

SENATE BILL 33

51ST LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2014

INTRODUCED BY

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AN ACT

RELATING TO PUBLIC HEALTH; AMENDING THE MEDICAID PROVIDER ACT;
DEFINING "CREDIBLE ALLEGATION OF FRAUD"; PROVIDING FOR JUDICIAL
REVIEW OF A DETERMINATION OF CREDIBLE ALLEGATION OF FRAUD;
AMENDING SECTION 30-44-7 NMSA 1978 (BEING LAWS 1989, CHAPTER
286, SECTION 7, AS AMENDED) TO CLARIFY THAT, IN THE ABSENCE OF
CLEAR AND CONVINCING EVIDENCE TO THE CONTRARY, MERE ERRORS
FOUND DURING THE COURSE OF AN AUDIT, BILLING ERRORS THAT ARE
ATTRIBUTABLE TO HUMAN ERROR AND INADVERTENT BILLING AND
PROCESSING ERRORS DO NOT CONSTITUTE MEDICAID FRAUD.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 27-11-1 NMSA 1978 (being Laws 1998,
Chapter 30, Section 1) is amended to read:

"27-11-1. SHORT TITLE.--~~[This act]~~ Chapter 27, Article 11
NMSA 1978 may be cited as the "Medicaid Provider Act"."

[bracketed material] = delete

1 SECTION 2. Section 27-11-2 NMSA 1978 (being Laws 1998,
2 Chapter 30, Section 2) is amended to read:

3 "27-11-2. DEFINITIONS.--As used in the Medicaid Provider
4 Act:

5 A. "credible allegation of fraud" means an
6 allegation of medicaid fraud, as defined in Subsection A of
7 Section 30-44-7 NMSA 1978, that has been verified as credible
8 by the department:

9 (1) considering the totality of the facts and
10 circumstances surrounding any particular allegation or set of
11 allegations;

12 (2) based upon a careful review of all
13 allegations, facts and evidence; and

14 (3) accompanied by sufficient indicia of
15 reliability to justify a decision by the department to refer a
16 medicaid provider or other person to the attorney general for
17 further investigation;

18 [~~A.~~] B. "department" means the human services
19 department;

20 [~~B.~~] C. "managed care organization" means a person
21 eligible to enter into risk-based prepaid capitation agreements
22 with the department to provide health care and related
23 services;

24 [~~C.~~] D. "medicaid" means the medical assistance
25 program established pursuant to Title 19 of the federal Social

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[bracketed material] = delete

1 Security Act and regulations issued pursuant to that act;

2 ~~[D.]~~ E. "medicaid provider" means a person,
3 including a managed care organization, operating under contract
4 with the department to provide medicaid-related services to
5 recipients;

6 ~~[E.]~~ F. "person" means an individual or other legal
7 entity;

8 ~~[F.]~~ G. "recipient" means a person whom the
9 department has determined to be eligible to receive
10 medicaid-related services;

11 ~~[G.]~~ H. "secretary" means the secretary of human
12 services; and

13 ~~[H.]~~ I. "subcontractor" means a person who
14 contracts with a medicaid provider to provide medicaid-related
15 services to recipients."

16 SECTION 3. A new section of the Medicaid Provider Act is
17 enacted to read:

18 "[NEW MATERIAL] CREDIBLE ALLEGATION OF FRAUD--JUDICIAL
19 REVIEW.--

20 A. A credible allegation of fraud determination by
21 the department shall be deemed a final decision as defined in
22 Section 39-3-1.1 NMSA 1978.

23 B. A medicaid provider or other person who is the
24 subject of a referral to the attorney general for further
25 investigation based upon a credible allegation of fraud may

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[bracketed material] = delete

1 seek judicial review of the department's credible allegation of
2 fraud determination pursuant to Section 39-3-1.1 NMSA 1978."

3 SECTION 4. Section 30-44-7 NMSA 1978 (being Laws 1989,
4 Chapter 286, Section 7, as amended) is amended to read:

5 "30-44-7. MEDICAID FRAUD--DEFINED--INVESTIGATION--
6 PENALTIES.--

7 A. Medicaid fraud consists of:

8 (1) paying, soliciting, offering or receiving:

9 (a) a kickback or bribe in connection
10 with the furnishing of treatment, services or goods for which
11 payment is or may be made in whole or in part under the
12 program, including an offer or promise to, or a solicitation or
13 acceptance by, a health care official of anything of value with
14 intent to influence a decision or commit a fraud affecting a
15 state or federally funded or mandated managed health care plan;

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

18 (c) anything of value, intending to
19 retain it and knowing it to be in excess of amounts authorized
20 under the program, as a precondition of providing treatment,
21 care, services or goods or as a requirement for continued
22 provision of treatment, care, services or goods; or

23 (d) anything of value, intending to
24 retain it and knowing it to be in excess of the rates
25 established under the program for the provision of treatment,

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1 services or goods;

2 (2) providing with intent that a claim be
3 relied upon for the expenditure of public money:

4 (a) treatment, services or goods that
5 have not been ordered by a treating physician;

6 (b) treatment that is substantially
7 inadequate when compared to generally recognized standards
8 within the discipline or industry; or

9 (c) merchandise that has been
10 adulterated, debased or mislabeled or is outdated;

