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

SPONSOR SPAC **ORIGINAL DATE** 02/04/15 **LAST UPDATED** 02/26/15 **HB**

SHORT TITLE Clarify Definition of Medicaid Fraud **SB** 55/SPACS

ANALYST Daly

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY15	FY16	FY17	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Potentially Significant	Potentially Significant	Potentially Significant	Recurring	Medicaid Recoveries

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From

Human Services Department (HSD)
Administrative Office of the Courts (AOC)
Children, Youth & Families Department (CYFD)

SUMMARY

Synopsis of Bill

The Senate Public Affairs Committee Substitute for Senate Bill 55 makes changes to the Medicaid Provider Act, including defining "credible allegation of fraud" and establishing certain procedures that HSD must follow regarding determinations of credible allegations of fraud as to Medicaid providers, such as requiring notice and an opportunity for a hearing for an impacted provider. It also provides an exemption for certain errors in the definition of Medicaid fraud in the Medicaid Fraud Act. The major provisions of SB 55 include:

- Defining "credible allegation of fraud" to require verification by HSD, considering the totality of the facts and circumstances, based upon careful review of all allegations, facts and evidence, and accompanied by sufficient indicia of reliability to justify referral of a provider or other person to the Attorney General for investigation (Section 2);

- Defining "overpayment" to mean an amount paid to a provider or subcontractor in excess of the Medicaid allowable amount, including any payment to which either is not entitled (Section 2);

- Authorizing HSD to audit, by a person who is appropriately licensed or otherwise credentialed or trained, a Medicaid provider or subcontractor for overpayment as to claims within two years from the date of submittal for payment. It permits sampling and limited extrapolation if the sample size for each type of service is statistically valid, but bars combining error rates for more than one type of service to reach a single extrapolated amount or utilizing the error rate for a type of service that was only provided for a portion of the period audited to extrapolate for the entire audit period. Prior to reaching a final determination of overpayment or credible allegation of fraud based in whole or part on overpayment, HSD must provide written notice of a tentative finding of overpayment, providing the specific factual and legal basis for each such finding, and advising the provider or subcontractor of its right to provide additional documentation within fifteen days and to request an informal conference. Such a conference must occur within seven days of receipt of a request. A provider or subcontractor is also entitled to an administrative hearing within 30 days of HSD's receipt of a hearing request, subject to extension to 90 days upon stipulation by the parties or for good cause shown. The hearing officer must issue a decision with 30 days after submission, and HSD must complete its review of that decision with 30 days of a request for that review. HSD also must allow the provider or subcontractor to correct clerical, typographical, scrivener's and computer errors or provide misplaced records prior to HSD making any final determination, but HSD may impose corrective action to address systemic conditions contributing to errors in the submission of claims in amounts to which a provider or subcontractor is not entitled. HSD cannot require the provider or subcontractor to conduct its own audit or sampling. (Section 3);

- Granting a provider or subcontractor the right to appeal any final determination of overpayment (Section 3);

- Prohibiting HSD from suspending payment: (1) before a final determination of overpayment and exhaustion of all administrative and civil remedies; (2) as to the amount of alleged overpayment that forms the basis of a credible allegation of fraud, after the posting of a bond by the provider or subcontractor; or (3) as to ongoing services after a credible allegation of fraud determination, unless there is evidence of material noncompliance or fraud following a good-faith prepayment review of claims (deemed good cause not to suspend) and remedial training or education of the provider's or subcontractor's employees. (Section 4);

- Requiring release of any suspended payments within seven days of the posting of a bond, notice that the AGO will not pursue legal action or the issuance of an administrative judicial decision that is not subject to further review in the provider's or subcontractor's favor. (Section 4);

- Granting a provider or subcontractor against whom HSD has made a credible allegation of fraud determination the right to judicial review (Section 5);

- Authorizing the award of attorney and witness fees in an administrative or court proceeding upon a finding that HSD has substantially prejudiced the provider's or subcontractor's rights and has acted arbitrarily and capriciously in making its determination. (Section 6);

- Amending the definition of Medicaid fraud in the Medicaid Fraud Act to provide that these matters do not constitute Medicaid fraud:

    - Mere errors found in the course of an audit;
    - Billing errors attributable to human error;
    - Inadvertent billing and processing errors;
    - Inadvertent failure to maintain complete licensing and other credentialing records; and
    - Failure to comply with a regulatory standard that is not a condition of payment. (Section 7); and

- Reducing the time in which an action may be brought under the Medicaid Fraud Act to four years (under existing law, that period is five years) (Sections 8 and 9).

