INDEX

8.351.2 SANCTIONS AND REMEDIES

This page intentionally left blank.

TITLE 8 SOCIAL SERVICES
CHAPTER 351 SANCTIONS OR REMEDIES
PART 2 SANCTIONS AND REMEDIES

8.351.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.351.2.1 NMAC - Rn, 8 NMAC 4.MAD.0001, 7/1/03]

8.351.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.351.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 7/1/03]

8.351.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.351.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7/1/03]

8.351.2.4 DURATION: Permanent
[2/1/95; 8.351.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 7/1/03]

8.351.2.5 EFFECTIVE DATE: November 1, 1996
[11/1/96; 8.351.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7/1/03]

8.351.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.351.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7/1/03]

8.351.2.7 DEFINITIONS: [RESERVED]

8.351.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.351.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7/1/03]

8.351.2.9 SANCTIONS AND REMEDIES: The New Mexico human services department (HSD) is required to impose sanctions or penalties against providers for fraud, violations of federal or state law, violations of the HIPAA regulations, failure to meet professional standards of conduct, non-compliance with medicaid policies promulgated by the medical assistance division (MAD), violations of the Medicaid Provider Act, and/or other misconduct. See 42 CFR Part 455; Section 30-44-3 NMSA 1978 (Repl. Pamp. 1998). HSD is also required to recover overpayments made to medicaid providers. This part describes the types of sanctions and remedies which can be imposed by HSD.
[11/1/96; 8/1/99; 8.351.2.9.9 NMAC - Rn, 8 NMAC 4.MAD.960 & A, 7/1/03]

8.351.2.10 SANCTIONS: HSD is required to impose sanctions against providers for violation of the provisions outlined in the medical assistance program manual. HSD has discretion to impose monetary or non-monetary sanctions against providers for fraud or other forms of misconduct. See Subsection H of 8.351.2.11 NMAC, *Sanctions and Remedies for Noncompliance with Nursing Facility and Intermediate Care Facility Certification Requirements*.

A. **Provider fraud:** Fraud is the intentional misappropriation, deception or misrepresentation made by a provider with the knowledge that the deception could result in some unauthorized benefit to the provider or some other person and includes, but is not limited to, the following conduct as specified in the New Mexico Medicaid Fraud Act, Section 30-44-7(A) NMSA 1978:

(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 medicaid program;

(b) a rebate of a fee or charge made to a provider for referring a recipient to a provider;

(c) anything of value, with intent to retain it, and knowing it to be in excess of amounts authorized under the medicaid 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, with intent to retain it, and knowing it to be in excess of the rates established under the medicaid program for the provision of treatment, services or goods.

(2) providing the following 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 provider;

(b) treatment that is substantially inadequate when compared to generally recognized standards within the profession or industry; or

(c) merchandise that has been adulterated, debased or mislabelled or is outdated.

(3) presenting or causing to be presented for allowance or payments with intent that a claim be relied upon for the expenditure of public money, any false, fraudulent, excessive, multiple or incomplete claims for furnishing treatment, services or goods.

B. **Misconduct defined:** Provider misconduct includes, but is not limited to, any of the following:

(1) engaging in a course of conduct or performing an act that violates any provision of federal or state law or regulation including HIPAA, or continuation of conduct after receipt of notice that the conduct should cease;

(2) failure to meet federal or state licensing or certification standards required of the provider, including the revocation or suspension of a license, and/or to notify HSD of such failure;

(3) failure to correct deficiencies in provider operations within time limits specified by HSD or its designee after receiving written notice of these deficiencies;

(4) failure to maintain and retain any medical or business records as are necessary to verify the treatment or care of any client for which the provider received payment from HSD to provide that benefit or service, services or goods provided to any client for which the provider received payment from HSD, amounts paid of HSD on behalf of any client, and other records required by HSD for at least six (6) years from the date of creation or until ongoing audits are settled, whichever is longer;

(5) furnishing services to medicaid recipients or billing medicaid for services which fall outside the scope of the provider's practice or outside the scope of prescribed practice;

(6) failure to comply with the terms of the provider certification on the medicaid claim form;

(7) failure to provide complete, accurate, and current information on a medicaid provider participation agreement;

