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

SPONSOR Papen **ORIGINAL DATE** 02/05/17 **LAST UPDATED** 02/06/17 **HB**

SHORT TITLE Medicaid, Access, Disputes and Fraud **SB** 217

ANALYST Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Unable to Determine/See Fiscal Impact	Unable to Determine/See Fiscal Impact	Unable to Determine/See Fiscal Impact	Recurring	General Fund and Federal Matching Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of Attorney General (NMAG)
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

SB 217 modifies the existing Medicaid Provider Act, NMSA 27-11-1 *et seq,* specifically in the areas of defining credible allegations of fraud and modifying 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 Managed Care and Provider 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 deleting the word "provider" wherever it appears, and replacing it with "managed care organization." The effect of this change appears to make this language not applicable to providers.

Section 4 addresses retention and production of records. The bill modifies the section by replacing the term "provider" with "managed care organization, [M]edicaid provider or subcontractor," expanding its applicability to MCOs and subcontractors as well as 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 create state licensing and certification requirements for persons auditing provider claims; require service upon the provider with a tentative finding of overpayment and audit report; create a right of the provider to an informal conference with the Department, or an expedited adjudicatory proceeding before a final determination of overpayment; and permits the Department 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 thirty days of receiving the tentative notice of overpayment. Once a request is received, the Department 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 appears to contemplate the creation of an adjudicatory body separate from the Department's existing Fair Hearings Bureau. The provider may request a hearing within thirty days of receiving the tentative notice of overpayment, at which point the "chief hearing officer" has 30 days to appoint a presiding administrative law judge. The hearing must occur within 30 days of the appointment of the Administrative Law Judge (ALJ) and cannot last more than 10 business days. The ALJ's findings and conclusions are due within 30 days of the close of the record, are binding on the Department, and constitute an appealable final decision under NMSA 39-3-1.1.

Section 8 is new and creates qualifications for ALJs conducting expedited adjudicatory proceedings. They must be licensed attorneys with at least 3 years' experience in health insurance or a healthcare related field, at least 5 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 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 the Department's findings or the credentials of the persons who participated in the Department'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 the Department 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 the Department 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 the Department, as outlined in Section 11. It also imposes a duty on the Department 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 the Department 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 $100,000.00. The definition of "substantially prevails" is not clear, and the provision does not provide a corresponding right of recovery for the Department. It also provides for recovery of interest by the prevailing provider of 1.5% 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 ALJs to be assigned to expedited proceedings by the "chief hearing officer."

Section 18 incorporates the element of a "culpable mental state" into the definition of Medicaid fraud. It does not define "culpable mental state."

FISCAL IMPLICATIONS

HSD notes SB217 could impact the state in several ways as described below:

1) The bill requires a different level of expertise for administrative law judges (ALJ) and states that they be separate and distinct from ALJ's in the Office of Inspector General. Based on HSD's ability to recruit and hire experienced attorneys, the additional cost for each attorney will be approximately $100 thousand and scalable dependent on the number of attorneys required to address each case.
2) To the extent required, HSD finds this bill is not aligned with federal law and the state could risk loss of federal funds; however, the exact amount at risk is difficult to estimate.
3) HSD argues this bill will make it more difficult to combat fraud, waste and abuse and as currently written, allows for recoveries by the providers not afforded to HSD (see Section 15).
4) Section 13 requires that recoupment 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 state based on the match rate in the original claim. Once the state portion is returned to the general fund it would remain there until there is a vehicle in statute to re-appropriate that amount to the Medicaid program.

SIGNIFICANT ISSUES

In summary, both NMAG and HSD express significant concerns regarding a number of the bill's proposed changes to the way HSD oversees managed care organizations (MCOs) and contracted healthcare providers, particularly with respect to the processes for determining credible allegations of fraud and the identification and recoupment of overpayments. NMAG notes SB217 could adversely impact its Medicaid Fraud Control Unit's ability to effectively prosecute cases, and both agencies find several instances where the requirements in the bill appear to conflict with both the language and intent of federal regulations, which could impact the state's eligibility for federal matching funds for the Medicaid program.

