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SENATE BILL 2

**53RD LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2018**

INTRODUCED BY

Mary Kay Papen

AN ACT

RELATING TO MEDICAID; PRESERVING ACCESS TO MEDICAID SERVICES;  
PROVIDING DUE PROCESS TO MEDICAID PROVIDERS AND SUBCONTRACTORS;  
PROVIDING FOR INDEPENDENT ADMINISTRATIVE LAW JUDGES;  
ESTABLISHING PROCEDURES TO RESOLVE OVERPAYMENT DISPUTES;  
PROVIDING FOR JUDICIAL REVIEW OF A CREDIBLE ALLEGATION OF FRAUD  
DETERMINATION; CLARIFYING THE DEFINITION OF "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 Managed Care and  
Provider Act"."

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

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1 "27-11-2. DEFINITIONS.--As used in the Medicaid Managed  
2 Care and Provider Act:

3 A. "claim" means a request for payment for  
4 services;

5 B. "clean claim" means a claim for reimbursement  
6 that:

7 (1) contains substantially all the required  
8 data elements necessary for accurate adjudication of the claim  
9 without the need for additional information from the medicaid  
10 provider or subcontractor;

11 (2) is not materially deficient or improper,  
12 including lacking substantiating documentation required by  
13 medicaid; and

14 (3) has no particular or unusual circumstances  
15 that require special treatment or that prevent payment from  
16 being made in due course on behalf of medicaid;

17 C. "credible" means having indicia of reliability  
18 after the state has reviewed all allegations, facts and  
19 evidence carefully and acted judiciously on a case-by-case  
20 basis;

21 D. "credible allegation of fraud" means an  
22 allegation that has been verified by the state from any source,  
23 including fraud hotline complaints, claims data mining and  
24 provider audits;

25 [~~A.~~] E. "department" means the human services

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1 department;

2 F. "fraud" means an intentional deception or  
3 misrepresentation made by a person with the knowledge that the  
4 deception could result in some unauthorized benefit to the  
5 person or some other person, including any act that constitutes  
6 fraud under state or federal law;

7 [~~B.~~] G. "managed care organization" means a person  
8 eligible to enter into risk-based prepaid capitation agreements  
9 with the department to provide health care and related  
10 services;

11 [~~G.~~] H. "medicaid" means the medical assistance  
12 program established pursuant to Title 19 of the federal Social  
13 Security Act and regulations issued pursuant to that act;

14 [~~D.~~] I. "medicaid provider" means a person,  
15 [~~including~~] other than a managed care organization, operating  
16 under contract with the department to provide medicaid-related  
17 services to recipients;

18 J. "overpayment" means an amount paid to a medicaid  
19 provider or subcontractor in excess of the medicaid allowable  
20 amount, including payment for any claim to which a medicaid  
21 provider or subcontractor is not entitled;

22 [~~E.~~] K. "person" means an individual or other legal  
23 entity;

24 [~~F.~~] L. "recipient" means a person whom the  
25 department has determined to be eligible to receive medicaid-

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1 related services;

2 [G.] M. "secretary" means the secretary of human  
3 services; and

4 [H.] N. "subcontractor" means a person who  
5 contracts with a medicaid managed care organization or a  
6 medicaid provider to provide medicaid-related services to  
7 recipients."

8 SECTION 3. Section 27-11-3 NMSA 1978 (being Laws 1998,  
9 Chapter 30, Section 3, as amended) is amended to read:

10 "27-11-3. REVIEW OF MEDICAID [~~PROVIDERS~~] MANAGED CARE  
11 ORGANIZATION--CONTRACT REMEDIES--PENALTIES.--

12 A. Consistent with the terms of any contract  
13 between the department and a medicaid [~~provider~~] managed care  
14 organization, the secretary shall have the right to be afforded  
15 access to such of the medicaid [~~provider's~~] managed care  
16 organization's records and personnel, as well as its  
17 subcontracts and that subcontractor's records and personnel, as  
18 may be necessary to ensure that the medicaid [~~provider~~] managed  
19 care organization is complying with the terms of its contract  
20 with the department.

21 B. Upon not less than two days' written notice to a  
22 medicaid [~~provider~~] managed care organization, the secretary  
23 may, consistent with the provisions of the Medicaid Managed  
24 Care and Provider Act and rules issued pursuant to that act,  
25 carry out an administrative investigation or conduct

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1 administrative proceedings to determine whether a medicaid  
2 [~~provider~~] managed care organization has:

3 (1) materially breached its obligation to  
4 furnish medicaid-related services to recipients, or any other  
5 duty specified in its contract with the department;

6 (2) violated any provision of the Public  
7 Assistance Act or the Medicaid Managed Care and Provider Act or  
8 any rules issued pursuant to those acts;

