SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 55

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

AN ACT

RELATING TO PUBLIC HEALTH; AMENDING THE MEDICAID PROVIDER ACT; DEFINING "CREDIBLE ALLEGATION OF FRAUD" AND "OVERPAYMENT"; ESTABLISHING RIGHTS AND REMEDIES OF MEDICAID PROVIDERS AND SUBCONTRACTORS FOR ALLEGED OVERPAYMENTS OR CREDIBLE ALLEGATION OF FRAUD BASED ON AUDIT FINDINGS AND SAMPLING; LIMITING EXTRAPOLATION; PROVIDING FOR JUDICIAL REVIEW, ATTORNEY FEES AND WITNESS FEES; AMENDING THE MEDICAID FRAUD ACT TO CLARIFY THAT MERE ERRORS FOUND DURING THE COURSE OF AN AUDIT, BILLING ERRORS THAT ARE ATTRIBUTABLE TO HUMAN ERROR, INADVERTENT BILLING AND PROCESSING ERRORS AND INADVERTENT FAILURE TO COMPLY WITH A REGULATORY STANDARD THAT IS NOT A CONDITION OF PAYMENT DO NOT CONSTITUTE MEDICAID FRAUD AND TO PROVIDE FOR INVESTIGATION AND LIMITATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 27-11-1 NMSA 1978 (being Laws 1998, Chapter 30, Section 1) is amended to read:

"27-11-1. SHORT TITLE.--[~~This act~~] Chapter 27, Article 11 NMSA 1978 may be cited as the "Medicaid Provider Act"."

SECTION 2. Section 27-11-2 NMSA 1978 (being Laws 1998, Chapter 30, Section 2) is amended to read:

"27-11-2. DEFINITIONS.--As used in the Medicaid Provider Act:

A. "credible allegation of fraud" means an allegation of medicaid fraud, as defined in Subsection A of Section 30-44-7 NMSA 1978, that has been verified as credible by the department:

(1) considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations;

(2) based upon a careful review of all allegations, facts and evidence; and

(3) accompanied by sufficient indicia of reliability to justify a decision by the department to refer a medicaid provider or other person to the attorney general for further investigation;

[~~A.~~] B. "department" means the human services department;

[~~B.~~] C. "managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements

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with the department to provide health care and related services;

[~~C.~~] D. "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

[~~D.~~] E. "medicaid provider" means a person, including a managed care organization, operating under contract with the department to provide medicaid-related services to recipients;

F. "overpayment" means an amount paid to a medicaid provider or subcontractor in excess of the medicaid allowable amount, including payment for any claim to which a medicaid provider or subcontractor is not entitled;

[~~E.~~] G. "person" means an individual or other legal entity;

[~~F.~~] H. "recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;

[~~G.~~] I. "secretary" means the secretary of human services; and

[~~H.~~] J. "subcontractor" means a person who contracts with a medicaid provider to provide medicaid-related services to recipients."

SECTION 3. A new section of the Medicaid Provider Act is enacted to read:

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"[NEW MATERIAL] DETERMINATION OF OVERPAYMENTS OR CREDIBLE ALLEGATION OF FRAUD BASED UPON AUDIT FINDINGS--SAMPLING--EXTRAPOLATION PROHIBITED--RIGHTS OF MEDICAID PROVIDER OR SUBCONTRACTOR.--

A. The department:

(1) may audit a medicaid provider or subcontractor for overpayment, using sampling for the time period audited;

(2) shall not audit claims more than two years from the date the claim was submitted for payment;

(3) shall not extrapolate audit findings:

(a) by combining error rates for more than one type of service to reach a single extrapolated amount;

(b) unless the sample size for each type of service is statistically valid; or

(c) utilizing the error rate for a type of service that was only provided for a portion of the period audited to extrapolate for the entire audit period; and

(4) shall require each person reviewing audited claims for the department to be licensed, certified, registered, credentialed or trained as to the matters such person audits, including coding or specific clinical practice.

B. Prior to reaching a final determination of overpayment or final determination of credible allegation of fraud based in whole or in part upon overpayment, the

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department shall provide written notice of a tentative finding of overpayment to the medicaid provider or subcontractor.

C. The notice of a tentative finding of overpayment shall:

(1) state with specificity the factual and legal basis for each finding of an alleged overpayment; and

(2) notify the medicaid provider or subcontractor that is the subject of a tentative finding of overpayment of the medicaid provider's or subcontractor's right to request, within thirty days of receipt of the notice of a tentative finding of overpayment:

(a) an informal conference with a representative of the department to address, resolve or dispute the department's overpayment allegations; and

(b) an administrative hearing to challenge the department's overpayment allegations.

D. Upon receipt of a request for an informal conference, the department shall set a date for the conference to occur no later than seven days following receipt of the request.

E. The medicaid provider or subcontractor shall have no less than fifteen days following receipt of the department's notice of a tentative finding of overpayment to provide additional documentation to the department to attempt to informally address or resolve a disputed tentative finding

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of overpayment.

