminal investigation, or if it is contemplated that the administrative process would fully run its course, (including any appeals of a determination of credible allegation of fraud, since Section 14 of this bill makes a determination of a credible allegation of fraud by HSD a final agency decision subject to judicial review) prior to a referral to the Attorney General's Office. Either timeline would likely require premature disclosure and/or discussion of potential evidence with providers. This likely would make prosecution of a criminal case more difficult. Allowing the administrative procedures to run concurrently creates a potential issue with confusing parallel proceedings and conflicting rulings. Requiring the Attorney General's Office to wait until all proceedings are completed creates statute of limitation issues and potential tainting of evidence.

Section 11 provides for release of payments suspended due to a referral of credible allegations of fraud upon the posting by the provider of a surety bond equal to the amount of the suspended payment, the bond constituting "good cause" for release, pursuant to 42 CFR 455.23. 42 CFR 455.23 provides that a state must suspend all Medicaid payments to a provider after it determines there is a credible allegation of fraud unless it has good cause not to suspend. 42 CFR 455.23 (e) and (f) define the specific grounds for which good cause exceptions may be granted. The purpose of the payment suspension is to prevent the flow of money to an entity that may be committing fraud. A bond is not identified in federal law as "good cause" in federal regulations to lift the payment suspension. Releasing claims payment under this circumstance (bond posting) may expose the State to risk of recovery by CMS or denial of Federal Financial Participation for the claims payments.

Section 12(A) would prohibit HSD from terminating a provider based upon a credible allegation of fraud, if the provider submits to prepayment review going forward and demonstrates that its employees have obtained remedial training. This does not address recovery of inappropriate or fraudulent payment made prior to entering into prepayment review. Section 12(C) sets a 10-day response time for reimbursement of clean claims, which could be problematic logistically.

The ability to manage contracts, including the ability to decide when a contract needs to be terminated for breach is an essential contracting power of an agency. Section 12 appears to place restrictions on HSD's ability to enforce contract provisions. This section would require that HSD continue to work with any provider who may be under investigation (even those under investigation for serious and significant allegations of fraud or abuse) during the pendency of the investigation. Furthermore, the section places a large administrative burden on HSD during the investigation to conduct ongoing prepayment review for the provider during the pendency of the investigation. Investigations for fraud can be long and difficult. State agencies have both legal (See ex 42 CFR 456.3) and ethical duties to prudently take care of state money and assets. Requiring an agency to continue to do business with someone the agency has determined to be a bad business partner is inconsistent with those duties.

Section 13 appears to direct any recouped Medicaid funds be deposited in the State's general fund "to be used for the state's Medicaid program." Presumably this would apply to the remittance of FFP to CMS. It is unclear what the mechanism would be for funds returned to the general fund to be reallocated to Medicaid. Currently the federal financial participation portion of any money recovered from providers is returned to the federal government. The remaining funds are used as a general fund offset for the agency and the monies are reinvested in other Medicaid services.

Section 14 makes a determination of a credible allegation of fraud by HSD a final agency decision subject to judicial review. This would conflict with NMRA Rule 1-074 and NMSA Section 39-1-1.1(H)(2) as to the definition of a final decision subject to appeal, and 42 CFR 455.23, which only provides for administrative review of suspensions based on credible allegations of fraud where state law so provides. It also imposes on HSD the affirmative burden on appeal to show that it did not abuse its discretion by failing to follow its own procedures – effectively creating a rebuttable presumption that HSD abused its discretion unless it proves otherwise. This, in effect, shifts the burden on appeal to the appellee. Inasmuch as HSD will have had the same burden at the hearing level, it creates a *de novo* review at the appellate level, which contradicts NMRA Rule 1-074.

Section 15 provides for an award of costs and fees to providers, up to $100,000.00, and interest on suspended payments at 18 percent per annum if providers "substantially prevail" with respect to the amount in controversy or the other issues in the hearing. What constitutes "substantially prevailing" is not clearly defined. There also is no corresponding provision for the awarding of costs to HSD if it prevails. It is generally contrary to state policy to award attorney fees from the state given the state's resources and opportunity costs. HSD is not aware of any deposit account that could be used that could provide 18 percent interest especially during the pendency of a payment hold.

ALTERNATIVES

The Administrative Hearings Office (AHO) suggests: 1) Change the bill language to allow AHO employees to serve as hearing officer if they meet the other qualifications, while continuing to prohibit other executive agency employees from serving as hearing officer; 2) Continue to require the Chief Hearing Officer to substantively select and designate the hearing officer for the proceeding (and approve/resolve any billing disputes), but leave the logistical contract support work such as approval from DFA of professional service contract, payment of contractor through direct disbursement from HSD's operating budget to HSD rather than adding extra logistical contract payment work to AHO which is a small agency with limited administrative support staff.

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