(8) breach of the terms of the medicaid provider participation agreement;

(9) failure to provide or maintain services which meet professionally recognized standards of care and quality;

(10) engaging in negligent or abusive practices which result in death or physical, emotional, or psychological injury to recipients;

(11) failure to repay or make arrangements to repay identified overpayments;

(12) failure to make records available upon request to HSD or its designees;

(13) violation of any laws, regulations or code of ethics governing the conduct of providers;

(14) convicted of crimes relating to the neglect or abuse of patients;

(15) conviction of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(16) convicted of program-related crimes under medicare and/or any other programs administered by the federal government or any state health care program or suspension or termination of a provider's participation by this or another state's medicaid agency;

(17) seeking payment from a medicaid client or any financially responsible relative or representative of that client for services furnished to the client, except as allowed and specifically delineated by HSD;

(18) refusing to furnish services to a medicaid recipient because he/she has HMO or health coverage from another insurer which is liable for payment; or

(19) advising a medicaid recipient to terminate his/her HMO or health care coverage.

C. **Violation of Medicaid Provider Act:** Violations of the Medicaid Provider Act include the following:

(1) material breach of a provider's obligation to furnish medicaid services to clients or any other duty specified under the terms of the medical assistance division provider participation agreement;

(2) violation of any provision of the Public Assistance Act or the Medicaid Provider Act or any rules issued pursuant to those Acts;

(3) provider intentionally or with reckless disregard made false statements with respect to any report or statement required by the Public Assistance Act, Medicaid Provider Act or rules issued pursuant to either of those Acts;

(4) provider intentionally or with reckless disregard advertised or marketed or attempted to advertise or market, services to clients in a manner to misrepresent its service or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing;

(5) provider hindered or prevented the secretary of the human services department from performing any duty imposed by the Public Assistance Act, the Human Services Act, the Medicaid Provider Act or any rules issued pursuant to those Acts; or

(6) provider fraudulently procured or attempted to procure any benefit from HSD.

[11/1/96; 8/1/99; 8.351.2.10 NMAC - Rn, 8 NMAC 4.MAD.961 & A, 7/1/03]

8.351.2.11 TYPES OF SANCTIONS: HSD is allowed to impose monetary or non-monetary sanctions against any medicaid provider for misconduct. HSD is required to impose certain sanctions against medicaid providers for fraud, HIPAA violations, and other actions.

A. **Prior approval:** As a condition of medicaid payment, HSD can require providers to obtain prior approval before delivering all or certain services. The prior approval requests must be submitted to the MAD utilization review (UR) contractor or UR agent in a manner prescribed for general utilization review. Failure to obtain prior approval prior to furnishing service may result in imposition of sanctions. In addition, MAD may sanction a provider by requiring that provider to obtain prior approval before furnishing all or certain services, even if other providers may furnish that service without the requirement of obtaining prior approval from MAD. See Section 8.302.5 NMAC, *Prior Approval and Utilization Review*.

B. **Education:** As a condition of medicaid payment, HSD can require a provider to attend an educational program if misconduct could be remedied with the provision of identified education. HSD may also require a provider who is seeking reinstatement to attend an educational program prior to the approval of the new application. Provider education programs may include, but are not limited to, the following:

(1) claim form completion;
(2) use and format of the MAD provider policy manual;
(3) use of procedure codes;
(4) substantive provisions of the New Mexico medicaid program;
(5) reimbursement rates;
(6) assistance in claims coding and billing; and
(7) continuing medical education.

C. **Closed-end agreements:** HSD can transfer the provider to a closed-end provider agreement. A closed-end medicaid provider participation agreement is an agreement for a specified period of time which terminates on a defined date not to exceed twelve (12) months. At the end of this term, a new provider agreement must be executed for continued medicaid participation.

D. **Suspension:** "Suspension" is an exclusion from participation in the medicaid program for a specified period or time.

(1) **Medicaid suspension:** HSD may suspend a provider from medicaid participation for misconduct or fraud.

(a) HSD is permitted to suspend a provider for up to thirty-six (36) months. The period of suspension is not less than the term of any court-imposed suspension.

(b) If the suspension is imposed by medicaid, the effective date of the medicaid suspension is the date of the notice of suspension. If the suspension is concurrent with a court-imposed suspension, the effective date is the date of the court-imposed suspension.

