Senate Study Bill 1127 - Introduced

SENATE/HOUSE FILE _____
BY (PROPOSED DEPARTMENT OF HUMAN SERVICES BILL)

A BILL FOR

An Act relating to Medicaid program integrity, and providing penalties.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 10A.108, subsections 6 and 7, Code 2013, are amended to read as follows:

6. The department shall pay, from moneys appropriated to the department for this purpose, recording fees as provided in section 331.604, for the recording of the lien~~, or for satisfaction of the lien~~.

7. Upon payment of a debt for which the director has filed notice with a county recorder, the director shall ~~file a~~ provide to the debtor a satisfaction of the debt. The debtor shall be responsible for filing the satisfaction of the debt with the recorder and the recorder shall enter the satisfaction on the notice on file in the recorder's office.

Sec. 2. Section 249A.2, Code 2013, is amended by adding the following new subsection:

NEW SUBSECTION. 8A. *"Overpayment"* means any funds that a provider receives or retains under the medical assistance program to which the person, after applicable reconciliation, is not entitled. For purposes of repayment, an overpayment may include interest in accordance with section 249A.41.

Sec. 3. NEW SECTION. **249A.39 Reporting of overpayment.**

1. A provider who has received an overpayment shall notify in writing, and return the overpayment to, the department, the department's agent, or the department's contractor, as appropriate. The notification shall include the reason for the return of the overpayment.

2. Notification and return of an overpayment under this section shall be provided by no later than the earlier of either of the following, as applicable:

a. The date which is sixty days after the date on which the overpayment was identified by the provider.

b. The date any corresponding cost report is due.

3. A violation of this section is a violation of chapter 685.

Sec. 4. NEW SECTION. **249A.40 Dissolved providers —— overpayments or incorrect payments.**

Medical assistance paid to a provider following administrative dissolution of the provider pursuant to chapter 490, division XIV, part B, shall be considered incorrectly paid for the purposes of section 249A.5 and the provider shall be considered to have received an overpayment for the purposes of this subchapter. Notwithstanding section 490.1422, or any other similar retroactive provision for reinstatement, the director shall recoup any medical assistance paid to a provider while the provider was dissolved. The principals of the provider shall be personally liable for the incorrect payment or overpayment.

Sec. 5. NEW SECTION. **249A.41 Overpayment — interest.**

1. Interest may be collected upon any overpayment determined to have been made and shall accrue at the rate and in the manner specified in this section.

2. Prior to the provision of a notice of overpayment to the provider pursuant to section 249A.30, interest shall accrue at the statutory rate for prejudgment interest applicable in civil actions.

3. After the provision of a notice of overpayment to the provider, interest shall accrue at the statutory rate for prejudgment interest applicable in civil actions plus five percent per annum, or the maximum legal rate, whichever is lower.

4. At the discretion of the director, interest on an overpayment may be waived in whole or in part when the department determines the imposition of interest would produce an unjust result, would unduly burden the provider, or would substantially delay the prompt and efficient resolution of an outstanding audit or investigation.

Sec. 6. NEW SECTION. **249A.42 Overpayment — limitations periods.**

1. An administrative action to recover an overpayment to a provider shall be commenced within ten years of the date the overpayment was incurred.

2. An administrative action to impose a sanction related to an overpayment to a provider shall be commenced within five years of the date the conduct underlying the sanction concluded, or the director discovered such conduct, whichever is later.

Sec. 7. NEW SECTION. **249A.43 Provider overpayment — notice — judgment.**

1. Any overpayment to a provider under this chapter shall become a judgment against the provider, by operation of law, ninety days after the notice of overpayment is personally served upon the enrolled provider as required in the Iowa rules of civil procedure or by certified mail, return receipt requested, by the director or the attorney general. The judgment is entitled to full faith and credit in all states.

