LEGISLATURE OF THE STATE OF IDAHO

Sixty-third Legislature Second Regular Session - 2016

IN THE SENATE

SENATE BILL NO. 1295

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; AMENDING SECTION 56-209h, IDAHO CODE, TO REVISE PROVISIONS REGARDING CIVIL MONETARY PENALTIES FOR PROVIDERS AND TO MAKE TECHNICAL CORRECTIONS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 56-209h, Idaho Code, be, and the same is hereby amended to read as follows:

56-209h. ADMINISTRATIVE REMEDIES. (1) Definitions. For purposes of this section:

(a) "Abuse" or "abusive" means provider practices that are inconsistent with sound fiscal, business, child care or medical practices, and result in an unnecessary cost to a public assistance program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a public assistance recipient.

(b) "Claim" means any request or demand for payment, or document submitted to initiate payment, for items or services provided under a public assistance program, whether under a contract or otherwise.

(c) "Fraud" or "fraudulent" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

(d) "Intentional program violation" means intentionally false or misleading action, omission or statement made in order to qualify as a provider or recipient in a public assistance program.

(e) "Knowingly," "known" or "with knowledge" means that a person, with respect to information or an action:

(i) Has actual knowledge of the information or action; or

(ii) Acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or

(iii) Acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action.

(f) "Managing employee" means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization or agency.

(g) "Medicaid fraud control unit" means that medicaid fraud control unit as provided for in section 56-226, Idaho Code.

(h) "Ownership or control interest" means a person or entity that:

(i) Has an ownership interest totaling twenty-five percent (25%) or more in an entity; or

(ii) Is an officer or director of an entity that is organized as a corporation; or

(iii) Is a partner in an entity that is organized as a partnership; or

(iv) Is a managing member in an entity that is organized as a limited liability company.

(i) "Provider" means an individual, organization, agency or other entity providing items or services under a public assistance program.

(j) "Public assistance program" means assistance for which provision is made in any federal or state law existing or hereafter enacted by the state of Idaho or the congress of the United States by which payments are made from the federal government to the state in aid, or in respect to payment by the state for welfare purposes to any category of needy person, and any other program of assistance for which provision for federal or state funds for aid may from time to time be made.

(2) The department shall establish and operate an administrative fraud control program to enforce violations of the provisions of this chapter and of the state plan pursuant to subchapters XIX and XXI, chapter 7, title 42, U.S.C., that are outside the scope of the duties of the medicaid fraud control unit and to render and receive referrals from and to said unit.

(3) Review of documentation of services. All claims submitted by providers for payment are subject to prepayment and postpayment review as designated by rule. Except as otherwise provided by rule, providers shall generate documentation at the time of service sufficient to support each claim, and shall retain the documentation for a minimum of five (5) years from the date the item or service was provided. The department or authorized agent shall be given immediate access to such documentation upon written request.

(4) Immediate action. In the event that the department identifies a suspected case of fraud or abuse and the department has reason to believe that payments made during the investigation may be difficult or impractical to recover, the department may suspend or withhold payments to the provider pending investigation. In the event that the department identifies a suspected case of fraud or abuse and it determines that it is necessary to prevent or avoid immediate danger to the public health or safety, the department may summarily suspend a provider agreement pending investigation. When payments have been suspended or withheld or a provider agreement suspended pending investigation, the department shall provide for a hearing within thirty (30) days of receipt of any duly filed notice of appeal.

(5) Recovery of payments. Upon referral of a matter from the medicaid fraud control unit, or if it is determined by the department that any condition of payment contained in rule, regulation, statute, or provider agreement was not met, the department may initiate administrative proceedings to recover any payments made for items or services under any public assistance contract or provider agreement the individual or entity has with the department. Interest shall accrue on overpayments at the statutory rate set forth in section 28-22-104, Idaho Code, from the date of final determination of the amount owed for items or services until the date of recovery.

(6) Provider status. The department may terminate the provider agreement or otherwise deny provider status to any individual or entity who:

(a) Submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in

a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item and amount is specifically identified; or

(b) Submits a fraudulent claim; or

(c) Knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the department; or

(d) Submits a claim for an item or service known to be medically unnecessary; or

(e) Fails to provide, upon written request by the department, immediate access to documentation required to be maintained; or

(f) Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments or other public assistance program payments; or

(g) Knowingly violates any material term or condition of its provider agreement; or

(h) Has failed to repay, or was a "managing employee" or had an "ownership or control interest" in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation or provider agreement; or

(i) Has been found, or was a "managing employee" in any entity ~~which~~ that has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care or public assistance items or services; or

(j) Fails to meet the qualifications specifically required by rule or by any applicable licensing board.

Any individual or entity denied provider status under this section may be precluded from participating as a provider in any public assistance program for up to five (5) years from the date the department's action becomes final.

(7) The department must refer all cases of suspected medicaid provider fraud to the medicaid fraud control unit and shall promptly comply with any request from the medicaid fraud control unit for access to and free copies of any records or information kept by the department or its contractors, computerized data stored by the department or its contractors, and any information kept by providers to which the department is authorized access by law.

(8) Civil monetary penalties. The department may also assess civil monetary penalties against a provider and any officer, director, owner, and/or managing employee of a provider in the circumstances listed in paragraphs (a) and (b) of this subsection. The penalties provided for in this subsection are intended to be remedial, recovering, at a minimum, costs of investigation and administrative review, and placing the costs associated with noncompliance on the offending provider. The department shall promulgate rules clarifying the methodology used when computing and assessing a civil monetary penalty.

(a) F~~f~~or conduct identified in subsection~~s~~ (6)(a) through ~~(6)~~(i) of this section~~. T~~, the amount of the penalties shall be up to one thousand dollars ($1,000) for each item or service improperly claimed, except that in the case of multiple penalties the department may reduce the penalties to not less than ~~twenty-five~~ ten percent (~~25~~10%) of the amount of each item or service improperly claimed if an amount can be readily

determined. Each line item of a claim, or cost on a cost report is considered a separate claim.

(b) For failing to perform required background checks or failing to meet required timelines for completion of background checks, the amount of the penalty shall be five hundred dollars ($500) for each month worked for each staff person for whom the background check was not performed or not timely performed up to a maximum of five thousand dollars ($5,000) per month. A partial month is considered a full month for purposes of determining the amount of the penalty.

~~These penalties are intended to be remedial, recovering at a minimum costs of investigation and administrative review, and placing the costs associated with noncompliance on the offending provider.~~

(9) Exclusion. Any individual or entity convicted of a criminal offense related to the delivery of an item or service under any state or federal program shall be excluded from program participation as a medicaid provider for a period of not less than ten (10) years. Unless otherwise provided in this section or required by federal law, the department may exclude any individual or entity for a period of not less than one (1) year for any conduct for which the secretary of the department of health and human services or designee could exclude an individual or entity.

(10) Sanction of individuals or entities. The department may sanction individuals or entities by barring them from public assistance programs for intentional program violations where the federal law allows sanctioning individuals from receiving assistance. Individuals or entities who are determined to have committed an intentional program violation will be sanctioned from receiving public assistance for a period of twelve (12) months for the first violation, twenty-four (24) months for the second violation and permanently for the third violation.

(11) Individuals or entities subject to administrative remedies as described in subsections (4) through (10) of this section shall be provided the opportunity to appeal pursuant to chapter 52, title 67, Idaho Code, and the department's rules for contested cases.

(12) Adoption of rules. The department shall promulgate such rules as are necessary to carry out the policies and purposes of this section.