(2) **Medicare suspension:** HSD must suspend a provider who is suspended by medicare or any other federal or state-funded health program.

(a) HSD is required to suspend a provider for the suspension term imposed by the medicare program or other federal or state-funded health programs.

(b) When the medicaid suspension is concurrent with a medicare suspension, the effective date of the medicaid suspension is the same day as the medicare suspension.

(3) **Special exception for health manpower shortage areas:** After assessing the nature of the violation or misconduct, HSD has the option of requesting action from the secretary of the federal department of health and human services (DHHS) if the suspension of a provider would result in the lack of adequate medical services for recipients in a given area. The secretary can be asked to:

(a) designate the community as a health manpower shortage area and place national health services corps personnel in the community; and/or

(b) waive the provider's suspension based upon submission of adequate documentation that the suspension would deprive the community of needed medical services because of a shortage of practitioners in the area.

(4) **Submission of claims following suspension:**

(a) If a provider is suspended from participation in the medicaid program, the provider is prohibited from submitting claims for payment to the MAD claims processing contractor.

(b) HSD will not pay claims submitted by clinics, groups, corporations, associations or other entities associated with a provider who is suspended from participation in the medicaid programs for services furnished by such provider after the effective date of the suspension.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the suspension can be submitted. The claims may be subject to pre-payment review.

(5) **Reinstatement:** Providers can apply for reinstatement at the end of a suspension period. Reinstatement is not automatic or guaranteed. A provider must furnish written documentation that he/she meets all relevant licensing, certification, or register requirement as specified by HSD, children, youth and families department, or department of health.

E. **Termination:** "Termination" is the termination of the provider's medicaid provider participation agreement for a specified period of time. HSD must terminate the agreement in certain specified instances and is permitted to terminate the agreement in other instances.

(1) **Mandatory termination:** HSD must terminate the agreement when any of the following events occur:

(a) provider is convicted of medicaid or medicare fraud;

(b) provider has a previous suspension from medicaid with failure to correct identified deficiencies; or

(c) provider is terminated from participation in the medicare program or another federal or state-funded health program.

(2) **Discretionary termination:** HSD may terminate the agreement when the violation(s) is so egregious, in the discretionary opinion of HSD, that other sanctions are not sufficient to address, reduce or eliminate the violation(s) or when the identified deficiency or violation(s) reflect a pattern of violation.

(3) **Effective date of termination:** The effective date of medicaid termination is the date of conviction for medicaid or medicare fraud or the date of termination from the medicare program. If termination follows a prior suspension from the medicaid program or the termination is discretionary, the date of termination is set by HSD.

(4) **Termination of nursing facility or intermediate care facility provider agreement:**

(a) MAD can terminate an NF or ICF-MR provider agreement instead of or in addition to other alternative remedies. Termination can occur in the instances which include, but are not limited to, the following:

(i) immediate jeopardy to NF or ICF-MR resident's health and safety which have not been removed;

(ii) provider is not in substantial compliance with participation requirements regardless of whether immediate jeopardy to NF or ICF-MR residents is present;

(iii) provider fails to submit an acceptable plan of correction within the specified timeframes;

(iv) provider fails to relinquish control to temporary manager; or

(v) DOH recommends termination as the most appropriate remedy.

(b) Termination of the agreement ends payment to the NF or ICF-MR provider.

(c) Notwithstanding Subparagraph (b) of Paragraph (4) of Subsection E of 8.351.2.11 NMAC, payment to the NF or ICF-MR provider can be continued for up to thirty (30) calendar days after the effective date of the agreement termination if the following conditions are met:

(i) The payments are for NF or ICF-MR residents admitted to the NF or ICF-MR before the effective date of the agreement termination; and

(ii) MAD is making reasonable efforts to transfer those residents to other facilities or to alternate care.

(iii) For purposes of this provision, the thirty (30) day period begins on the effective date of the agreement termination by HCFA, MAD, or the NF or ICF-MR provider.

