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

SPONSOR SFL **ORIGINAL DATE** 2/10/18 **LAST UPDATED** 2/14/18 **HB**

SHORT TITLE Medicaid Changes **SB** 2/SFLS

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY18	FY19	FY20	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$65.0-$277.7	$65.0-$277.7	$195.0-$833.1	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Administrative Hearings Office
Administrative Office of the Courts
New Mexico Attorney General
Human Services Department

SUMMARY

Synopsis of Bill

The Senate Floor substitute for Senate Bill 2 (SB2) 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. The Senate Floor substitute removed the original bill's clarification of new definitions of Medicaid fraud and now provides for the use of hearing officers instead of administrative law judges as was the case in the original bill.

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 Department; 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, 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 would use hearing officers at the Administratve 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 the Department, 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 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 thousand. The definition of "substantially prevails" is not clear, and the provision does not provide a corresponding right of recovery for HSD. 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, 2019.

FISCAL IMPLICATIONS

The Administrative Hearings Office (AHO) indicates although the substitute 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 $65 thousand.

Based on HSD's comments in 2017 on a similar bill, the department indicated:

1)The bill would require use of the Administrative Hearings Office's hearings officers separate and distinct from HSD's Office of Inspector General.

2) HSD found the bill was not aligned with federal law and the state could risk loss of federal funds; however, the exact amount at risk was difficult to estimate.

3) HSD argued the bill would make it more difficult to combat fraud, waste and abuse and allow for recoveries by the providers not afforded to HSD (see Section 15).

4) Section 13 required 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

The New Mexico Attorney General (NMAG) notes the administrative process outlined in SB2/SFCS may affect the Office of 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.

NMAG writes the bill provides for an administrative process whereby the department 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 HSD "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. The bill requires HSD 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, the bill 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.

NMAG indicates the bill 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 (42 CFR § 455.23) also provide for this contingency in that the department may find "good cause" as defined by that section in § 455.23 (e) and (f). Therefore, both contingencies should be consistent so as to not conflict with federal law.

The bill 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.

ADMINISTRATIVE IMPLICATIONS

The Human Services Department (HSD) previously indicated the bill calls for an administrative hearings body separate from HSD's Fair Hearings Bureau.

TECHNICAL ISSUES

NMAG notes a consistent definition is needed for clean claim as the bill defines a "clean claim" as one that does not lack substantiating documentation and also as a claim paid in "due course."

NMAG notes the bill also creates an additional definition of fraud which is also defined as statutory fraud at § 30-16-6 NMSA and Medicaid fraud at § 30-44-7 NMSA.

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 videoconference testimony.

AHO suggests it be given subpoena authority to compel production of relevant materials and attendance at hearings. 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.

The 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.

OTHER SUBSTANTIVE ISSUES

The Human Services Department (HSD) noted regarding the original bill significant concerns regarding a number of the bill's proposed changes to the way 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. HSD noted several instances where the requirements in the bill appeared to conflict with both the language and intent of federal regulations, which could impair the state's eligibility for federal matching funds for the Medicaid program.

HSD listed several issues with the originally introduced version of SB2 (see attachment).

RAE/jle

SIGNIFICANT ISSUES

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 the state's Medicaid costs, otherwise known as the "federal financial participation ('FFP') also known as the Federal Medical Assistance Percentage (FMAP)." As participants in the Medicaid program, states are required by federal regulations to establish program integrity requirements. Failure to do so could jeopardize the FFP/FMAP. This bill proposes a number of significant changes with how 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. 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.

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 & 6 of this bill requires the Department 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.

42 CFR §455.23 requires that the HSD "must" suspend all payments and "must" make a referral to the Medicaid Fraud Control Unit (MFCU) when the Department 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.

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 bill does not provide for an appropriation to cover any additional cost for the state of obtaining such experts.

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 ALJs 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 Administrative Law Judge binding, rather than advisory to the MAD 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 Sections 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.

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 agency that may be committing fraud. 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 the Department 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% 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. 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% 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 you have the legal capacity to enter into the contract, you have an obligation to understand the terms and requirements of the contracts that you are signing. 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 you have the capacity to voluntarily enter into a contract with the state, it should be assumed that you are 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.