9 (3) intentionally or with reckless disregard  
10 made any false statement with respect to any report or  
11 statement required by the Public Assistance Act or the Medicaid  
12 Managed Care and Provider Act, rules issued pursuant to either  
13 of those acts or a contract with the department;

14 (4) intentionally or with reckless disregard  
15 advertised or marketed, or attempted to advertise or market,  
16 its services to recipients in a manner as to misrepresent its  
17 services or capacity for services, or engaged in any deceptive,  
18 misleading or unfair practice with respect to advertising or  
19 marketing;

20 (5) hindered or prevented the secretary from  
21 performing any duty imposed by the Public Assistance Act, the  
22 Human Services Department Act or the Medicaid Managed Care and  
23 Provider Act or any rules issued pursuant to those acts; or

24 (6) fraudulently procured or attempted to  
25 procure any benefit from medicaid.

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1           C. Subject to the provisions of Subsection D of  
2 this section, after affording a medicaid [~~provider~~] managed  
3 care organization written notice of hearing not less than ten  
4 days before the hearing date and an opportunity to be heard,  
5 and upon making appropriate administrative findings, the  
6 secretary may take any or any combination of the following  
7 actions against the [~~provider~~] medicaid managed care  
8 organization:

9                   (1) impose an administrative penalty of not  
10 more than five thousand dollars (\$5,000) for engaging in any  
11 practice described in [~~Paragraphs (1) through (6) of~~]  
12 Subsection B of this section; provided that each separate  
13 occurrence of such practice shall constitute a separate  
14 offense;

15                   (2) issue an administrative order requiring  
16 the [~~provider~~] medicaid managed care organization to:

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

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

22                           (c) provide any service that has been  
23 denied;

24                           (d) take steps to provide or arrange for  
25 any service that it has agreed or is otherwise obligated to

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1 make available; or

2 (e) enter into and abide by the terms of  
3 a binding or nonbinding arbitration proceeding, if agreed to by  
4 any opposing party, including the secretary; or

5 (3) suspend or revoke the contract between the  
6 ~~[provider]~~ medicaid managed care organization and the  
7 department pursuant to the terms of that contract.

8 D. If a contract between the department and a  
9 medicaid ~~[provider]~~ managed care organization explicitly  
10 specifies a dispute resolution mechanism for use in resolving  
11 disputes over performance of that contract, the dispute  
12 resolution mechanism specified in the contract shall be used to  
13 resolve such disputes in lieu of the mechanism set forth in  
14 Subsection C of this section.

15 E. If a medicaid ~~[provider's]~~ managed care  
16 organization's contract so specifies, the medicaid ~~[provider]~~  
17 managed care organization shall have the right to seek de novo  
18 review in district court of any decision by the secretary  
19 regarding a contractual dispute."

20 SECTION 4. Section 27-11-4 NMSA 1978 (being Laws 1998,  
21 Chapter 30, Section 4, as amended) is amended to read:

22 "27-11-4. RETENTION AND PRODUCTION OF RECORDS.--

23 A. Medicaid managed care organizations, medicaid  
24 providers and their subcontractors shall retain, for a period  
25 of at least six years from the date of creation, all medical

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1 and business records that are necessary to verify the:

2 (1) treatment or care of any recipient for  
3 which the medicaid [~~provider~~] managed care organization,  
4 medicaid provider or subcontractor received payment from the  
5 department to provide that benefit or service;

6 (2) services or goods provided to any  
7 recipient for which the medicaid [~~provider~~] managed care  
8 organization, medicaid provider or subcontractor received  
9 payment from the department to provide that benefit or service;

10 (3) amounts paid by medicaid or the medicaid  
11 [~~provider~~] managed care organization on behalf of any  
12 recipient; and

13 (4) records required by medicaid under any  
14 contract between the department and the medicaid [~~provider~~]  
15 managed care organization.

16 B. Upon written request by the department to a  
17 medicaid managed care organization, medicaid provider or any  
18 subcontractor for copies or inspection of records pursuant to  
19 the Public Assistance Act, the medicaid managed care  
20 organization, medicaid provider or subcontractor shall provide  
21 the copies or permit the inspection, as applicable within two  
22 business days after the date of the request unless the records  
23 are held by a subcontractor, agent or satellite office, in  
24 which case the records shall be made available within ten  
25 business days after the date of the request.

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1           C. Failure to provide copies or to permit  
2 inspection of records requested pursuant to this section shall  
3 constitute a violation of the Medicaid Managed Care and  
4 Provider Act within the meaning of Paragraph (3) of Subsection  
5 B of Section 27-11-3 NMSA 1978."