(d) Before termination of a NF or ICF-MR provider agreement, MAD must notify the provider

and the public at least fifteen (15) calendar days before the effective date of the termination with non-immediate jeopardy deficiencies that constitute the noncompliance. For termination due to deficiencies that pose immediate jeopardy to residents, MAD must notify the provider and the public at least two (2) working days before the effective date of the termination.

(e) If termination of provider agreement is chosen due to immediate jeopardy to NF or ICF-MR residents, the effective date of the termination is within twenty-three (23) calendar days of the last date of the survey.

(5) **Submission of claims following termination:**

(a) If a provider is terminated from participation in the medicaid program, the provider is prohibited from submitting claims for payment to the MAD claims processing contractor.

(b) HSD will not pay claims submitted by clinics, groups, corporations, associations, or other entities associated with a provider who is terminated from participation in the medicaid programs for services furnished by such provider after the effective date of the termination.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the termination can be submitted. The claims may be subject to pre-payment review.

(6) **Re-application for medicaid participation:** Providers must submit a new application after the end of the termination period to participate in medicaid. Providers must meet certification and licensing requirements specified by HSD, children, youth and families department, or department of health to be eligible to once again become a medicaid provider.

F. **Civil monetary penalties:** HSD is permitted to impose civil monetary penalties in addition to other penalties, in accordance with the Medicaid Fraud Act. See Section 30-44-1 et.seq. NMSA 1978.

(1) **Amount of penalty:** The provider is liable for the following:

(a) payment of interest on the amount received by the provider from MAD in excess of payment at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to HSD;

(b) a civil monetary penalty in an amount of up to two times the amount of such excess payment;

(c) a civil monetary penalty of $500 for each false or fraudulent claim submitted for furnishing treatment, services, or goods; and

(d) payment of legal fees and costs of investigation and enforcement of civil remedies.

(2) **Payment of penalty amounts:** Penalties and interest amounts must be remitted to the state. Any legal fees, costs of investigation and costs of enforcement of civil remedies recovered on behalf of the state must also be remitted to the state.

(3) **Criminal action:** The filing of a criminal action for violation of the Medicaid Fraud Act is not a condition precedent to HSD's imposition of civil monetary penalties.

G. **Reduction of payment:** HSD may reduce the amount of any payment due a provider, in addition to other sanctions, if the provider seeks to collect an amount in excess of the medicaid allowable amount from a medicaid recipient, his/her family or financially responsible relative or any other source. See 42 CFR Section 447.20 - 447.21.

(1) The reduction may be equal to up to three (3) times the amount that the provider sought to collect.

(2) For purposes of this provision, the "medicaid allowable amount" is equal to the amount payable under the state plan.

H. **Sanctions and remedies for noncompliance with nursing facility or intermediate care facility certification requirements:** The New Mexico medicaid program is required to impose additional remedies against nursing facility (NF) providers who fail to comply with federal and state medicaid participation requirements with respect to licensing and certification. One or more of the following remedies can be imposed by MAD for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance: termination of the NF provider's medicaid provider participation agreement; temporary management; denial of payment for new admissions; civil money penalties; NF closure and/or transfer of residents; state monitoring; directed plan of correction; directed inservice training; and other state remedies approved by the health care financing administration. HSD is also required to impose remedies against intermediate care facilities for the mentally retarded (ICF-MR) providers who fail to comply with federal and state medicaid licensing and certification requirements. HSD may terminate a ICF-MR provider's certification or deny payment for new admissions if the provider fails to meet the conditions for participation or certain deficiencies are identified by the DOH.

(1) **Authority of survey agency:** The licensing and certification bureau of the New Mexico department of health (DOH) is the survey agency. When the rationale for imposition of the remedies is tied to

DOH's licensing and certification responsibilities, criteria for imposition of remedies and description of these specific remedies are based on regulations promulgated by the DOH. See DOH Regulations.

(2) **Recommendations for imposition of additional remedies:** Following completion of a survey, DOH may recommend that specified remedies be imposed against a NF or ICF-MR provider for failure to meet certification or licensing required which are based on the type, extent and seriousness of an identified deficiency(ies). HSD has five (5) working days from receipt of the DOH recommendation to impose remedies or to oppose the DOH recommendation. Unless a response from HSD is received in writing prior to the expiration of the time period, the DOH recommendations are accepted by HSD as submitted and the recommended remedy is imposed.