2. The notice of overpayment shall include the amount and cause of the overpayment, the provider's appeal rights, and a disclaimer that a judgment may be established if an appeal is not timely filed or if an appeal is filed and at the conclusion of the administrative process under chapter 17A a determination is made that there is an overpayment.

3. An affidavit of service of a notice of entry of judgment shall be made by first class mail at the address where the debtor was served with the notice of overpayment. Service is completed upon mailing as specified in this paragraph.

4. On or after the date an unpaid overpayment becomes a judgment by operation of law, the director or the attorney general may file all of the following with the district court:

a. A statement identifying, or a copy of, the notice of overpayment.

b. Proof of service of the notice of overpayment.

c. An affidavit of default, stating the full name, occupation, place of residence, and last known post office address of the debtor; the name and post office address of the department; the date or dates the overpayment was incurred; the program under which the debtor was overpaid; and the total

amount of the judgment.

5. Nothing in this section shall be construed to impede or restrict alternative methods of recovery of the overpayments specified in this section or of overpayments which do not meet the requirements of this section.

Sec. 8. NEW SECTION. **249A.44 Overpayment — emergency relief.**

1. Concurrently with a withholding of payment, the imposition of a sanction, or the institution of a criminal, civil, or administrative proceeding against a provider or other person for overpayment, the director or the attorney general may bring an action for a temporary restraining order or injunctive relief to prevent a provider or other person from whom recovery may be sought, from transferring property or otherwise taking action to protect the provider's or other person's business inconsistent with the recovery sought.

2. To obtain such relief, the director or the attorney general shall demonstrate all necessary requirements for the relief to be granted.

3. If an injunction is granted, the court may appoint a receiver to protect the property and business of the provider or other person from whom recovery may be sought. The court shall assess the costs of the receiver to the provider or other person.

4. The director or the attorney general may file a lis pendens on the property of the provider or other person during the pendency of a criminal, civil, or administrative proceeding.

5. When requested by the court, the director, or the attorney general, a provider or other person from whom recovery may be sought shall have an affirmative duty to fully disclose all property and liabilities to the requester.

6. An action brought under this section may be brought in the district court for Polk county or any other county in which a provider or other person from whom recovery may be sought has

its principal place of business or is domiciled.

Sec. 9. NEW SECTION. **249A.45 Provider's third-party submissions.**

1. The department may refuse to accept a financial and statistical report, cost report, or any other submission from any third party acting under a provider's authority or direction to prepare or submit such documents or information, for good cause shown. For the purposes of this section, *"good cause"*, includes but is not limited to a pattern or practice of submitting unallowable costs on cost reports; making a false statement or certification to the director or any representative of the department; professional negligence or other demonstrated lack of knowledge of the cost reporting process; conviction under a federal or state law relating to the operation of a publicly funded program; or submission of a false claim under chapter 685.

2. If the department refuses to accept a cost report from a third party for good cause under this section, the third party shall be strictly liable to the provider for all fees incurred in preparation of the cost report, as well as reasonable attorney fees and costs. The department shall not take any adverse action against a provider that results from the unintentional delay in the submission of a new cost report or other submission necessitated by the department's refusal to accept a cost report or other submission under this section.

Sec. 10. NEW SECTION. **249A.46 Liability of other persons — repayment of claims.**

1. The department may require repayment of medical assistance paid from the person submitting an incorrect or improper claim, the person causing the claim to be submitted, or the person receiving payment for the claim.

2. The department may require repayment of medical assistance paid for inappropriate, improper, unnecessary, or excessive care, services, or supplies from the person furnishing the care, services, or supplies; the person

under whose supervision the care, services, or supplies were furnished; or the person causing the care, services, or supplies to be furnished. In such an instance, the department may recover the amount paid for such care, services, or supplies from the person ordering or prescribing the care, services, or supplies, even though payment was made to another person. Medical care, services, or supplies ordered or prescribed shall be considered excessive or not medically necessary unless the medical basis and specific need for the care, services, or supplies are fully and properly documented in the client's medical record.