FISCAL IMPLICATIONS

HSD asserts a fiscal impact on it as the State Medicaid agency in its efforts to recover identified fraud and audit overpayments. The bill provides that reasonable attorney fees and witness fees may be assessed against HSD upon a finding by an administrative law judge or district court judge that HSD has substantially prejudiced the provider's or subcontractor's right and has acted arbitrarily or capriciously in its determination of credible allegation of fraud or overpayment. This could increase payments that HSD would be ordered to pay, although exact dollar amounts cannot be predicted with specificity.

SIGNIFICANT ISSUES

AGO advises that, as discussed with the bill's sponsor, the AGO will not be submitting an analysis of this bill.

HSD, as the State Medicaid Agency, is responsible for administering the Medicaid program, including investigating and making determinations of credible allegations of Medicaid fraud. It raises these concerns:

Definition of Medicaid fraud: Section 2 defines credible allegations of fraud otherwise than as defined in 42 CFR §455.2, the federal regulation which is used by HSD and MFEAD in determining whether investigation of potential fraud is warranted. It will be unwieldy to apply two separate definitions for the same concept in attempting to investigate and sanction providers on fraud claims.

Definition of Overpayment: Similarly, the definition in Section 2 differs from the governing federal law, which uses this definition: any funds that a person receives or retains under [state health care program] to which the person, after applicable reconciliation, is not entitled under such [program].

Time Limit on Auditing Claims

Section 3(A)(2) bars HSD from auditing claims more than two years after the date the claim was submitted for payment. Currently, providers must maintain documents that

support their claims for 6 years. The federal Center for Medicare and Medicaid Services (CMS) requires a specific grant of permission to reach back less than three years, so this bill might require negotiation with CMS and a potential revision of the State Plan.

Time Limits on Administrative Hearings

Section 3(F) requires the hearing officer to issue a decision within 30 days of submittal. However, under existing rule, provider administrative hearings are conducted and a written decision is issued by the MAD (Medicaid Assistance Division) director or designee to the provider within 120 calendar days from the date the FHB receives the provider administrative hearing request, unless the parties otherwise agree to an extension. See 8.351.2 NMAC for information concerning time limits when the action is a MAD sanction. The right to request a stay is cited in 8.351.2.15 NMAC.

Limits on Suspension of Payments: Section 4's prohibition on suspension of payments upon determinations of credible allegations of fraud differs with the governing federal rule, 42 CFR Section 455.23., which describes credible allegations of fraud as the "basis for suspension":

(1) The State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
(2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.

The bill appears to conflate the concepts of overpayment and credible allegation of fraud. It is hard to always track the process. It is entirely possible to determine a credible allegation of fraud based on an alleged overpayment (using the terms in the bill) before the exact scope or amount of the overpayment is determined. Federal regulation, at 42 CFR §455.15, requires HSD to refer a credible allegation of fraud as soon as it is determined to exist, and immediately suspend payments pursuant to §455.23. The bill language would prevent a suspension for overpayment until the entire administrative and judicial process of proving the overpayment is complete. Arguably, under Section 4(A)(2), if the overpayment is part of the credible allegation of fraud, HSD can still suspend unless the provider posts a bond, but that is not clear. HSD proposes language to clarify in the Amendments section below.

Award of Costs and Attorney Fees:

Section 6's inclusion of an administrative law judge as being an individual who can assess such fees is particularly inappropriate because under current law administrative law judges make recommendations and do not issue final orders; rather, it is the Director of the Medicaid Fraud Division at HSD that issues a written decision. There is no other section of the law which gives this type of judge similar power or authority. Only four per cent of HSD fair hearing requests come from providers, but they would be the only claimants for whom this remedy is available.

Exclusions from Medicaid Fraud:

As to the exclusion set forth in Section 7(B)(4) regarding inadvertent failure to maintain complete credentialing, licensure or training records, the language is unclear. If the intent is to exclude poor record-keeping, rather than one of not keeping credentials, licensing and training current, it needs to say so. A proposed amendment is set forth below in the Amendments section.