(3) **Informal reconsideration for ICF-MR providers:** An ICF-MR provider can request an informal reconsideration of the decision to deny, terminate or not renew the medicaid provider participation agreement if the decision requesting through the formal provider hearing process will not be completed prior to the effective date of the termination. The informal reconsideration must be completed prior to the effective date of the termination. The informal reconsideration includes the following:

(a) written notice to the ICF-MR provider of the denial, termination or nonrenewal of the agreement;

(b) reasonable opportunity for the ICF-MR provider to refute the findings upon which the decision was based; and

(c) a written affirmation or reversal of the denial, termination or nonrenewal of the agreement.

I. **Sanction for violation of the Medicaid Provider Act:** HSD may take any or any combinations of the following delineated actions against a provider for violations of the Medicaid Provider Act.

(1) imposition of an administrative penalty of not more than $5,000 for engaging in any practice that violates the Act; each separate occurrence of such practice constitutes a separate offense;

(2) issue an administrative order requiring the provider to:

(a) cease or modify any specified conduct or practices engaged in by it or its employees, subcontractors, or agents;

(b) fulfill its contractual obligations in the manner specified in the order;

(c) provide any service that has been denied;

(d) take steps to provide or arrange for any services that it has agreed to or is otherwise obligated to make available; or

(e) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by any opposing parties.

(3) suspend or terminate the provider's medical assistance division provider participation agreement.

[11/1/96; 8/1/99; 8.351.2.11 NMAC - Rn, 8 NMAC 4.MAD.962 & A, 7/1/03

8.351.2.12 IMPOSITION OF SANCTIONS:

A. **Mandatory sanctions:** HSD must impose sanctions when a provider receives a formal reprimand or censure for unethical practice by a professional association of the provider's peers or when a provider is suspended or terminated from participation in medicare or any federal or state-funded health care program.

B. **Permissive sanctions:** HSD can impose monetary or non-monetary sanctions against providers for fraud or other forms of misconduct.

C. **Criteria used in assessment of permissive sanctions:** HSD uses the following criteria to determine the type of permissive or mandatory sanction to impose:

(1) seriousness of the violation(s);
(2) number and nature of the violation(s);
(3) history of prior violation(s) or prior sanction(s);
(4) actions or recommendations of peer review groups or licensing boards;
(5) nature and degree of adverse impact of the sanction upon medicaid recipients;
(6) cost to HSD of the violation(s);
(7) mitigating circumstances; and
(8) other relevant facts.

[11/1/96; 8.351.2.12 NMAC - Rn, 8 NMAC 4.MAD.963, 7/1/03]

8.351.2.13 RECOVERY OF OVERPAYMENTS: HSD can seek recovery of overpayments through the recoupment or repayment process. "Overpayments" are amounts paid to medicaid providers in excess of the medicaid allowable amount. Overpayment amounts must be collected within twenty-four (24) months of the

initiation of recovery.

A. **AUDITING PROCEDURES**

(1) **Prima facie evidence:** The audit findings generated through the audit procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

(2) **Use of statistical sampling techniques:** The department's procedures for auditing medicaid providers may include the use of random sampling and extrapolation. When this procedure is used, all sampling will be performed using generally accepted statistical methods and will yield statistically significant results at a confidence level of at least 90% (ninety percent). Findings of the sample will be extrapolated to the universe for the audit period.

(3) **Burden of proof:** When the department's final audit findings have been generated through the use of sampling and extrapolation, and the provider disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence must include a one hundred percent (100%) audit of the universe of provider records used by the department in the drawing of the department's sample. Any such audit must:

(a) be arranged and paid for by the provider;

(b) be conducted by a certified public accountant;

(c) demonstrate that a (statistically) significantly higher number of claims and records not reviewed in the department's sample were in compliance with program regulations, and

(d) be submitted to the department with all supporting documentation.

B. **Repayment process:** A provider can repay all or part of an overpayment with a lump sum payment or a series of payments based on a schedule developed and mutually agreed to by MAD and the provider. If a provider fails to comply with the schedule, HSD will recover the overpayment and interest or initiate other collection efforts.