Due to the complexity of the bill's proposed changes, the complete agency analyses are provided below. NMAG concurrences and overlap with HSD analysis are noted.

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. In exchange, the federal government pays a portion of the state's Medicaid costs, otherwise known as the "federal financial participation ('FFP') aka Federal Medical Assistance Percentage (FMAP)." 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 the FFP/FMAP. This bill proposes a number of significant changes in the way the HSD oversees MCOs 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 Medicaid Fraud and Elder Abuse Division (MFEAD) in determining whether an allegation warrants further investigation.

Section 3 appears to withdraw Medicaid providers from direct HSD review, instead requiring HSD to conduct its reviews solely through MCO records. Both NMAG and HSD argue this creates a potential conflict with oversight rights HSD has contained in its contracts with individual providers and also jeopardizes HSD compliance with federal requirements. The NMAG notes also it also makes the department reliant on the Medicaid managed care organization, a private entity, for all information regarding review of providers.

HSD contracts separately with both providers and the MCOs. In addition, some services are still provided by the traditional fee-for-service model wherein state funds are used to directly pay the medical service providers. 42 USC §1396a(a)(27) requires HSD to provide for agreements with "every person or institution providing services … under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance … and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services..."

42 CFR 456.3 requires each Medicaid agency to implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate Medicaid services and excess payments. The tools provided to HSD in NMSA §27-11-3 are essential to ensuring the state's ability to meet the requirements of federal law as well as enforce contracts and resolve disputes. HSD needs to be able to collect and review all relevant information from each party it is contracted with so that an informed decision can be made.

Section 4 creates some inconsistency and enforcement issues with Section 3. "Providers" were struck from Section 3 requirements. However, Medicaid Providers are included in Section 4 requirements. Failure to comply with Section 4 is a violation of Section 3 of this bill.

Sections 5 and 6 describe an informal conference process that a provider may request upon receipt of a tentative 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 would require audited claims of providers and subcontractors 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 also would prohibit extrapolation of audit results.

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 this bill requires HSD to make a "tentative" 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.

Both HSD and NMAG note 42 CFR §455.23 requires that HSD "must" suspend all payments and "must" make a referral to the Medicaid Fraud Control Unit (MFCU) when HSD has made a determination of a credible allegation of fraud. Requiring HSD to provide an entire administrative process on any tentative 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.

NMAG notes also that allowing the administrative and potential criminal process to proceed at the same time creates the potential for confusing parallel proceedings, with a potential judicial determination that there is not a credible allegation of fraud before the MFCU has had an opportunity to do any or limited investigation. If on the other hand, SB 217 contemplates allowing the administrative process to fully run its course, including any potential appeals of a final determination of credible allegation of fraud prior to referral to the MFCU, as outlined in Section 14 of SB 217, any case referred to the MFCU would be very difficult to prosecute at that point. Not only would enough time have passed to make investigation generally more difficult in its effect on witnesses and other evidence, but the Unit would face a much more challenging statute of limitations target. Since the MFCU relies on the department for many of its fraud referrals, this would generally make the prosecution of fraud referrals from the department 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. There is no corresponding limitation on experts retained by providers.

The prohibition on extrapolation of claims in Section 5 is financially and logistically burdensome for the state. This prohibition is also inconsistent with CMS guidelines. Overpayments, whether they be attributable to fraud or abuse or created by other overpayment situations, still contain a FFP/FMAP. 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. The number of claims involved renders a claim by claim 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 administrative law judges (ALJ) conducting provider hearings, allocate the cost of the ALJ to HSD and allows a Medicaid provider to challenge the entire process on various 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 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 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 poor 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 ALJ binding, rather than advisory to the Medical Assistance Division Director, effectively making the ALJ's determination a "final agency decision," appealable under Sec. 39-3-1.1 NMSA. Decisions in favor of the provider, however, are not appealable by HSD.