As to the Section 7(B)(5)'s exclusion for inadvertent failure to comply with a regulatory standard that is not a condition of payments, that exclusion conflicts with Section 1128B [42 USC 1320a-7b], which provides criminal penalties for acts involving federal health care programs. The SSA asserts that whoever having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized shall be guilty of a felony. The federal definition is based on the knowledge the provider has and the actions of the provider. The bill provides for an exemption from "fraud" if there is an "inadvertent failure" to do something on the part of the provider. This type of "exemption" is not included in the federal definition of fraud, so it could cause conflict.

In addition, both AOC and HSD draw attention to Section 5, which grants the right of judicial review to a provider or subcontractor against whom HSD has made a credible allegation of fraud determination "pursuant to Section 39-3-1.1 NMSA 1978", which in Subsection (H) defines "final decision" to mean in part, "The determination of whether there is a final decision by an agency shall be governed by the law regarding the finality of decisions by district courts." Whether a credible allegation of fraud determination constitutes a final decision permitting appeal to the district court therefore will be determined by a district court. HSD also points to language in that subsection defining the term to mean "an agency ruling that as a practical matter resolves all issues arising from a dispute within the jurisdiction of the agency, once all administrative remedies available within the agency have been exhausted." HSD advises that a determination of credible allegations of fraud by definition does not resolve issues, but rather identifies them and becomes the basis for further investigation.

Further, HSD comments that Section 5 does not specify whether the judicial review must occur before or after the referral to Medicaid Fraud Control Unit (MFCU). If before, it would be inconsistent with the requirements of the federal Medicaid rule, 42 CFR 455.15, which requires referral to such a unit once the agency makes a determination of credible allegations of fraud. If after, then a question arises as to what happens to MFCU's investigation if it has accepted a referral but a court subsequently rules the allegations were not credible? Again, HSD notes that under federal rules, MFCU's decision to investigate is based on its own analysis of the allegations, not a separate judicial determination.

In addition, AOC comments that the language in Section 7(B) describing actions that do not constitute Medicaid fraud (including mere errors found during an audit, billing errors that are attributable to human error, inadvertent billing processing errors and inadvertent failure to maintain complete credentialing, licensure or training records or comply with a regulatory standard that is not a condition of payment) requires a subjective decision that these matters are

not intentional and fraudulent. Section 2 of this bill's definition of "credible allegation of fraud," may provide guidance as to how to make the determination of whether there has been fraud, providing also, by inference, the steps by which a determination may be made that there is *no* credible allegation and thus no Medicaid fraud. AOC suggests this inference may not provide enough guidance as to by whom and how determinations are to be made regarding the nature of billing, audit and processing errors, and failure to maintain records.

PERFORMANCE IMPLICATIONS

HSD reports that SB 55 will adversely impact its agency staff in its duties to clearly identify fraud, collect monies that should be returned to the State and require changes in the audit process because of the conflict in regulatory language.

ADMINISTRATIVE IMPLICATIONS

CYFD reported in its earlier analysis that its divisions heavily utilize Medicaid behavioral health providers, and when one or more are subject to such a suspension, services to CYFD clients in that catchment area are disrupted. When necessary services are unavailable there is a decrease in reunification of children with their families and an increase in commitments to juvenile justice facilities.

Additionally, when a behavioral health provider goes out of business and another provider assumes responsibility for service delivery, CYFD-Behavioral Health Services Licensing and Certification must immediately respond to minimize disruption of services and ensure that services are adequate and delivered by properly trained, licensed, and cleared staff. It must credential any new providers and existing survey schedules are disrupted, resulting in delays for licensure and certification of other provider agencies.

HSD will be required to amend its rules, including the definitions of credible allegation of fraud and overpayment, and clarifying what constitutes Medicaid fraud. It notes that this bill conflicts with federal requirements in several ways that will create confusion in administering the affected programs.

AMENDMENTS

HSD suggests amending Section 4 to require that once a credible allegation of fraud is determined on any basis, including possible overpayment, HSD shall comply with 42 CFR §455.23 with respect to suspension of payments, but that a good cause exception may be made in the event the provider posts a bond in an amount equivalent to the suspended payments and adequate assurances are given regarding rendering of services prospectively.

Additionally, HSD suggests amending the language in Section 7(B)(4), lines 12-13 to read "advertent failure to maintain complete records of credentialing, licensure, or training," so that "records" modifies all three categories, and makes it clear that representing credentials, licenses, or required training to be current when they are not current does constitute fraud under the federal definition.

MD/aml