C. **Recoupment process:** Upon written notice, HSD may withhold all or a portion of provider payments on pending and subsequently received claims, to recover an overpayment, or may suspend payment on all pending or subsequently submitted claims pending a final determination of the amount of overpayment. All amounts must be recouped within twenty-four (24) months.

D. **Combination of processes:** HSD can use both recoupment and repayment process to collect an overpayment if:

(1) the provider is unlikely to remain a medicaid provider long enough for full recovery using recoupment alone; or

(2) the average monthly payment to a provider is so low that recoupment within twelve (12) months is not feasible.

E. **Prepayment review:** HSD may require pre-payment review of claims submitted during a recoupment or repayment process to ensure that subsequent claims are not inflated to compensate for amounts recovered during the recoupment or repayment process. Prepayment review may also be conducted as part of MAD's administrative responsibilities.

[11/1/96; 8.351.2.13 NMAC - Rn, 8 NMAC 4.MAD.964, 7/1/03; A, 9/1/04]

8.351.2.14 NOTICE REQUIREMENTS:

A. **Content of provider notice:** When HSD seeks overpayment recovery, or to impose sanctions or remedies, written notice is sent to the provider. The notice sent to non-nursing facility provider contains the following information:

(1) nature of the violation or misconduct;

(2) dollar value, if applicable, method and/or criteria for determining the overpayment, intended sanction, or amount of civil monetary penalty to be imposed;

(3) provider's right to a hearing, right to be represented by counsel at the hearing proceeding and method of requesting a hearing;

(4) statement notifying the provider that if he/she does not request a hearing, the action proposed by HSD will be deemed final for purposes of collection of overpayment and imposition of sanctions; and

(5) statement that provider has thirty (30) calendar days from the date of the notice to request a hearing.

B. **Additional notice requirements for overpayment recovery:**

(1) The notice for overpayment recovery contains the following additional information, See 42 CFR

Section 455.23 (b):

(a) statement that payments are being withheld on a temporary or permanent basis and delineate which types or type of medicaid claim to which the termination applies, when appropriate;

(b) statement informing the provider of his/her right to submit written information for HSD's consideration regarding release of payments; and

(c) information listing the conditions or circumstances under which the withholding is terminated.

(2) Time limits for withholding for fraud or misrepresentation: If payments are to be withheld in instances of suspected fraud or willful misrepresentation, notice is sent to the provider within five (5) calendar days of taking such action.

(3) Time limits for withholding in other situations: If payments are to be withheld in instances not involving fraud or misrepresentation, notice is sent to the provider five (5) calendar days before taking the action.

C. **Notice to other organizations:** When a medicaid provider is sanctioned, HSD notifies the applicable professional societies, boards of certification, licensing or registration, and state or federal agencies of the sanctions imposed and rationale for imposition of sanctions. If HSD learns that a provider is convicted of a medicaid-related offense, HSD also notifies the secretary of the federal DHHS of the conviction.

D. **Notice to recipients:** When a provider is terminated or suspended from participation in medicaid, HSD notifies those recipients for whom the provider has submitted claims for services after the date of the alleged fraud or misconduct.

E. **Notice deadlines for NF or ICF-MR providers:** The notice period begins on the date of the notice. In no event will the effective date of the action be later than twenty (20) calendar days after HSD sends the notice.

(1) The notice informing the NF or ICF-MR provider of HSD's intent to impose remedies is given at least two (2) calendar days before the effective date of the action in instances where there is immediate jeopardy to NF or ICF-MR residents.

(2) The notice informs the NF or ICF-MR provider of HSD's intent to impose remedies is given at least fifteen (15) calendar days before the effective date of the remedies in instances where immediate jeopardy to NF or ICF-MR residents is not involved.

F. **Exceptions to the notice requirements:** Notice is not sent and a provider hearing is not available if the basis for the provider sanction is the non-nursing facility provider's failure to meet standards for licensing, certification, or registration required by federal or state laws for participation in the medicaid program. Additional notice is not required if HSD has notified the provider in writing of the failure to meet standards and has given the provider thirty (30) calendar days notice to correct or produce necessary documentation curing the failure and the provider fails to respond.