It is unclear if the process described in Section 7-10 of this bill allows for the providers administrative process to run concurrently with any 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 MFCU. Either timeline would likely require premature discussion of potential evidence with witnesses. This would likely 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 MFCU to wait until all proceedings are completed creates statute of limitation issues and potential spoliation/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.

Both NMAG and HSD note 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. Both NMAG and HSD argue the purpose of the federal mandate to suspend payments when fraud is suspected is to prevent the continued flow of money to a provider who may be committing fraud. Allowing otherwise may be considered inconsistent with the federal position as it relates to fraud in the Medicaid system. A bond is not identified in federal law as "good cause" in federal regulation to lift the payment suspension.

Section 12(A) would prohibit HSD from terminating a provider based upon a credible allegation of fraud, if the provider submits to a prepayment review going forward and demonstrates that its

employees have obtained remedial training. 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 any 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 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 an 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 contradicts those duties.

Section 13 appears to direct any recouped Medicaid funds be deposited in the state's general fund "to be used for the Medicaid program, unless required to do otherwise by law. 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 also 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, and requiring HSD on appeal to prove that its determination of credible allegations of fraud was supported by the evidence. This, in effect, shifts the burden on appeal to the appellee.

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 the 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 is also no corresponding provision for the awarding of costs to HSD in the event that it prevails. HSD and NMAG note that aside from the issues of what witnesses might be required to testify about whether the department has substantially prejudiced a Medicaid provider's rights, it is generally contrary to state policy to award attorney fees from the state given the states resources and opportunity costs. HSD is not aware of any account that could be used that could provide 18 percent interest especially during the pendency of a payment hold.

Section 18(B) adds a "culpable mental state" as an element of Medicaid fraud based on a failure to comply with service definitions or guidelines, or a breach of contract. Medicaid providers voluntarily contract with the state Medicaid program. Each provider has the legal capacity to enter into contracts. If one has the legal capacity to enter into the contract, one must have an obligation to understand the terms and requirements of the contracts being signed. Service

definitions describe the services that providers can be paid for in the state's Medicaid program. Service definitions enable HSD, the customer and the service provider to understand the services being provided. The contracts that HSD enters into with its customers are important to its long-term sustainability. Service definitions are an essential tool that HSD uses to properly manage utilization under these contracts. It is the obligation of every provider to understand the service definitions and to understand the terms of the contract.

Although it is not entirely clear what constitutes a culpable mental state in Section 18(B), it appears to indicate that a provider could intentionally participate in fraudulent activity, but as long as they claim they didn't "know" it was wrong…and thus lack "culpable mental state"…the state cannot pursue fraud. If one has the capacity to voluntarily enter into a contract with the state, it should be assumed that the individual is able to fully understand the contract language and its possible implications. "Culpable mental state" insulates the providers from their obligations and adds unnecessary burden to the state as a contracting party.

TECHNICAL ISSUES

NMAG noted the following technical issues:

The definition section, SB 217 defines a "clean claim" as one that does not lack substantiating documentation, and also as a claim paid in "due course." This allows for an inherent contradiction within the statute because a Medicaid claim paid in "due course" does not require substantiating documentation to be demonstrated at the time of payment.

SB 217 also creates an additional definition of fraud. This seems unnecessary and potentially confusing, since there is both a definition of statutory fraud at § 30-16-6 NMSA and a definition of Medicaid Fraud at § 30-44-7 NMSA. Creating an additional definition of fraud within the Medicaid Provider Act may create inconsistencies.

PERFORMANCE IMPLICATIONS

As mentioned above, as written the bill could impact HSD's ability to administer the Medicaid Program and could also impact the MFCU's ability to effectively prosecute cases.

ADMINISTRATIVE IMPLICATIONS

The bill potentially calls for the creation of a new administrative hearings body, separate from the department's Fair Hearings, and a new set of occupational requirements for ALJs not applicable to the ALJs currently employed by the bureau.

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