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

SPONSOR SJC **ORIGINAL DATE** 02/18/14 **LAST UPDATED** **HB**

SHORT TITLE Due Process for Medicaid Fraud Allegations **SB** 181/SJCS

ANALYST Geisler/Daly

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY14	**FY15**		
	$500.0	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY14	**FY15**	**FY16**		
	(See Narrative)	(See Narrative)	Recurring	

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY14	FY15	FY16	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		See Narrative	See Narrative			

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to: SB 33, SB 126 and SJM 22

SOURCES OF INFORMATION
LFC Files

Responses Received From

Attorney General's Office (AGO)
Human Services Department (HSD)
Children, Youth & Families Department (CYFD)

SUMMARY

Synopsis of Bill

The Senate Judiciary Committee Substitute for Senate Bill 181 makes changes to both the Medicaid Provider Act and the Medicaid Fraud Act, including defining "credible allegation of fraud" and providing an exemption for certain errors in the definition of Medicaid fraud. It also establishes certain procedures that HSD must follow regarding determinations of credible allegations of fraud as to Medicaid providers, including notice and providing opportunities for hearings for the impacted providers. The major provisions of the amendment include:

- Defining "credible allegation of fraud" in both the Medicaid Provider Act and the Medicaid Fraud Act to require verification by HSD, considering the totality of the facts and circumstances, careful review of all allegations, facts and evidence in accordance with the definition of Medicaid fraud, and accompanied by sufficient indicia of reliability to justify referral of a provider or other person to the Attorney General for further investigation. The definition of "Medicaid fraud"currently found in the Medicaid Fraud Act is also included as a new definition in the Medicaid Provider Act. (Sections 2 and 5);

- Requiring the HSD secretary to promulgate rules to minimize any disruption in services when a Medicaid provider stops offering services, which rules must provide for an orderly transition of recipients' records and services from that provider to another and public hearings in geographic areas of the state affected by such a transition at which consumers and advocates may voice their concerns about the transition. (Section 3);

- Requiring, after HSD makes a credible allegation of fraud against a provider and in the absence of good cause, a suspension of all Medicaid program payments to that provider, subject to certain notice requirements and provider rights. At least five days prior to making such an allegation, HSD must provide notice of contemplated action to the provider of the general nature of the allegations, the types of claims or business units affected and the provider's right to seek a good cause exception. Upon making such an allegation, HSD may suspend payment without further notification, but within five days following the making of that allegation must give notice of suspension unless law enforcement has requested up to a 90 day delay in giving notice. HSD's second notice must contain general allegations as to the nature of the suspension action, the temporary nature of the suspension and circumstances under which it will be terminated, the claims or business units effected, and information about the provider's right to seek a good cause exception. In addition, the provider may, within 30 days, request an adjudicatory hearing pursuant to the Administrative Procedures Act as to whether good cause exists not to suspend payments pending the outcome of the investigation, which hearing must be held within 30 days of the request. (Section 4);

- Providing a good cause exception to payment suspension based on enumerated factors, including law enforcement requests, law enforcement declining to certify the matter is still under investigation, the availability of other remedies that provide more protection to Medicaid funding, a favorable determination based on an adjudicatory hearing or any delay in such a hearing, a determination from an independent financial intermediary that suspension is not in the program's best interest, jeopardy to recipients' access to care, or any other grounds that suspension is not in the medicaid program's best interest. (Section 4);

- Prior to making a determination of credible allegation of fraud, HSD must provide the provider with notice of tentative investigation results and allow the provider an opportunity within 30 days to make limited corrections of clerical, typographical, scrivener's and computer errors and to provide additional evidence not provided to the department during the investigation. In determining a credible allegation of fraud exists HSD must certify it allowed the provider these opportunities and that the department's inspector general reviewed the findings before the determination is made. (Section 6); and

- Declaring that unless there is clear and convincing evidence to the contrary, mere errors found during an audit, billing errors due to human error and inadvertent billing and processing errors do not constitute Medicaid fraud. (Section 6).