3. Any person furnishing, or supervising the furnishing of, medical care, services, or supplies is jointly and severally liable for any overpayments resulting from the furnishing of the care, services, or supplies. The amount of repayment which may be recovered from any person under this section is the amount paid for furnishing the medical care, services, or supplies, plus the amount paid to any other person as a result of the person's ordering or prescribing medical care, services, or supplies, less any amount actually recovered from any other person which relates to the care, services, or supplies for which repayment is sought.

4. Nothing in this section shall be construed to impede or restrict alternative recovery methods for claims specified in this section or claims which do not meet the requirements of this section.

Sec. 11. NEW SECTION. **249A.47 Improperly filed claims — other violations — imposition of monetary recovery and sanctions.**

1. In addition to any other remedies or penalties prescribed by law, including but not limited to those specified pursuant to section 249A.8 or chapter 685, all of the following shall be applicable to violations under the medical assistance program:

a. A person who knowingly presents or causes to be presented to the department a claim that the department determines meets

any of the following criteria is subject to a civil penalty of not more than ten thousand dollars for each item or service:

(1) A claim for medical or other items or services that the provider knows or should have known was not provided as claimed, including a claim by any provider who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a billing code that the provider knows or should have known will result in a greater payment to the provider than the billing code the provider knows or should have known is applicable to the item or service actually provided.

(2) A claim for medical or other items or services the provider knows or should have known to be false or fraudulent.

(3) A claim for a physician service or an item or service incident to a physician service by a person who knows or should have known that the individual who furnished or supervised the furnishing of the service meets any of the following:

(a) Was not licensed as a physician.

(b) Was licensed as a physician, but such license had been obtained through a misrepresentation of material fact.

(c) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified.

(4) A claim for medical or other items or services furnished during a period in which the provider was excluded from providing such items or services.

(5) A claim for a pattern of medical or other items or services that a provider knows or should have known were not medically necessary.

b. A provider who knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of either of the following is subject to a civil penalty of not more than ten thousand dollars for each item or service:

(1) An agreement with the department or a requirement of a state plan under Tit. XIX or XXI of the federal Social Security Act not to charge a person for an item or service in excess of the amount permitted to be charged.

(2) An agreement to be a participating provider.

c. A provider who is not an organization, agency, or other entity, and knowing that the provider is excluded from participating in a program under Tit. XVIII, XIX, or XXI of the federal Social Security Act at the time of the exclusion, who does any of the following, is subject to a civil penalty of ten thousand dollars for each day that the prohibited relationship occurs:

(1) Retains a direct or indirect ownership or control interest in an entity that is participating in such programs, and knows or should have known of the action constituting the basis for the exclusion.

(2) Is an officer or managing employee of such an entity.

d. A provider who knowingly offers to or transfers remuneration to any individual eligible for benefits under Tit. XIX or XXI of the federal Social Security Act and who knows or should have known such offer or remuneration is likely to influence such individual to order or receive from a particular provider any item or service for which payment may be made, in whole or in part, under Tit. XIX or XXI of the federal Social Security Act, is subject to a civil penalty of not more than ten thousand dollars for each item or service.

e. A provider who knowingly arranges or contracts, by employment or otherwise, with an individual or entity that the provider knows or should have known is excluded from participation under Tit. XVIII, XIX, or XXI of the federal Social Security Act, for the provision of items or services for which payment may be made under such titles, is subject to a civil penalty of not more than ten thousand dollars for each item or service.

f. A provider who knowingly offers, pays, solicits, or

receives payment, directly or indirectly, to reduce or limit services provided to any individual eligible for benefits under Tit. XVIII, XIX, or XXI of the federal Social Security Act, is subject to a civil penalty of not more than fifty thousand dollars for each act.

g. A provider who knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under Tit. XIX or XXI of the federal Social Security Act, is subject to a civil penalty of not more than fifty thousand dollars for each false record or statement.

