SENATE JUDICIARY COMMITTEE SUBSTITUTE FOR
SENATE BILL 181

51ST LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2014

AN ACT

RELATING TO MEDICAID DUE PROCESS; AMENDING THE MEDICAID PROVIDER ACT TO DEFINE "CREDIBLE ALLEGATION OF FRAUD" AND PROVIDE FOR NOTICE AND GOOD-CAUSE EXCEPTIONS TO PAYMENT SUSPENSIONS IN MATTERS RELATING TO DETERMINATIONS OF CREDIBLE ALLEGATIONS OF FRAUD; AMENDING SECTION 30-44-7 NMSA 1978 (BEING LAWS 1989, CHAPTER 286, SECTION 7, AS AMENDED) TO PROVIDE A STANDARD OF REVIEW FOR MEDICAID FRAUD; PROVIDING FOR MEDICAID PROVIDER TRANSITIONS; 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 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. "credible allegation of fraud" means an allegation of medicaid fraud that has been verified by the department:

(1) considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations;

(2) based upon a careful review of all allegations, facts and evidence in accordance with Section 30-44-7 NMSA 1978; and

(3) accompanied by sufficient indicia of reliability to justify a decision by the department to refer a medicaid provider or other person to the attorney general for further investigation;

[~~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~~] Titles 19 and 21 of the federal Social Security Act and waivers and regulations issued

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pursuant to that act;

E. "medicaid fraud" means:

(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 medicaid, 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 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 medicaid provider;

(c) anything of value, intending to retain it and knowing it to be in excess of amounts authorized under medicaid, 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 medicaid 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;

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(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, excessive, multiple or incomplete claim for furnishing treatment, services or goods; or

(4) executing or conspiring to execute a plan or action to:

(a) defraud a state or federally funded or mandated managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or

(b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements

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of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services;

[~~D.~~] F. "medicaid provider" means a person, including a managed care organization, operating under contract with the department to provide medicaid-related services to recipients;

[~~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:

"[NEW MATERIAL] MEDICAID PROVIDER TRANSITION--HEARINGS.--The secretary shall adopt and promulgate department rules to minimize any disruption in services when a medicaid provider ceases to offer services to recipients. At a minimum, the rules relating to medicaid providers shall provide for:

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A. an orderly transition of recipients' medical records and services from one medicaid provider to another; and

B. public hearings in geographic areas of the state affected by a medicaid provider transition at which consumers and their advocates may voice their concerns about the transition."

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

"[NEW MATERIAL] CREDIBLE ALLEGATION OF FRAUD--BASIS FOR SUSPENSION OF PROGRAM PAYMENTS--NOTICE--HEARING RIGHTS--GOOD CAUSE FOR REMOVING PROGRAM PAYMENT SUSPENSION.--

A. Unless the department has good cause not to suspend program payments, the department shall suspend all medicaid program payments to a provider after the department makes a credible allegation of fraud against the provider. The suspension shall remain in effect pending the outcome of an investigation made pursuant to the Medicaid Fraud Act.

B. At least five days before making a credible allegation of fraud against a provider, the department shall notify the provider through a notice of contemplated credible allegation of fraud that sets forth:

(1) the general allegations as to the nature of the contemplated credible allegation of fraud, but need not disclose any specific information concerning an ongoing investigation;

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(2) which type or types of medicaid claims or business units of a provider to which a credible allegation of fraud is contemplated; and

(3) the provider's right to seek a good-cause exception for the application of a payment suspension pursuant to Subsection F of this section.

C. After making a credible allegation of fraud against a provider, the department may suspend program payments without first notifying the provider of its intention to suspend payments.

D. The department shall provide notice of its suspension of program payments within the following time frames:

(1) five days after suspending program payments, unless requested in writing by a law enforcement agency to temporarily withhold notice; or

(2) a period of time that a law enforcement agency requests in writing to the department in the following manner:

(a) the law enforcement agency makes its request that the department delay notification for law enforcement purposes for a period not to exceed thirty days;

(b) the law enforcement agency renews its request that the department delay notification for a period not to exceed thirty days; and

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(c) the cumulative delay in notification does not exceed ninety days.

