FIFTY-FIRST LEGISLATURE SB 181/a
SECOND SESSION, 2014

February 7, 2014

Mr. President:

Your **PUBLIC AFFAIRS COMMITTEE**, to whom has been referred

SENATE BILL 181

has had it under consideration and reports same with recommendation that it **DO PASS**, amended as follows:

1. On page 1, line 11, before "MAKING", insert "RELATING TO MEDICAID DUE PROCESS; AMENDING THE MEDICAID PROVIDER ACT TO DEFINE "CREDIBLE ALLEGATION OF FRAUD" AND PROVIDE FOR NOTICE, JUDICIAL REVIEW 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;".

2. On page 1, line 11, after "APPROPRIATION", strike the remainder of the line, strike lines 12 and 13 in their entirety and insert in lieu thereof a period.

3. On page 1, between lines 15 and 16, insert the following new sections:

"**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~~] <u>Chapter 27, Article 11 NMSA 1978</u> 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:

<u>A. "credible allegation of fraud" means an allegation of medicaid fraud that has been verified by the department:</u>

(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 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;

(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 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] 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.

B. A medicaid provider or other person 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 4. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] CREDIBLE ALLEGATION OF FRAUD--EXTERNAL MEDICAID PROGRAM AUDITORS--MINIMUM REQUIREMENTS.--

A. In establishing the basis for a credible allegation of fraud determination against a provider, the department shall employ an external medicaid program auditor that meets the criteria set forth in Subsections B and C of this section.

B. An external medicaid program auditor shall:

(1) demonstrate to the state that it has the technical capability to carry out a program audit. The secretary shall establish by rule guidelines for ensuring that the external medicaid program auditor has the technical capability to carry out the medicaid program audit, including a requirement that the medicaid program auditor employ health care professionals with expertise and experience relevant to the medicaid claims they review pursuant to the program audit;

(2) engage for at least thirty-five hours per week the following individuals who have met criteria the department has established for minimum work and educational experience relating to the subject of the medicaid program audit:

(a) a medical director, who is a doctor of medicine licensed pursuant to the Medical Practice Act or an osteopathic physician licensed pursuant to Chapter 61, Article 10 NMSA 1978; and

(b) in medicaid program audits that relate to the review of medicaid program claims for behavioral health services, a behavioral health director, who is an individual licensed or otherwise legally authorized to provide behavioral health services in the regular course of business;

(3) hire certified coders to conduct the medicaid program audit, unless the secretary determines that certified coders are not required for the effective review of medicaid claims and documents the reasons for this determination;

(4) work with the department to develop an education and outreach program that includes notification to providers of audit policies and protocols;

(5) provide minimum service measures, including:

(a) providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. mountain time;

(b) compiling and maintaining provider-approved addresses and points of contact; and

(c) accepting provider submissions of electronic medical records on compact disc or digital versatile disc or via facsimile, at the provider's request; and

(6) refer suspected cases of medicaid fraud to the department in a timely manner, as the secretary defines by rule.

C. An external medicaid program auditor shall not:

(1) review claims that are older than three years from the date of the claim, unless the department:

(a) directs it to do so in writing; and

(b) documents its justification for doing so in writing; or

(2) audit claims that have already been audited or that are currently being audited by another person.

D. As used in this section:

(1) "certified coder" means an expert in the procedural and diagnostic coding related to written or electronically submitted requests for payment of health care services who has been certified by the AAPC or the American health information management association; and

(2) "health care professional" means an individual licensed or otherwise legally authorized to provide behavioral or physical health care services in the ordinary course of business."

SECTION 5. 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;

(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:

(a) seek judicial review of a credible allegation of fraud determination pursuant to Section 3 of this 2014 act;

(b) seek a good-cause exception for the application of a payment suspension pursuant to Subsection F of this section; or

(c) simultaneously seek judicial review pursuant to Section 3 of this 2014 act and 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

(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:

(a) seek judicial review of a credible allegation of fraud determination pursuant to Section 3 of this 2014 act;

(b) seek a good-cause exception for the application of a payment suspension pursuant to Subsection F of this section; or

(c) simultaneously seek judicial review pursuant to Section 3 of this 2014 act and 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 request within thirty days of receiving notification that the department has applied a program payment suspension. The provider may simultaneously seek judicial review pursuant to Section 3 of this 2014 act and a good-cause exception for the application of a payment suspension pursuant to this subsection. 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;

(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 6. 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 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;

H. "external medicaid program auditor" means a person that:

(1) is not a division or employee of a state agency; and

(2) in the regular course of business conducts audits of the medicaid program or medicaid providers;

[~~G.~~] I. "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.~~] J. "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.~~] K. "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;

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

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

[~~M.~~] O. "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.~~] P. "provider" means [~~any~~] a person who has applied to participate or who participates in the program as a supplier of treatment, services or goods;

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

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

SECTION 7. 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 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 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. The department shall use the findings of an external medicaid program auditor to review provider claims or practices for purposes of determining whether grounds for a credible allegation of fraud exist. Before making a credible allegation of fraud determination, the department shall provide to a provider under review a notice of tentative audit results 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 audit performed pursuant to this section; and

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

C. In order for the external medicaid program auditor's findings to give rise to a credible allegation of fraud:

(1) the department shall certify that, before a final determination of the audit was made, the department permitted the audited 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 audit within thirty days from the date of receipt of the department's notice of tentative audit results;

(2) the office of the inspector general of the department has reviewed the findings before the credible allegation of fraud is determined; and

(3) the findings shall have been produced by an external medicaid program auditor that:

(a) the department certifies to have employed for purposes of reviewing audited claims or practices for the department only individuals who are licensed, certified, registered or otherwise credentialed in New Mexico as to the matters that those individuals have audited, including coding or specific clinical practices;

(b) the department has chosen from a list of external medicaid program auditors that the state auditor has approved; and

(c) the department has hired pursuant to a request for proposals pursuant to the Procurement Code that is not a sole-source or emergency procurement.

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 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.

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[~~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 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 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."".

4. Renumber the succeeding section accordingly.

5. On page 1, line 20, after "allegations", insert "pursuant to this act".,

and thence referred to the **JUDICIARY COMMITTEE.**

Respectfully submitted,

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Gerald Ortiz y Pino, Chairman

Adopted_______________________ Not Adopted_______________________
(Chief Clerk) (Chief Clerk)

Date ________________________

The roll call vote was 5 For 0 Against
Yes: 5
No: 0
Excused: Brandt, Griggs, Kernan
Absent: None