11 (3) presenting or causing to be presented for
12 allowance or payment with intent that a claim be relied upon
13 for the expenditure of public money any false, fraudulent,
14 excessive, multiple or incomplete claim for furnishing
15 treatment, services or goods; or

16 (4) executing or conspiring to execute a plan
17 or action to:

18 (a) defraud a state or federally funded
19 or mandated managed health care plan in connection with the
20 delivery of or payment for health care benefits, including
21 engaging in any intentionally deceptive marketing practice in
22 connection with proposing, offering, selling, soliciting or
23 providing any health care service in a state or federally
24 funded or mandated managed health care plan; or

25 (b) obtain by means of false or

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1 fraudulent representation or promise anything of value in
2 connection with the delivery of or payment for health care
3 benefits that are in whole or in part paid for or reimbursed or
4 subsidized by a state or federally funded or mandated managed
5 health care plan. This includes representations or statements
6 of financial information, enrollment claims, demographic
7 statistics, encounter data, health services available or
8 rendered and the qualifications of persons rendering health
9 care or ancillary services.

10 B. In the absence of clear and convincing evidence
11 to the contrary, the following do not constitute medicaid
12 fraud:

13 (1) mere errors found during the course of an
14 audit;

15 (2) billing errors that are attributable to
16 human error; and

17 (3) inadvertent billing and processing errors.

18 [~~B.~~] C. Except as otherwise provided for in this
19 section regarding the payment of fines by an entity, whoever
20 commits medicaid fraud as described in Paragraph (1) or (3) of
21 Subsection A of this section is guilty of a fourth degree
22 felony and shall be sentenced pursuant to the provisions of
23 Section 31-18-15 NMSA 1978.

24 [~~C.~~] D. Except as otherwise provided for in this
25 section regarding the payment of fines by an entity, whoever

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1 commits medicaid fraud as described in Paragraph (2) or (4) of
2 Subsection A of this section when the value of the benefit,
3 treatment, services or goods improperly provided is:

4 (1) not more than one hundred dollars (\$100)
5 is guilty of a petty misdemeanor and shall be sentenced
6 pursuant to the provisions of Section 31-19-1 NMSA 1978;

7 (2) more than one hundred dollars (\$100) but
8 not more than two hundred fifty dollars (\$250) is guilty of a
9 misdemeanor and shall be sentenced pursuant to the provisions
10 of Section 31-19-1 NMSA 1978;

11 (3) more than two hundred fifty dollars (\$250)
12 but not more than two thousand five hundred dollars (\$2,500) is
13 guilty of a fourth degree felony and shall be sentenced
14 pursuant to the provisions of Section 31-18-15 NMSA 1978;

15 (4) more than two thousand five hundred
16 dollars (\$2,500) but not more than twenty thousand dollars
17 (\$20,000) ~~[shall be]~~ is guilty of a third degree felony and
18 shall be sentenced pursuant to the provisions of Section
19 31-18-15 NMSA 1978; and

20 (5) more than twenty thousand dollars
21 (\$20,000) ~~[shall be]~~ is guilty of a second degree felony and
22 shall be sentenced pursuant to the provisions of Section
23 31-18-15 NMSA 1978.

24 ~~[D.]~~ E. Except as otherwise provided for in this
25 section regarding the payment of fines by an entity, whoever

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1 commits medicaid fraud when the fraud results in physical harm
2 or psychological harm to a recipient is guilty of a fourth
3 degree felony and shall be sentenced pursuant to the provisions
4 of Section 31-18-15 NMSA 1978.

5 ~~[E.]~~ F. Except as otherwise provided for in this
6 section regarding the payment of fines by an entity, whoever
7 commits medicaid fraud when the fraud results in great physical
8 harm or great psychological harm to a recipient is guilty of a
9 third degree felony and shall be sentenced pursuant to the
10 provisions of Section 31-18-15 NMSA 1978.

11 ~~[F.]~~ G. Except as otherwise provided for in this
12 section regarding the payment of fines by an entity, whoever
13 commits medicaid fraud when the fraud results in death to a
14 recipient is guilty of a second degree felony and shall be
15 sentenced pursuant to the provisions of Section 31-18-15 NMSA
16 1978.

17 ~~[G.]~~ H. If the person who commits medicaid fraud is
18 an entity rather than an individual, the entity shall be
19 subject to a fine of not more than fifty thousand dollars
20 (\$50,000) for each misdemeanor and not more than two hundred
21 fifty thousand dollars (\$250,000) for each felony.

22 ~~[H.]~~ I. The unit shall coordinate with the human
23 services department, department of health and children, youth
24 and families department to develop a joint protocol
25 establishing responsibilities and procedures, including prompt

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1 and appropriate referrals and necessary action regarding
2 allegations of program fraud, to ensure prompt investigation of
3 suspected fraud upon the medicaid program by any provider.
4 These departments shall participate in the joint protocol and
5 enter into a memorandum of understanding defining procedures
6 for coordination of investigations of fraud by medicaid
7 providers to eliminate duplication and fragmentation of
8 resources. The memorandum of understanding shall further
9 provide procedures for reporting to the legislative finance
10 committee the results of all investigations every calendar
11 quarter. The unit shall report to the legislative finance
12 committee a detailed disposition of recoveries and distribution
13 of proceeds every calendar quarter."

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