E. The notice of suspension of program payments issued pursuant to Subsection D of this section shall include:

(1) a statement that payments are being suspended in accordance with the provisions of this section;

(2) the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;

(3) a statement that the program payment suspension is for a temporary period and that cites the circumstances under which the suspension will be terminated;

(4) a specification, when applicable, as to which types of medicaid claims or business units of a program payment suspension are effective;

(5) information specifying the provider's right to seek a good-cause exception for the application of a payment suspension pursuant to Subsection F of this section; and

(6) citations to applicable state law.

F. A provider may request an adjudicatory hearing pursuant to the Administrative Procedures Act for a finding as to whether good cause exists not to suspend program payments pending the outcome of the investigation relating to the credible allegation of fraud. The provider shall make the

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request within thirty days of receiving notification that the department has applied a program payment suspension. The hearing to determine good cause shall be granted within thirty days of the provider's request.

G. The department shall find that good cause not to suspend program payments exists where:

(1) law enforcement officials have specifically requested that a payment suspension not be imposed because a payment suspension may compromise or jeopardize an investigation;

(2) the department has other remedies available that will protect medicaid funds more effectively or quickly than a payment suspension;

(3) the department finds, as a result of the adjudicatory hearing provided pursuant to Subsection F of this section, that good cause exists for the program payment suspension to be removed;

(4) recipients' access to items or services would be jeopardized by a program payment suspension because:

(a) the provider is a sole provider of physician services or essential specialized services in a community; or

(b) the provider serves a large number of recipients within a federally designated medically underserved area;

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(5) law enforcement declines to certify that a matter continues to be under investigation for fraud; or

(6) the department determines that payment suspension is not in the best interests of the medicaid program. The department shall determine that payment suspension is not in the best interests of the medicaid program if:

(a) an independent financial intermediary that the state auditor has approved reports to the state auditor and to the department its determination that a payment suspension is not in the best interests of the medicaid program;

(b) pursuant to Subsection F of this section, a provider has requested an adjudicatory hearing to determine whether good cause exists for not suspending program payments, and the hearing has not taken place within thirty days of the request; or

(c) the department determines on any other grounds that program payment suspension is not in the best interests of the medicaid program."

SECTION 5. Section 30-44-2 NMSA 1978 (being Laws 1989, Chapter 286, Section 2, as amended) is amended to read:

"30-44-2. DEFINITIONS.--As used in the Medicaid Fraud Act:

A. "benefit" means money, treatment, services,

goods or anything of value authorized under the program;

B. "claim" means [~~any~~] a communication, whether oral, written, electronic or magnetic, that identifies a treatment, good or service as reimbursable under the program;

C. "cost document" means [~~any~~] a cost report or similar document that states income or expenses and is used to determine a cost reimbursement-based rate of payment for a provider under the program;

D. "covered person" means an individual who is entitled to receive health care benefits from a managed health care plan;

E. "credible allegation of fraud" means an allegation of medicaid fraud that the department has verified as credible:

(1) considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations;

(2) based upon a careful review of all allegations, facts and evidence in accordance with Section 30-44-7 NMSA 1978; and

(3) accompanied by sufficient indicia of reliability to justify a decision by the department to refer a medicaid provider or other person to the attorney general for further investigation;

[~~E.~~] F. "department" means the human services

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department;

[~~F.~~] G. "entity" means a person other than an individual and includes corporations; partnerships; associations; joint-stock companies; unions; trusts; pension funds; unincorporated organizations; governments and their political subdivisions [~~thereof~~]; and nonprofit organizations;

[~~G.~~] H. "great physical harm" means physical harm of a type that causes physical loss of a bodily member or organ or functional loss of a bodily member or organ for a prolonged period of time;

[~~H.~~] I. "great psychological harm" means psychological harm that causes mental or emotional incapacitation for a prolonged period of time [~~or~~]; that causes extreme behavioral change or severe physical symptoms; or that requires psychological or psychiatric care;