F. Upon receipt of a request for an administrative hearing, the department shall set a date for the hearing no later than thirty days, or as stipulated by the parties or upon a showing of good cause, no later than ninety days following receipt of the request. The hearing officer shall issue a decision within thirty days after the matter is submitted to the hearing officer. The department shall complete its review of the hearing officer's decision within thirty days of a request to review the hearing officer's decision.

G. The department shall allow a medicaid provider or subcontractor to correct clerical, typographical, scrivener's and computer errors or to provide misplaced credentialing, licensure or training records prior to making a final determination of overpayment or final determination of credible allegation of fraud based in whole or in part upon overpayment and may impose corrective action upon the medicaid provider or subcontractor to address systemic conditions contributing to errors in the submission of claims for payment to which a medicaid provider or subcontractor is not entitled.

H. A medicaid provider or subcontractor shall be permitted to challenge the accuracy of the department's audit, the statistical methodology of the department's original sample, the credentials of the persons who participated in the audit or the good faith of a prepayment review of claims and to

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present evidence to dispute any factual findings of the department as to any matter.

I. The department shall not require a medicaid provider or subcontractor to conduct its own audit or sampling to challenge the department's tentative or final audit determinations.

J. A medicaid provider or subcontractor shall have a right of appeal to district court from a final determination of overpayment pursuant to Section 39-3-1.1 NMSA 1978."

SECTION 4. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] SUSPENSION OF PAYMENTS--PREPAYMENT REVIEW--REMEDIAL TRAINING AND EDUCATION--RETURN OF SUSPENDED PAYMENTS--DISPOSITION OF RECOVERED OVERPAYMENTS.--

A. The department shall not suspend payment to a medicaid provider or subcontractor:

(1) before a final determination of overpayment is made and until all administrative and civil remedies and appeals have been exhausted by the medicaid provider or subcontractor;

(2) with respect to the amount of an alleged overpayment that forms the basis of a credible allegation of fraud, after the posting of a bond or other surety by the medicaid provider or subcontractor in the amount of the suspended payment, which shall be deemed good cause not to

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suspend payment; or

(3) with respect to ongoing services after a determination of credible allegation of fraud, unless there is evidence of material noncompliance or fraud following:

(a) a good-faith prepayment review of claims, which shall be deemed good cause not to suspend payment; and

(b) remedial training or education of employees of the medicaid provider or subcontractor.

B. The department shall release suspended payments no later than seven days following the earlier of:

(1) the posting of a bond or other surety by the medicaid provider or subcontractor in the amount of the suspended payment;

(2) notice from the attorney general that the attorney general will not pursue legal action arising out of the referral of the medicaid provider or subcontractor;

(3) the date on which an administrative decision as to the basis for suspending such payments, or portion of such payments, in favor of the medicaid provider or subcontractor becomes final; or

(4) the date on which a judicial decision as to the basis for suspending such payments, or portion of such payments, in favor of the medicaid provider or subcontractor becomes final and not subject to further appeal.

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C. The department shall not pay any portion of overpayments recovered by the state from a medicaid provider or subcontractor to any other person unless expressly authorized or required to do so by state or federal statute."

SECTION 5. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] CREDIBLE ALLEGATION OF FRAUD--JUDICIAL REVIEW.--A medicaid provider or subcontractor who is the subject of a referral to the attorney general for further investigation based upon a credible allegation of fraud may seek judicial review, pursuant to Section 39-3-1.1 NMSA 1978, of the procedures used by the department to determine that the allegation of fraud was credible."

SECTION 6. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] ATTORNEY FEES--WITNESS FEES.--Reasonable attorney fees and witness fees may be assessed against the department upon a finding by an administrative law judge or district court judge that the department has substantially prejudiced the medicaid provider's or subcontractor's rights and has acted arbitrarily or capriciously in its determination of credible allegation of fraud or overpayment under the Medicaid Provider Act."

SECTION 7. Section 30-44-7 NMSA 1978 (being Laws 1989, Chapter 286, Section 7, as amended) is amended to read:

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"30-44-7. MEDICAID FRAUD--DEFINED--[~~INVESTIGATION~~] PENALTIES.--

A. Medicaid fraud consists of:

(1) paying, soliciting, offering or receiving:

(a) a kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the program, including an offer or promise to, or a solicitation or acceptance by, a health care official of anything of value with intent to influence a decision or commit a fraud affecting a state or federally funded or mandated managed health care plan;

(b) a rebate of a fee or charge made to a provider for referring a recipient to a provider;

(c) anything of value, intending to retain it and knowing it to be in excess of amounts authorized under the program, as a precondition of providing treatment, care, services or goods or as a requirement for continued provision of treatment, care, services or goods; or

(d) anything of value, intending to retain it and knowing it to be in excess of the rates established under the program for the provision of treatment, services or goods;

(2) providing with intent that a claim be relied upon for the expenditure of public money:

(a) treatment, services or goods that

have not been ordered by a [~~treating physician~~] provider;

(b) treatment that is substantially inadequate when compared to generally recognized standards within the discipline or industry; or

(c) merchandise that has been adulterated, debased or mislabeled or is outdated;

(3) presenting or causing to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent or excessive [~~multiple or incomplete~~] claim for furnishing treatment, services or goods; or

(4) executing or conspiring to execute a plan or action to:

(a) defraud a state or federally funded or mandated managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or

(b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed

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health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.