h. A provider who knowingly fails to grant timely access, upon reasonable request, to the department for the purpose of audits, investigations, evaluations, or other functions of the department, is subject to a civil penalty of fifteen thousand dollars for each day of the failure.

i. A provider who knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under Tit. XVIII, XIX, or XXI of the federal Social Security Act, including a managed care organization or entity that applies to participate as a provider of services or supplier in such a managed care organization or plan, is subject to a civil penalty of fifty thousand dollars for each false statement, omission, or misrepresentation of a material fact.

j. A provider who knows of an overpayment and does not report and return the overpayment in accordance with section 249A.41 is subject to a civil penalty of ten thousand dollars for each failure to report and return an overpayment.

2. In addition to the civil penalties prescribed under subsection 1, for any violation specified in subsection 1, a provider shall be subject to the following, as applicable:

a. For violations specified in subsection 1, paragraph *"a"*, *"b"*, *"c"*, *"d"*, *"e"*, *"g"*, *"h"*, or *"j"*, an assessment of not

more than three times the amount claimed for each such item or service in lieu of damages sustained by the department because of such claim.

b. For a violation specified in subsection 1, paragraph *"f"*, damages of not more than three times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose.

c. For a violation specified in subsection 1, paragraph *"i"*, an assessment of not more than three times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement, omission, or misrepresentation of a material fact.

3. In determining the amount or scope of any penalty or assessment imposed pursuant to a violation specified in subsection 1, the director shall consider all of the following:

a. The nature of the claims and the circumstances under which they were presented.

b. The degree of culpability, history of prior offenses, and financial condition of the person against whom the penalties or assessments are levied.

c. Such other matters as justice may require.

4. Of any amount recovered arising out of a claim under Tit. XIX or XXI of the federal Social Security Act, the department shall receive the amount bearing the same proportion paid by the department for such claims, including any federal share that must be returned to the centers for Medicare and Medicaid services of the United States department of human services. The remainder of any amount recovered shall be deposited in the general fund of the state.

5. Civil penalties levied under this section are appealable under 441 IAC ch. 7, but, notwithstanding any provision to the contrary in that chapter, the appellant shall bear the burden to prove by clear and convincing evidence that the claim was not filed improperly.

6. For the purposes of this section, *"claim"* includes but is not limited to the submission of a cost report.

Sec. 12. NEW SECTION. **249A.48 Costs.**

1. The department may seek recovery of investigative costs from any provider or other person who submits, or causes to be submitted, a claim for reimbursement for services the provider or other person knows or reasonably should have known would result in the incorrect payment of medical assistance. Investigative costs include but are not limited to the costs the department incurs in an audit and reasonable attorney fees. Investigative costs do not include billing errors that result in unintentional overcharges.

2. For the purposes of calculating a rate of payment for a provider, allowable costs shall not include professional fees, including but not limited to accountant or attorney fees, incurred by the provider relating to any proceeding or prospective proceeding relating to overpayment, sanction, or other medical assistance program integrity proceedings.

Sec. 13. NEW SECTION. **249A.49 Temporary moratoria.**

1. The Iowa Medicaid enterprise shall impose a temporary moratorium on the enrollment of new providers or provider types identified by the centers for Medicare and Medicaid services of the United States department of health and human services as posing an increased risk to the medical assistance program.

a. This section shall not be interpreted to require the Iowa Medicaid enterprise to impose a moratorium if the Iowa Medicaid enterprise determines that imposition of a temporary moratorium would adversely affect access of recipients to medical assistance services.

b. If the Iowa Medicaid enterprise makes a determination as specified in paragraph *"a"*, the Iowa Medicaid enterprise shall notify the centers for Medicare and Medicaid services of the United States department of health and human services in writing.

