HOUSE BILL 66

50TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2012

INTRODUCED BY

Ray Begaye

AN ACT

RELATING TO MEDICAID; DIRECTING THE HUMAN SERVICES DEPARTMENT TO IMPLEMENT PROGRAM INTEGRITY PROVISIONS FOR MEDICAID FRAUD PREVENTION, REPORTING AND LOSS RECOVERY; PROVIDING FOR SHARED SAVINGS CONTRACTS; CREATING A MEDICAID FRAUD SUSPENSE FUND; ENACTING A TEMPORARY PROVISION TO REQUIRE THE HUMAN SERVICES DEPARTMENT TO ISSUE AN INVITATION FOR BIDS FOR INFORMATION TECHNOLOGY TO IMPLEMENT THE DEPARTMENT'S MEDICAID FRAUD DETECTION, PREVENTION AND LOSS RECOVERY PROGRAM; MAKING AN APPROPRIATION.

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

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

"27-11-1. SHORT TITLE.--[~~This act~~] Chapter 27, Article 11

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NMSA 1978 may be cited as the "Medicaid Provider Act"."

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

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

A. "claim" means a written or electronically submitted request for payment for items or services rendered to a recipient;

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

[~~B.~~] C. "managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements with the department to provide health care and related services;

[~~C.~~] D. "medicaid" means the medical assistance program established pursuant to Title 19 or Title 21 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. "medical code" means a system that transcribes descriptions of medical diagnoses and procedures into universal medical code numbers;

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

H. "real time" means the actual time in which an event or process occurs, or a period of time that is within milliseconds of an actual event or process;

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

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

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

L. "vendor" means a person that provides information technology service or infrastructure to the department pursuant to the provisions of the Medicaid Provider Act."

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

"[NEW MATERIAL] MEDICAID FRAUD PREVENTION, REPORTING AND LOSS RECOVERY PROGRAM--MEDICAID PROVIDER SCREENING--MEDICAID PROVIDER EDUCATION--AUTOMATIC CLAIMS REVIEW.--

A. The department shall implement a medicaid fraud prevention, reporting and loss recovery program that uses information technology to review and process medicaid claims

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and medicaid provider data against a continually maintained database of medicaid claims and medicaid providers. The department shall integrate the medicaid fraud prevention information technology system into the existing medicaid claims processing system to:

(1) identify and prevent errors in medicaid claims in real time, using automated protocols that the American medical association or the federal centers for medicare and medicaid services has developed;

(2) be automated to minimize human intervention and maximize accuracy, efficiency and speed before a claim is paid, denied or settled;

(3) use predictive modeling and analysis technology to identify and analyze billing or utilization patterns that represent a high risk of inappropriate, inaccurate or erroneous activity;

(4) prioritize potentially inappropriate, inaccurate or erroneous claims for additional review for any potential waste, fraud or abuse before the department makes payment;

(5) analyze medical codes, medical records, historical claims data and provider databases to automatically screen claims for data entry error, duplication and fraud; and

(6) capture outcome information from claims that have been paid, denied or settled to allow for refinement

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and enhancement of the predictive analytics technologies based on historical data and algorithms within the system.

B. The claims processing system that the department develops for the medicaid fraud prevention, reporting and loss recovery program shall analyze medicaid claims and benefits utilization for all medicaid providers and recipients statewide. It shall identify and analyze those claims or utilization patterns that represent a high risk of fraudulent activity, then prioritize these identified transactions for additional review before payment is made based on likelihood of potential waste, fraud or abuse. The department shall prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent or abusive until the claims have been verified as valid.

C. The department shall conduct regular audits of medicaid claims after payment of the claims to ensure that the diagnoses and procedure codes are accurate and valid based on the supporting medicaid provider documentation within the recipient's medical record. The department shall:

(1) identify improper payments due to fraud as well as those payments made for nonfraudulent reasons;

(2) obtain medicaid provider acknowledgment of the department's audit results; and

(3) recover validated overpayments from the medicaid provider.

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D. The department shall establish and implement fraud investigation procedures that combine retrospective claims analysis and prospective waste, fraud or abuse detection techniques. These investigations shall include the analysis of medical codes, medical records, historical claims data, suspect provider databases and lists of medicaid providers at high risk of fraud, as well as data collected from direct recipient and medicaid provider interviews. The department shall emphasize medicaid provider education to ensure that medicaid providers have the opportunity to review and correct any possibly fraudulent claims before their claims are filed or adjudicated. The department shall prevent fraudulent payments to medicaid providers that:

(1) are deceased or are otherwise not legally extant;

(2) the department has sanctioned and that are unauthorized to submit claims for payment;

(3) do not have a valid professional license in the field of practice for which the claim is submitted; or

(4) do not have a valid mailing address.

E. The department may contract with a vendor to provide the information technology necessary to carry out the provisions of this section. The department shall provide any vendor with access to claims and other data necessary for the entity to carry out the functions required by in this section

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and as consistent with other federal and state law. The department shall provide to the vendor current and historical medicaid claims and medicaid provider database information and promulgating any rules necessary to facilitate appropriate public-private data sharing."

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

"[NEW MATERIAL] MEDICAID CLAIMS DATABASE.--

A. The department shall establish and maintain an information technology-based medicaid claims database of all claims-based data for the state's medicaid program. Data in the medicaid claims database shall include both claims for the programs that the department administers directly and claims for the programs administered pursuant to its contracts with managed care organizations.

B. Data in the medicaid claims database shall be unadulterated data, exactly the claims data that medicaid providers submit to the medicaid program or to managed care organizations before any data manipulation or claims processing has occurred or any data are lost.

