

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 RE-
VISE 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 inconsis-
tent with sound fiscal, business, child care or medical practices, and
result in an unnecessary cost to a public assistance program, in reim-
bursement for services that are not medically necessary or that fail to
meet professionally recognized standards for health care, or in physi-
cal harm, pain or mental anguish to a public assistance recipient.

(b) "Claim" means any request or demand for payment, or document sub-
mitted to initiate payment, for items or services provided under a pub-
lic assistance program, whether under a contract or otherwise.

(c) "Fraud" or "fraudulent" means an intentional deception or misrep-
resentation 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 mis-
leading 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 in-
formation 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

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

3 (iv) Is a managing member in an entity that is organized as a lim-
4 ited liability company.

5 (i) "Provider" means an individual, organization, agency or other en-
6 tity providing items or services under a public assistance program.

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

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

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

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

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

47 (6) Provider status. The department may terminate the provider agree-
48 ment or otherwise deny provider status to any individual or entity who:

49 (a) Submits a claim with knowledge that the claim is incorrect, includ-
50 ing reporting costs as allowable which were known to be disallowed in

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

4 (b) Submits a fraudulent claim; or

5 (c) Knowingly makes a false statement or representation of material
6 fact in any document required to be maintained or submitted to the de-
7 partment; or

8 (d) Submits a claim for an item or service known to be medically unnec-
9 essary; or

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

12 (f) Fails repeatedly or substantially to comply with the rules and reg-
13 ulations governing medical assistance payments or other public assis-
14 tance program payments; or

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

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

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

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

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

30 (7) The department must refer all cases of suspected medicaid provider
31 fraud to the medicaid fraud control unit and shall promptly comply with any
32 request from the medicaid fraud control unit for access to and free copies of
33 any records or information kept by the department or its contractors, com-
34 puterized data stored by the department or its contractors, and any informa-
35 tion kept by providers to which the department is authorized access by law.

36 (8) Civil monetary penalties. The department may also assess civil
37 monetary penalties against a provider and any officer, director, owner,
38 and/or managing employee of a provider in the circumstances listed in para-
39 graphs (a) and (b) of this subsection. The penalties provided for in this
40 subsection are intended to be remedial, recovering, at a minimum, costs of
41 investigation and administrative review, and placing the costs associated
42 with noncompliance on the offending provider. The department shall promul-
43 gate rules clarifying the methodology used when computing and assessing a
44 civil monetary penalty.

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

1 determined. Each line item of a claim, or cost on a cost report is con-
2 sidered a separate claim.

3 (b) For failing to perform required background checks or failing to
4 meet required timelines for completion of background checks, the amount
5 of the penalty shall be five hundred dollars (\$500) for each month
6 worked for each staff person for whom the background check was not per-
7 formed or not timely performed up to a maximum of five thousand dollars
8 (\$5,000) per month. A partial month is considered a full month for pur-
9 poses of determining the amount of the penalty.

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

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

21 (10) Sanction of individuals or entities. The department may sanction
22 individuals or entities by barring them from public assistance programs for
23 intentional program violations where the federal law allows sanctioning in-
24 dividuals from receiving assistance. Individuals or entities who are deter-
25 mined to have committed an intentional program violation will be sanctioned
26 from receiving public assistance for a period of twelve (12) months for the
27 first violation, twenty-four (24) months for the second violation and perma-
28 nently for the third violation.

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

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