SENATE BILL

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

INTRODUCED BY

FOR THE COURTS, CORRECTIONS AND JUSTICE COMMITTEE AND THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

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; PROHIBITING EXTRAPOLATION; PROVIDING FOR JUDICIAL REVIEW, INJUNCTIVE RELIEF, 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 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:

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1 **SECTION 1.** Section 27-11-1 NMSA 1978 (being Laws 1998,
2 Chapter 30, Section 1) is amended to read:
3 "27-11-1. SHORT TITLE.--[~~This act~~] Chapter 27, Article 11
4 NMSA 1978 may be cited as the "Medicaid Provider Act"."
5 **SECTION 2.** Section 27-11-2 NMSA 1978 (being Laws 1998,
6 Chapter 30, Section 2) is amended to read:
7 "27-11-2. DEFINITIONS.--As used in the Medicaid Provider
8 Act:
9 A. "credible allegation of fraud" means an
10 allegation of medicaid fraud, as defined in Subsection A of
11 Section 30-44-7 NMSA 1978, that has been verified as credible
12 by the department:
13 (1) considering the totality of the facts and
14 circumstances surrounding any particular allegation or set of
15 allegations;
16 (2) based upon a careful review of all
17 allegations, facts and evidence; and
18 (3) accompanied by sufficient indicia of
19 reliability to justify a decision by the department to refer a
20 medicaid provider or other person to the attorney general for
21 further investigation;
22 [~~A.~~] B. "department" means the human services
23 department;
24 [~~B.~~] C. "managed care organization" means a person
25 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 extrapolate audit findings; and

(3) shall require each person reviewing audited claims for the department to be licensed, certified, registered or otherwise credentialed in New Mexico 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 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

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1 overpayment of the medicaid provider's or subcontractor's right
2 to request, within thirty days of receipt of the notice of a
3 tentative finding of overpayment:
4 (a) an informal conference with a
5 representative of the department to address, resolve or dispute
6 the department's overpayment allegations; and
7 (b) an administrative hearing to
8 challenge the department's overpayment allegations.
9 D. Upon receipt of a request for an informal
10 conference, the department shall set a date for the conference
11 to occur no later than seven days following receipt of the
12 request.
13 E. The medicaid provider or subcontractor shall
14 have no less than thirty days following receipt of the
15 department's notice of a tentative finding of overpayment to
16 provide additional documentation to the department to attempt
17 to informally address or resolve a disputed tentative finding
18 of overpayment.
19 F. Upon receipt of a request for an administrative
20 hearing, the department shall set a date for the hearing no
21 later than thirty days, or as stipulated by the parties or upon
22 a showing of good cause, no later than ninety days following
23 receipt of the request.
24 G. The department shall allow a medicaid provider
25 or subcontractor to correct clerical, typographical,

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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 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 as a condition precedent to challenging 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

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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; or

(2) 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 suspend payment.

B. The provisions of this section shall not prevent the department from:

(1) conducting a good-faith prepayment review of subsequent claims by a medicaid provider or subcontractor that is the subject of a tentative overpayment determination; or

(2) requiring a medicaid provider or subcontractor that is the subject of a tentative overpayment determination or its employees to complete remedial training or education to prevent the submission of claims for payment to which a medicaid provider or subcontractor is not entitled.

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

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(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.

D. 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. A credible allegation of fraud determination by the department shall be deemed a final decision as defined in Section 39-3-1.1 NMSA 1978.

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B. 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 of the department's credible allegation of fraud determination pursuant to Section 39-3-1.1 NMSA 1978."

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

"[NEW MATERIAL] INJUNCTIVE RELIEF.--A medicaid provider or subcontractor appealing a final determination of overpayment or seeking judicial review of the department's credible allegation of fraud determination shall be entitled to:

A. injunctive relief during the pendency of any investigation of alleged fraud, waste or abuse based upon a credible allegation of fraud and of related court proceedings, including:

(1) enjoining the department from suspending payments, subject to the requirement that the medicaid provider or subcontractor post a bond or other surety; and

(2) requiring the department to pay for ongoing services rendered by the medicaid provider or subcontractor, subject to a good-faith prepayment review of claims; and

B. such other relief as the court deems appropriate to protect the professional and property interests of the medicaid provider or subcontractor and of its officers,

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directors and employees during the pendency of any investigation of alleged fraud, waste or abuse based upon a credible allegation of fraud and of related court proceedings."

SECTION 7. 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 8. Section 30-44-7 NMSA 1978 (being Laws 1989, Chapter 286, Section 7, as amended) is amended to read:

"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

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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

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1 treatment, services or goods; or
2 (4) executing or conspiring to execute a plan
3 or action to:
4 (a) defraud a state or federally funded
5 or mandated managed health care plan in connection with the
6 delivery of or payment for health care benefits, including
7 engaging in any intentionally deceptive marketing practice in
8 connection with proposing, offering, selling, soliciting or
9 providing any health care service in a state or federally
10 funded or mandated managed health care plan; or
11 (b) obtain by means of false or
12 fraudulent representation or promise anything of value in
13 connection with the delivery of or payment for health care
14 benefits that are in whole or in part paid for or reimbursed or
15 subsidized by a state or federally funded or mandated managed
16 health care plan. This includes representations or statements
17 of financial information, enrollment claims, demographic
18 statistics, encounter data, health services available or
19 rendered and the qualifications of persons rendering health
20 care or ancillary services.
21 B. The following do not constitute medicaid fraud:
22 (1) mere errors found during the course of an
23 audit;
24 (2) billing errors that are attributable to
25 human error;

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(3) inadvertent billing and processing errors;

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

(5) 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, 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

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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 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

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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 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~~

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1 of proceeds every calendar quarter.]"

2 **SECTION 9.** Section 30-44-8 NMSA 1978 (being Laws 1989,

3 Chapter 286, Section 8, as amended) is amended to read:

4 "30-44-8. CIVIL PENALTIES--CREATED--ENUMERATED--

5 PRESUMPTION [LIMITATION OF ACTION].--

6 A. Any person who receives payment for furnishing

7 treatment, services or goods under the program, which payment

8 the person is not entitled to receive by reason of a violation

9 of the Medicaid Fraud Act, shall, in addition to any other

10 penalties or amounts provided by law, be liable for:

11 (1) payment of interest on the amount of the

12 excess payments at the maximum legal rate in effect on the date

13 the payment was made, for the period from the date payment was

14 made to the date of repayment to the state;

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

16 three times the amount of excess payments;

17 (3) payment of a civil penalty of up to ten

18 thousand dollars ($10,000) for each false or fraudulent claim

19 submitted or representation made for providing treatment,

20 services or goods; and

21 (4) payment of legal fees and costs of

22 investigation and enforcement of civil remedies.

23 B. Interest amounts, legal fees and costs of

24 enforcement of civil remedies assessed under this section shall

25 be remitted to the state treasurer for deposit in the general

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

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

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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 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."

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