2. The Iowa Medicaid enterprise may impose a temporary

moratorium on the enrollment of new providers, or impose numerical caps or other limits that the Iowa Medicaid enterprise and the centers for Medicare and Medicaid services identify as having a significant potential for fraud, waste, or abuse.

a. Before implementing the moratorium, caps, or other limits, the Iowa Medicaid enterprise shall determine that its action would not adversely impact access by recipients to medical assistance services.

b. The Iowa Medicaid enterprise shall notify, in writing, the centers for Medicare and Medicaid services, if the Iowa Medicaid enterprise seeks to impose a moratorium under this subsection, including all of the details of the moratorium. The Iowa Medicaid enterprise shall receive approval from the centers for Medicare and Medicaid services prior to imposing a moratorium under this subsection.

3. *a.* The Iowa Medicaid enterprise shall impose any moratorium for an initial period of six months.

b. If the Iowa Medicaid enterprise determines that it is necessary, the Iowa Medicaid enterprise may extend the moratorium in six-month increments. Each time a moratorium is extended, the Iowa Medicaid enterprise shall document, in writing, the necessity for extending the moratorium.

Sec. 14. NEW SECTION. **249A.50 Internet site — providers found in violation of medical assistance program.**

1. The director shall maintain on the department's internet site, in a manner readily accessible by the public, all of the following:

a. A list of all providers that the department has terminated, suspended, placed on probation, or otherwise sanctioned.

b. A list of all providers that have failed to return an identified overpayment of medical assistance within the time frame specified in section 249A.41.

c. A list of all providers found liable for a false claims

law violation related to the medical assistance program under chapter 685.

2. The director shall take all appropriate measures to safeguard the protected health information, social security numbers, and other information of the individuals involved, which may be redacted or omitted as provided in rule of civil procedure 1.422. A provider shall not be included on the internet site until all administrative and judicial remedies relating to the violation have been exhausted.

Sec. 15. CODE EDITOR DIRECTIVES. The Code editor shall do all of the following:

1. Create a new subchapter in chapter 249A, entitled "Medical Assistance Eligibility and Miscellaneous Provisions", which shall include sections 249A.1 through 249A.4, section 249A.4B, sections 249A.9 through 249A.13, sections 249A.15 through 249A.18A, and sections 249A.20 through 249A.38, Code 2013. The Code editor may renumber sections within the subchapter and shall correct internal references as necessary.

2. Create a new subchapter in chapter 249A, entitled "Medical Assistance Program Integrity", which shall include sections 249A.39 through 249A.50, as enacted in this Act.

3. a. Transfer section 249A.4A, sections 249A.5 through 249A.8, section 249A.14, and section 249A.19, Code 2013, to the new subchapter entitled "Medical Assistance Program Integrity". The Code editor shall renumber the transferred sections as follows:

(1) Section 249A.4A as section 249A.53.

(2) Section 249A.5 as section 249A.54.

(3) Section 249A.6 as section 249A.55.

(4) Section 249A.6A as section 249A.56.

(5) Section 249A.7 as section 249A.51.

(6) Section 249A.8 as section 249A.52.

(7) Section 249A.14 as section 249A.57.

(8) Section 249A.19 as section 249A.58.

b. The Code editor shall correct internal references as

necessary.

EXPLANATION

This bill relates to medical assistance (Medicaid) program integrity.

The bill amends Code section 10A.108, which provides that if a person refuses or neglects to repay benefits or provider payments inappropriately obtained from the department of human services (DHS), the amount inappropriately obtained constitutes a debt and is a lien in favor of the state upon all property belonging to the person. The bill provides that DHS is no longer responsible for paying the fee for recording of the satisfaction of the lien or the debt, but that this is the responsibility of the debtor.

The bill requires a provider who has received an overpayment to provide notification in writing and return the overpayment to the department, department's agent, or the department's contractor, as applicable. The notification and return of the overpayment are to be completed the earlier of 60 days after the date on which the overpayment was identified by the provider or the date any corresponding cost report is due, as applicable. Violation of this provision constitutes a violation of the false claims Act (Code chapter 685).