B. The following do not constitute medicaid fraud:

(1) mere errors found during the course of an audit;

(2) billing errors that are attributable to human error;

(3) inadvertent billing and processing errors;

(4) inadvertent failure to maintain complete credentialing, licensure or training records; and

(5) inadvertent failure to comply with a regulatory standard that is not a condition of payment.

[~~B.~~] C. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud as described in Paragraph (1) or (3) of Subsection A of this section is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~C.~~] D. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud as described in Paragraph (2) or (4) of Subsection A of this section when the value of the benefit,

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treatment, services or goods improperly provided is:

(1) not more than one hundred dollars ($100) is guilty of a petty misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

(2) more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

(3) more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978;

(4) more than two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) [~~shall be~~] is guilty of a third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978; and

(5) more than twenty thousand dollars ($20,000) [~~shall be~~] is guilty of a second degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~D.~~] E. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in physical harm or psychological harm to a recipient is guilty of a fourth

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degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~E.~~] F. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in great physical harm or great psychological harm to a recipient is guilty of a third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~F.~~] G. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in death to a recipient is guilty of a second degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~G.~~] H. If the person who commits medicaid fraud is an entity rather than an individual, the entity shall be subject to a fine of not more than fifty thousand dollars ($50,000) for each misdemeanor and not more than two hundred fifty thousand dollars ($250,000) for each felony.

[~~H. The unit shall coordinate with the human services department, department of health and children, youth and families department to develop a joint protocol establishing responsibilities and procedures, including prompt and appropriate referrals and necessary action regarding allegations of program fraud, to ensure prompt investigation of~~

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~~suspected fraud upon the medicaid program by any provider. These departments shall participate in the joint protocol and enter into a memorandum of understanding defining procedures for coordination of investigations of fraud by medicaid providers to eliminate duplication and fragmentation of resources. The memorandum of understanding shall further provide procedures for reporting to the legislative finance committee the results of all investigations every calendar quarter. The unit shall report to the legislative finance committee a detailed disposition of recoveries and distribution of proceeds every calendar quarter.~~]"

SECTION 8. Section 30-44-8 NMSA 1978 (being Laws 1989, Chapter 286, Section 8, as amended) is amended to read:

"30-44-8. CIVIL PENALTIES--CREATED--ENUMERATED--PRESUMPTION [~~LIMITATION OF ACTION~~].--

A. Any person who receives payment for furnishing treatment, services or goods under the program, which payment the person is not entitled to receive by reason of a violation of the Medicaid Fraud Act, shall, in addition to any other penalties or amounts provided by law, be liable for:

(1) payment of interest on the amount of the excess payments at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to the state;

(2) a civil penalty in an amount of up to

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three times the amount of excess payments;

(3) payment of a civil penalty of up to ten thousand dollars ($10,000) for each false or fraudulent claim submitted or representation made for providing treatment, services or goods; and

(4) payment of legal fees and costs of investigation and enforcement of civil remedies.

B. Interest amounts, legal fees and costs of enforcement of civil remedies assessed under this section shall be remitted to the state treasurer for deposit in the general fund.

C. Any penalties and costs of investigation recovered on behalf of the state shall be remitted to the state treasurer for deposit in the general fund except an amount not to exceed two hundred fifty thousand dollars ($250,000) in fiscal year 2004, one hundred twenty-five thousand dollars ($125,000) in fiscal year 2005 and seventy-five thousand dollars ($75,000) in fiscal year 2006 may be retained by the unit and expended, consistent with federal regulations and state law, for the purpose of carrying out the unit's duties.

D. A criminal action need not be brought against a person as a condition precedent to enforcement of civil liability under the Medicaid Fraud Act.

E. The remedies under this section are separate from and cumulative to any other administrative and civil

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remedies available under federal or state law or regulation.

F. The department may adopt regulations for the administration of the civil penalties contained in this section.

[~~G. No action under this section shall be brought after the expiration of five years from the date the action accrues.~~]"

SECTION 9. A new section of the Medicaid Fraud Act is enacted to read:

"[NEW MATERIAL] INVESTIGATION--LIMITATION OF ACTIONS.--

A. The unit shall coordinate with the human services department, department of health and children, youth and families department to develop a joint protocol establishing responsibilities and procedures, including prompt and appropriate referrals and necessary action regarding allegations of program fraud, to ensure prompt investigation of suspected fraud upon the medicaid program by any provider. These departments shall participate in the joint protocol and enter into a memorandum of understanding defining procedures for coordination of investigations of fraud by medicaid providers to eliminate duplication and fragmentation of resources. The memorandum of understanding shall further provide procedures for reporting to the legislative finance committee the results of all investigations every calendar quarter. The unit shall report to the legislative finance

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committee a detailed disposition of recoveries and distribution of proceeds every calendar quarter.

B. No action under the Medicaid Fraud Act shall be brought after the expiration of four years from the date the action accrues."