In addition, SB 181/CS appropriates $500,000 from the general fund HSD to fund enhanced administrative due process in FY15 matters involving pending Medicaid provider fraud allegations. Any unexpended balance at the end of FY 15 will revert to the general fund.

FISCAL IMPLICATIONS

In its analysis of the previous committee amendment which contained many of the same provisions that are in this substitute, HSD predicted that the bill would probably cost the State tens of millions of dollars in federal financial participation for adopting a Medicaid fraud investigatory procedure that conflicts with federal law.

Similarly, in its analysis of that amendment, AGO reported that as a condition of New Mexico receiving approximately $6 billion in federal Medicaid funds per year, the state is required to maintain a Medicaid fraud control unit (MFCU). It expressed concern that the definition of credible allegation of fraud contained in this bill conflicts with the governing federal regulation (42 C.F.R. 455.23) and creates ambiguity between federal and state statutes, regulations and processes, which put the MFCU, housed at AGO, at risk, and perhaps Medicaid funding to the state as well. Further, AGO believed that the state, HSD and the MFCU will be required to expend substantial time and significant taxpayer dollars to defend and clarify provisions contained in this bill and resolve issues arising from those provisions with numerous federal entities that fund and set standards for the performance and operation of the state's MFCU.

As to the appropriation contained in Section 7, HSD would receive $500,000 that could potentially be matched equally with federal funds, depending on the actual activity for which the funds are used.

SIGNIFICANT ISSUES

<u>Definition of "Credible Allegation of Fraud"</u>

Both HSD and AGO advised that the definition of credible allegation of fraud which is contained in the current substitute differs from the federal definition of the same term. HSD provided these arguments in opposition to the definition and other related provisions contained in this bill:

> The definition set out in the bill differs from the federal definition in 42 CFR §455.2, which defines a credible allegation as one that "may be an allegation, which has been verified by the State, from any source, including but not limited to

> the following:
> (1) Fraud hotline complaints.
> (2) Claims data mining.
> (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis."
>
> Further, Section 1903(i)(2) of the Social Security Act provides Federal financial participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud. Therefore, receipt of the FFP is tied to enforcement of what HHS considers to be a "credible allegation of fraud."

AGO commented that the proposed additions and changes relating to the "credible allegation of fraud" definition along with "verified" review of "facts and circumstances" and "allegations" and "evidence" create confusion relating to due process issues, administrative proceeding processes, and criminal and civil prosecutorial jurisdiction which could render the Medicaid Fraud Act moot, or at the very least require court action to determine whether these provisions require "exhaustion of administrative remedies" prior to filing criminal and civil pleadings.

On the other hand, how a State defines "credible allegation of fraud" was addressed by the federal Centers for Medicare & Medicaid Services, in its March 25, 2011 CPI-CMCS Informational Bulletin (CMCS Bulletin) which provides operational guidance regarding its regulation regarding suspension of payments pending an investigation of a credible allegation of fraud. As to the definition of that term in 42 C.F.R.§ 455.2, CMS states such an allegation may be one that "has been verified by a State and that has indicia of reliability that comes from any source." CMS comments that it recognizes that States may have different considerations in determining what may be a credible allegation of fraud, and "believes States should have the flexibility to determine what constitutes such an allegation of fraud." In describing what action a Sate should take when it receives an allegation of fraud, CMS directs the State to follow the regulation, and that it "must also review all allegations, facts and evidence carefully and act judiciously on a case-by-case basis." It also encourages States not "to rely solely on a singular allegation without considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations."

<u>Changes to Definition of Medicaid Fraud as to Certain Billing and Other Errors</u>

HSD called attention to the language in Section 6(D) amending Section 30-44-7 of the Medicaid Fraud Act to require that, "[i]n the absence of clear and convincing evidence" to the contrary, "mere errors," billing errors and inadvertent billing and processing errors do not constitute Medicaid fraud. HSD advised:

> "Clear and convincing evidence" is a civil, not a criminal standard; it is found nowhere else in the New Mexico Criminal Code; and should not be part of the

> Medicaid Fraud Act, which is part of that code.