The bill provides that if a provider is administratively dissolved and receives payments following the dissolution, the payments are considered to be overpayments and to be incorrectly paid.

The bill provides for the accrual of interest on, and the rate of interest applicable to, overpayments.

The bill requires that an administrative action to recover an overpayment be commenced within 10 years of the date the overpayment occurred. An administrative action to impose a sanction on a provider related to an overpayment must be commenced within five years of the date the conduct underlying the sanction concluded, or the director of human services discovered such conduct, whichever is first.

The bill provides a process to establish a judgment by operation of law for any overpayment to a Medicaid provider 90 days after the notice of overpayment is served upon the provider.

The bill provides for emergency relief relating to overpayments to Medicaid providers or others. The bill provides that the director of human services or the attorney general may bring an action for a temporary restraining order or injunctive relief to prevent a provider or other person from transferring property or otherwise taking actions to protect the provider's or other person's business inconsistent with the recovery being sought.

The bill authorizes DHS to refuse to accept financial and statistical reports, cost reports, and other submissions from third parties acting under the authority or direction of a provider for good cause, and defines "good cause". If DHS refuses to accept a submission from such a third party, the third party is strictly liable to the provider for all fees incurred, attorney fees, and other costs. The bill provides that DHS shall not take any adverse action against the provider under circumstance that result from any unintentional delay on the part of the provider in submitting a new submission.

The bill provides for repayment by persons other than the provider for improper payments including the person submitting an incorrect or improper claim, the person causing the claim to be submitted, or the person receiving payment for the claim. The bill also provides that DHS may require repayment for inappropriate, improper, unnecessary, or excessive care, services, or supplies from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished. Any person furnishing, or supervising the furnishing of, medical care, services, or supplies is jointly and severally liable for any overpayments resulting from the furnishing of the care, services, or supplies.

The bill provides specific civil penalties and assessments or damages for improperly filed claims and other violations relating to improper reimbursement under the Medicaid program.

The bill authorizes the department to recover investigative costs from any provider or other person who submits, or causes to be submitted, a claim for reimbursement for services the provider or other person knows or reasonably should have known would result in the incorrect payment of medical assistance. The bill also provides that in calculating a rate of payment for a provider, allowable costs do not include professional fees incurred by the provider relating to any Medicaid program integrity proceeding.

The bill directs the Iowa Medicaid enterprise (IME) to impose temporary moratoria on enrollment of new providers or provider types identified by the centers for Medicare and Medicaid services of the United States department of health and human services (CMS) as posing an increased risk to the Medicaid program. The moratoria are not required if the IME determines that imposition of a temporary moratorium would adversely affect access of recipients to Medicaid services. However, if the IME makes such a determination, IME is to notify CMS in writing. The bill also authorizes IME to impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that the IME and CMS identify as having a significant potential for fraud, waste, or abuse. Before implementing the moratoria, caps, or other limits, IME must determine that its action would not adversely impact access by recipients to Medicaid services, notify CMS in writing, and receive approval from CMS. Any moratorium is to be imposed for an initial period of six months and may then be extended in six-month increments. The necessity for any extension is to be documented in writing.

The bill requires the director of human services to maintain on the department's internet site, in a manner readily accessible by the public, lists of all providers that the

department has terminated, suspended, placed on probation, or otherwise sanctioned; all providers that have failed to return an identified overpayment; and all providers found liable for a false claims law violation related to Medicaid.

The bill provides for all Medicaid program integrity provisions to be codified in a new subchapter under Code chapter 249A (medical assistance), including the new provisions enacted in the bill and existing provisions under Code sections 249A.4A (garnishment), 249A.5 (recovery of payment), 249A.6 (assignment —— lien), 249A.6A (restitution), 249A.7 (fraudulent practices —— investigations and audits —— Medicaid fraud fund), 249A.8 (fraudulent practice), 249A.14 (county attorney to enforce), and 249A.19 (health care facilities —— penalty).