[11/1/96; 8.351.2.14 NMAC - Rn, 8 NMAC 4.MAD.965, 7/1/03]

8.351.2.15 REQUEST FOR PROVIDER HEARING: Providers can request a hearing if they disagree with any of the aforementioned actions taken or sanctions or remedies imposed by HSD. Requests for a hearing must be made within thirty (30) calendar days or within the time limit specified on the notice of HSD action. An NF or ICF-MR provider must submit the request to the DOH within sixty (60) calendar days of the notice of the proposed imposition of remedies related to noncompliance with certification requirements. If a provider fails to request a hearing during this time frame, the provider waives its right to an appeal. See 8.353.2 NMAC, *Provider Hearings*, for information on the hearing process and provider rights and responsibilities.

A. **Imposition of remedies:** HSD can impose all remedies on a provider participating in the medicaid program after notifying the provider in a timely manner of the deficiencies and/or impending sanction or remedy. Except for the imposition of civil monetary penalties against a nursing facility provider and imposition of sanctions for violation of the Medicaid Provider Act, any applicable sanctions or remedy may be imposed prior to a provider hearing.

B. **Stay granted:** The provider can request that the imposition of sanctions or remedies be stayed during the pendency of the hearing process by submitting such request in writing to HSD. Granting of a stay is at the discretion of the MAD director upon consideration of health service available and other related concerns. Interest on civil money penalties or overpayments accrues from the date of the initial determination.

C. **Collection of civil monetary penalties for noncompliance:** HSD may not collect a civil money penalty against a NF provider until a final decision is made that supports the imposition of the penalty. In instances where imposition of civil money penalties are proposed due to noncompliance with certification requirements, a NF provider may waive its right to a hearing by submitting a written request to the DOH. Waiver of the right to a

hearing reduces the amount of the specified penalty by thirty-five percent (35%). An NF provider may submit a plan of correction or request a resurvey without prejudicing its position during the hearing.
[11/1/96; 8/1/99; 8.351.2.15 NMAC –Rn, 8 NMAC 4.MAD 966, 7/1/03]

8.351.2.16 INCENTIVE PROGRAM FOR HIGH QUALITY NURSING FACILITY CARE: Nursing facilities that meet the criteria for high quality care are eligible to participate in an incentive program that bestows annual awards for excellent quality care.

A. **Requirements:** Nursing facilities providing high quality care must demonstrate that their programs exceed requirements and enhance resident quality of life. For example, the facility might have an activities program that offers frequent and unique activities that are widely attended, possibly led or taught by the residents or a restorative program that yields an unusually high number of non-wheelchair-bound residents or an absence of in-house acquired decubiti and foley catheters.

B. **Submission of applications:** Eligible facilities must submit applications and supporting documentation to HSD by May of each calendar year. The application packets and supporting documentation are evaluated by a committee of the following composition:

(1) (1) state survey agency;
(2) (1) MAD;
(3) (1) state agency on aging;
(4) (2) provider representatives recommended by the nursing facility provider association.

C. **Award selection criteria:** From the applicant group, the incentive committee selects up to three (3) facilities to receive the excellent care awards. The following measures are used to select the recipient:

(1) largest number of programs which exceed requirements for certification; or
(2) highest percentage of residents with enhanced quality of life due to participation in the programs.

D. **Award:** The facilities selected for the excellent quality care award receive a plaque, major press release, letter of commendation from the governor's office, and a $ 1,000 award. The monetary award must be directed toward a program or purchase that enhances resident quality of life. The residents in each awarded facility influence the use of the monetary award.
[11/1/96; 8.351.2.16 NMAC - Rn, 8 NMAC 4.MAD.967, 7/1/03]

HISTORY OF 8.351.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 305.3000, Provider Sanctions, filed 1/7/80.
ISD 305.4000, Provider Notification and Right to Review, filed 1/7/80.
ISD 305.5000, Repayment of Medicaid Funds, filed 1/7/80.
ISD 305.6000, Periods of Suspension, filed 1/7/80.
SP-004.0500, Section 4, General Program Administration Medicaid Agency Fraud Detection and Investigation Program, filed 1/23/81.
SP-004.3000, Section 4, General Program Administration Suspension of Practitioners Convicted of Crimes Related to Medicare or Medicaid, filed 3/17/81.

History of Repealed Material: [RESERVED]