C. The department shall run automated data analysis on data in the medicaid claims database and use the data to:

(1) ensure the integrity and appropriate level of payment for recipients' care; and

(2) establish capitation rates for managed

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care organizations."

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

"[NEW MATERIAL] MEDICAID FRAUD DETECTION, PREVENTION AND LOSS RECOVERY REPORTING.--By September 1, 2013 and by September 1 every third year thereafter, the department shall complete and submit to the legislative health and human services committee and to the legislative finance committee a report relating to the medicaid fraud detection, prevention and loss recovery measures that includes the following:

A. a description of the measures the department has taken to implement the provisions of Section 3 of this 2012 act;

B. an audit report from the office of the state auditor that specifies the actual and projected savings to the state's medicaid program as a result of implementing the medicaid fraud detection, prevention and loss recovery provisions of Section 3 of this 2012 act. This audit report shall include:

(1) estimates of the amounts of income resulting from improper payments to providers that the department has recovered;

(2) an estimate of the amount of savings resulting from denial of improper claims for payment;

(3) the actual and projected savings to the

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medicaid program as a result of implementing the medicaid fraud detection, prevention and loss recovery provisions of Section 3 of this 2012 act; and

(4) information on any return on investment the department has received by implementing the provisions of this 2012 act compared with strategies the department used prior to the effective date of this 2012 act;

C. an analysis of the extent to which the use of medicaid fraud detection, prevention and loss recovery provisions of Section 3 of this 2012 act have detected and prevented waste, fraud or abuse in the medicaid program;

D. any modifications or refinements that should be made to increase the amount of actual or projected savings or mitigate any adverse impact on recipients or providers;

E. a review of whether the provisions of Section 3 of this 2012 act have affected access to, or the quality of, items and services furnished to recipients; and

F. a review of any effect on medicaid providers by implementing the provisions of Section 3 of this 2012 act, including:

(1) an assessment of the department's efforts to educate providers on compliance with medicaid fraud prevention measures; and

(2) the department's documentation of processes for providers to review and correct problems that

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fraud prevention measures have identified."

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

"[NEW MATERIAL] VENDOR CONTRACT--SHARED SAVINGS--LIMITS.--

A. The department may enter into shared savings contracts with vendors pursuant to the medicaid fraud detection, prevention and loss recovery provisions of the Medicaid Provider Act. The department shall negotiate the proportion of shared savings with a vendor; provided that, exclusive of reimbursement for reasonable costs and expenses and irrespective of the number of vendors retained under a contract, the total amount payable to vendors pursuant to one contract shall not exceed the following amounts:

(1) if the total amount of recovered medicaid losses due to fraud in a given year is less than ten million dollars ($10,000,000), the vendor's savings share shall not exceed twenty-five percent of the amount recovered;

(2) if the total amount of recovered medicaid losses due to fraud in a given year is equal to or greater than ten million dollars ($10,000,000) but less than fifteen million dollars ($15,000,000), the vendor's savings share shall not exceed two million five hundred thousand dollars ($2,500,000) plus twenty percent of the amount recovered over ten million dollars ($10,000,000);

(3) if the total amount of recovered medicaid

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losses due to fraud in a given year is equal to or greater than fifteen million dollars ($15,000,000) but less than twenty million dollars ($20,000,000), the vendor's savings share shall not exceed three million five hundred thousand dollars ($3,500,000) plus fifteen percent of the amount recovered over fifteen million dollars ($15,000,000);

(4) if the total amount of recovered medicaid losses due to fraud in a given year is equal to or greater than twenty million dollars ($20,000,000) but less than twenty-five million dollars ($25,000,000), the vendor's savings share shall not exceed four million two hundred fifty thousand dollars ($4,250,000) plus ten percent of the amount recovered over twenty million dollars ($20,000,000); and

(5) if the total amount of recovered medicaid losses due to fraud in a given year is equal to or greater than twenty-five million dollars ($25,000,000), the vendor's savings share shall not exceed four million seven hundred fifty thousand dollars ($4,750,000) plus five percent of the amount recovered over twenty-five million dollars ($25,000,000); except that, regardless of the amount recovered, the total savings share, exclusive of reimbursement for costs and expenses, shall not exceed twenty million dollars ($20,000,000).

B. Each vendor's shared savings contract shall include a provision that mandates the termination of the

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contract with no additional payments due to the vendor if the vendor or any partner, associate or employee of the vendor is found guilty of fraud or has been assessed a civil penalty for violating the provisions of the Medicaid False Claims Act, the Medicaid Fraud Act, the Medicaid Provider Act or the Fraud Against Taxpayers Act.

C. The "medicaid fraud suspense fund" is created in the state treasury. Each vendor's shared savings contract shall provide that all amounts received by the vendor pursuant to this section as satisfaction of a claim shall be transferred to the department and deposited into the medicaid fraud suspense fund. Upon the issuance of a voucher by the secretary of human services or the secretary of human services' designee, the secretary of finance and administration shall issue by warrant from the medicaid fraud suspense fund to the vendor any compensation due to the vendor under this section. After a disbursement to a vendor, the balance of each deposit shall be distributed to the appropriate permanent fund or other appropriate fund from which the loss occurred that originated the claim pursued by the vendor."

SECTION 7. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] SEVERABILITY.--If any part or application of the Medicaid Provider Act is held invalid, the remainder or its application to other situations or persons shall not be

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affected."

SECTION 8. TEMPORARY PROVISION--MEDICAID FRAUD DETECTION, PREVENTION AND LOSS RECOVERY INFORMATION TECHNOLOGY VENDOR PROCUREMENT.--Notwithstanding any existing contract to update the human services department's information technology system for medicaid claims processing and payment, by June 1, 2012, the department shall initiate a new invitation for bids process under the Procurement Code to implement the provisions of Section 3 of this act.

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