Additionally, HSD commented:

> The new language conflicts with the federal False Claims Act (FCA). Section 6402 of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. 111-148, sets a 60-day deadline for providers to repay and report overpayments of federal funds – this would include "mere errors," billing errors and "inadvertent billing and processing errors." Section 6402(a) of the ACA asserts a 60-day deadline to report and return any overpayment to the Secretary, the State, or other appropriate party. The obligation under the ACA to return and report overpayments is specifically linked to the FCA. The ACA states that "[a]ny overpayment retained by a person after the deadline for reporting and returning the overpayment . . . is an obligation [as defined in the False Claims Act]." As amended by the Fraud Enforcement Recovery Act of 2009, liability under the FCA includes the improper retention of an overpayment of federal funds. Improper retention of overpayments may trigger both treble damages and penalties of up to $11,000 per claim under the FCA.

New Mexico statutes contain no provision imposing a provider sanction or penalty for failure to timely report errors once the provider is aware of errors being made.

AGO also objected to Section 6(D):

> the use of the words "mere," "human error," "inadvertent," and "processing errors" in relation to an evidentiary standard and the definition of "Medicaid fraud" appear "indefinable" and/or incapable of being statutorily construed under the MFA and current New Mexico statutes, regulations, and case law.

AGO made this further comment:

> The existing enacted MFA language, including the definition of "Medicaid fraud" relies upon federal Medicaid statutory and regulatory wording as a condition of New Mexico receiving funding for Medicaid and the NMAG MFCU. The proposed changes are problematic, while also conflicting and/or creating ambiguities with federal Medicaid statutes and regulations and NMAG MFCU criminal and civil jurisdiction, standards of proof, applicable intent standards and rules of evidence.

<u>Notice to Provider Prior to Credible Allegation of Fraud Determination</u>

LFC staff cautions that Section 4(B)'s requirement that HSD provide notice at least five days prior to making a making a credible allegation of fraud and referral to the MCFU may violate federal code. 42 CFR 455.23(a) dictates that the funding must be suspended immediately after the agency makes its determination. A five day waiting period would not be in compliance with this section. Subsection (b)(i) of that regulation only requires the agency send notice of payment suspension within five days after the payments are suspended. The five days prior notice could potentially compromise or interfere with an ongoing investigation. Additionally, it would not provide any true benefit to the provider, since it only provides general allegations but no specific information concerning an ongoing investigation, and purports to allow the provider to seek a good cause exception from a determination of credible allegation of fraud when no such determination has been made.

Other Conflicts

Further, in addition to expressing concerns similar to HSD's concerning the FCA, AGO called attention to problems, ambiguities and conflicts it sees between language found in this bill and the Medicaid False Claims Act (MFCA. under which New Mexico collects substantial Medicaid related qui tam monies. See Sections 27-14-1 through 15, NMSA 1978. It commented that provisions contained in this substitute may impact or terminate those recoveries and monies that the State currently receives from global federal qui tam settlements that rely upon the current state law definition of Medicaid fraud and existing administrative processes. Those same concerns arise, AGO noted, in the context of the Fraud Against Taxpayers Act (FATA), §§ 44-9-1 *et seq.* which at § 44-9-3(B) states that "proof of specific intent to defraud is not required for a violation of Subsection A of this section."

In addition, HSD noted that "enhanced administrative due process" does not currently exist under federal nor state law. Also, on July 25, 2013, the US District Court for the District of New Mexico in Border Area Mental Health Services, Inc. et al. v. Squier, Case No. 2:13-cv-00613-MCA-WPL, held that the process utilized by HSD in withholding the Medicaid payments of eight (8) behavioral health providers and determining that credible allegations of fraud existed as to each of the providers fully complied with federal and state due process requirements.