[~~I.~~] J. "health care official" means:

(1) an administrator, officer, trustee, fiduciary, custodian, counsel, agent or employee of a managed [~~care~~] health care plan;

(2) an officer, counsel, agent or employee of an organization that provides or proposes to or contracts to provide services to a managed health care plan; or

(3) an official, employee or agent of a state or federal agency with regulatory or administrative authority over a managed health care plan;

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[~~J.~~] K. "managed health care plan" means a government-sponsored health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with or employed by a health care insurer or provider service network. A "managed health care plan" includes the health care services offered by a health maintenance organization, preferred provider organization, health care insurer, provider service network, entity or person that contracts to provide or provides goods or services that are reimbursed by or are a required benefit of a state or federally funded health benefit program, or [~~any~~] a person or entity who contracts to provide goods or services to the program;

[~~K.~~] L. "person" includes individuals, corporations, partnerships and other associations;

[~~L.~~] M. "physical harm" means an injury to the body that causes pain or incapacitation;

[~~M.~~] N. "program" means the medical assistance program authorized under [~~Title XIX~~] Titles 19 and 21 of the federal Social Security Act, 42 U.S.C. 1396, et seq., or waiver of that act, and implemented under [~~Section 27-2-12 NMSA 1978~~] the Public Assistance Act;

[~~N.~~] O. "provider" means [~~any~~] a person who has applied to participate or who participates in the program as a

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supplier of treatment, services or goods;

[~~O.~~] P. "psychological harm" means emotional or psychological damage of such a nature as to cause fear, humiliation or distress or to impair a person's ability to enjoy the normal process of [~~his~~] life;

[~~P.~~] Q. "recipient" means [~~any~~] an individual who receives or requests benefits under the program;

[~~Q.~~] R. "records" means [~~any~~] medical or business documentation, however recorded, relating to the treatment or care of [~~any~~] a recipient, to services or goods provided to [~~any~~] a recipient or to reimbursement for treatment, services or goods, including [~~any~~] documentation required to be retained by regulations of the program; and

[~~R.~~] S. "unit" means the medicaid fraud control unit or any other agency with power to investigate or prosecute fraud and abuse of the program."

SECTION 6. 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

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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 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;

(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

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allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent, excessive, multiple or incomplete claim for furnishing treatment, services or goods; or

(4) executing or conspiring to execute a plan or action to:

(a) defraud a state or federally funded or mandated managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or

(b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.

B. Before making a credible allegation of fraud determination, the department shall provide to a provider under

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review a notice of tentative results of its investigation that states that the department will permit a provider under review:

(1) the opportunity to make limited correction of clerical, typographical, scrivener's and computer errors by the provider prior to final determination of an investigation performed pursuant to this section; and

(2) the opportunity to provide additional evidence not provided to the department during the investigation within thirty days from the date of receipt of the department's notice of tentative investigation results.

C. In order for the department's findings to give rise to a credible allegation of fraud:

(1) the department shall certify that, before making its final determination, the department permitted the provider:

(a) an opportunity to make limited correction of clerical, typographical, scrivener's and computer errors; and

(b) the opportunity to provide additional evidence not provided to the department during the review within thirty days from the date of receipt of the department's notice of tentative results of the department's investigation; and

(2) the office of the inspector general of the department has reviewed the findings before the credible

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allegation of fraud is determined.

D. In the absence of clear and convincing evidence to the contrary, the following do not constitute medicaid fraud:

(1) mere errors found during the course of an audit;

(2) billing errors that are attributable to human error; and

(3) inadvertent billing and processing errors.

[~~B.~~] E. 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.~~] F. 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

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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 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.~~] G. 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.~~] H. 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

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third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~F.~~] I. 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 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.~~] J. 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.~~] K. 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

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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."

SECTION 7. APPROPRIATION.--Five hundred thousand dollars ($500,000) is appropriated from the general fund to the human services department for expenditure in fiscal year 2015 to fund enhanced administrative due process in matters involving pending medicaid provider fraud allegations pursuant to this act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2015 shall revert to the general fund.

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