However, the appropriation in SB 181/CS could support the additional administrative process required by this substitute.

PERFORMANCE IMPLICATIONS

HSD expressed concern that the provisions in this substitute could greatly complicate the current day to day audit functions that occur within the Medicaid program. The provisions would impact its ability to meet federal requirements and to cooperate with federally contracted auditing firms.

In addition, AGO noted that by directly conflicting with federal Medicaid law, provisions in this substitute create new and additional significant prosecutorial issues and confusion regarding administrative processes.

ADMINISTRATIVE IMPLICATIONS

HSD reported that provisions contained in this substitute attempt to define terms and processes which have already been defined by the federal government which causes conflicts with many federal requirements which HSD must follow. HSD also commented that those provisions would add significant steps in the conducting of audits that are currently under state contracts but are required by federal law.

RELATIONSHIP

Relates to SB 126, Medicaid Audits, Fraud Review and Procurement, which contains the same definition of credible allegation of fraud, requires use of external medicaid program auditors, provides notice and hearing requirements, provides for judicial review, codifies the good cause exception, requires notice of tentative results of audit and opportunity to make limited corrections and to provide additional evidence, requires certification by HSD prior to making a credible allegation of fraud, and creates the same exemption in the definition of Medicaid fraud for certain errors.

Also relates to SB 33, Clarify Definition of Medicaid Fraud, which provides a near duplicate definition of credible allegation of fraud, provides for judicial review of a credible allegation of fraud, and creates the same exemption in the definition of Medicaid fraud for certain errors.

Also relates to SJM 22 Due Process for New Mexico Medicaid providers.

Each of these bills attempts to provide enhanced due process for New Mexico Medicaid providers at risk of financial loss due to HSD withholding Medicaid payments upon a finding of a credible allegation of fraud.

TECHNICAL ISSUES

- Page 2, (3) (lines 13-16) should be underlined, as it contains new language that is part of the new definition of credible allegation of fraud being added to an existing section of the Medicaid Provider Act.
- Page 7-8, Section 5(D)(2)(c) provides the cumulative delay occasioned by law enforcement requests cannot exceed 90 days, but (a) and (b) together appear to authorize a delay (and a renewal) of only 60 days in total.
- Page 9, line 3, "grant" might be changed to "conduct" or "take place" to clarify that the hearing must be occur within 30 days of the provider's request for hearing, consistent with the language on page 10 at lines 16-17.

OTHER SUBSTANTIVE ISSUES

HSD's Office of the Inspector General noted the following regarding the definition of a credible allegation of fraud contained in this substitute, which it believed conflicts with Title 42, CFR 455, which specifies:

> 42 CFR 455.14, Preliminary Investigations, provides for the single state agency, if the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, that it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
>
> 42 CFR 455.15, Full Investigations, if the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:
>
> (1) If a provider is suspected of fraud or abuse, the agency must—
>
> (a) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under § 1002.309 of this title;
>
> 42 CFR 455.16 Resolution of full investigation, a full investigation must continue until-
>
> (a) Appropriate legal action is initiated;
>
> (b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or beneficiary. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;
(2) Suspending or terminating the provider from participation in the Medicaid program;
(3) Seeking recovery of payments made to the provider; or
(4) Imposing other sanctions provided under the State plan.

In addition, CYFD noted in its earlier analysis that language in Section 2(E)(a) (page 3) limits authorization for services to treating physicians. In both physical and behavioral health, it commented, there are other, authorized, licensed professionals that also "order" treatment (e.g. physician assistants, nurses, psychologists, social workers) and they should be included. It appears that this language duplicates existing language in the definition of Medicaid fraud contained in the Medicaid Fraud Act at Section 30-44-7(A)(2)(a).

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

AGO commented that New Mexico will remain in compliance with federal Medicaid law and 42 CFR 455.23.

GG/MD/ds:jl