6           **SECTION 5.** A new section of the Medicaid Managed Care and  
7 Provider Act is enacted to read:

8           "[NEW MATERIAL] DETERMINATION OF OVERPAYMENTS--AUDIT  
9 FINDINGS--SAMPLING--EXTRAPOLATION PROHIBITED--NOTICE OF RIGHT  
10 TO INFORMAL CONFERENCE AND EXPEDITED ADJUDICATORY PROCEEDING.--

11           A. The department may audit a medicaid provider or  
12 subcontractor for overpayment, using sampling for the time  
13 period audited. Each audited claim shall be reviewed by a  
14 person who is licensed, certified, registered or otherwise  
15 credentialed in New Mexico as to the matters such person  
16 reviews, including coding or specific clinical practice.

17           B. The department shall not extrapolate audit  
18 findings.

19           C. Prior to reaching a final determination of  
20 overpayment, including an overpayment based in whole or in part  
21 on a credible allegation of fraud, the department shall serve  
22 the medicaid provider or subcontractor with a written tentative  
23 finding of overpayment.

24           D. The tentative finding of overpayment shall:

25           (1) state with specificity the factual and

1 legal basis for each claim forming the basis of an alleged  
2 overpayment;

3 (2) include a copy of the final audit report  
4 if the alleged overpayment is based on an audit; and

5 (3) notify the medicaid provider or  
6 subcontractor that is the subject of a tentative finding of  
7 overpayment of the medicaid provider's or subcontractor's right  
8 to request, within thirty calendar days of service of the  
9 tentative finding of overpayment:

10 (a) an informal conference with a  
11 representative of the department who is knowledgeable about the  
12 department's tentative finding of overpayment and with a member  
13 of the audit team, if an audit formed the basis of any alleged  
14 overpayment, to informally address, resolve or dispute the  
15 department's tentative finding of overpayment; and

16 (b) an expedited adjudicatory proceeding  
17 pursuant to the Administrative Procedures Act to challenge the  
18 department's tentative finding of overpayment.

19 E. Prior to making a final determination of  
20 overpayment, including an overpayment based in whole or in part  
21 on a credible allegation of fraud, the department may impose  
22 corrective action upon the medicaid provider or subcontractor  
23 to address systemic conditions contributing to errors in the  
24 submission of claims for payment to which a medicaid provider  
25 or subcontractor is not entitled."

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1           SECTION 6. A new section of the Medicaid Managed Care and  
2 Provider Act is enacted to read:

3           "[NEW MATERIAL] INFORMAL CONFERENCE--REQUIREMENTS.--

4           A. A medicaid provider or subcontractor seeking an  
5 informal conference pursuant to this section shall serve the  
6 department with a written request for such conference no later  
7 than thirty calendar days following the service of a tentative  
8 finding of overpayment by the department on the medicaid  
9 provider or subcontractor. Upon receipt of a request for an  
10 informal conference, the department shall set a date for the  
11 conference to occur no later than fourteen business days  
12 following receipt of the request.

13           B. The medicaid provider or subcontractor shall  
14 have no less than thirty calendar days following the informal  
15 conference to:

16                   (1) provide additional documentation to the  
17 department to attempt to informally address or resolve a  
18 disputed tentative finding of overpayment; and

19                   (2) correct clerical, typographical,  
20 scrivener's and computer errors or to provide requested  
21 credentialing, licensure or training records.

22           C. A medicaid provider's or subcontractor's  
23 decision to seek an informal conference pursuant to this  
24 section does not extend the time by which the medicaid provider  
25 or subcontractor shall request an expedited adjudicatory

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1 proceeding pursuant to Section 7 of this 2018 act. The  
2 informal resolution process shall run concurrently with the  
3 expedited adjudicatory proceeding, and the informal resolution  
4 process shall be discontinued once the presiding administrative  
5 law judge issues findings of fact and conclusions of law with  
6 respect to the department's tentative finding of overpayment."

7 SECTION 7. A new section of the Medicaid Managed Care and  
8 Provider Act is enacted to read:

9 "[NEW MATERIAL] EXPEDITED ADJUDICATORY PROCEEDINGS--  
10 REQUIREMENTS.--

11 A. A medicaid provider or subcontractor seeking an  
12 expedited adjudicatory proceeding pursuant to the Medicaid  
13 Managed Care and Provider Act shall serve the department and  
14 the administrative hearings office with a written request for  
15 such proceeding no later than thirty calendar days following  
16 the service of a tentative finding of overpayment by the  
17 department on the medicaid provider or subcontractor.

18 B. The chief hearing officer of the administrative  
19 hearings office shall appoint a presiding administrative law  
20 judge no later than thirty calendar days after service upon the  
21 administrative hearings office of a request for an expedited  
22 adjudicatory proceeding pursuant to the Medicaid Managed Care  
23 and Provider Act by a medicaid provider or subcontractor.

24 C. The expedited adjudicatory proceeding requested  
25 by a medicaid provider or subcontractor in accordance with the

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1 Medicaid Managed Care and Provider Act shall commence no later  
2 than thirty calendar days following the appointment of the  
3 presiding administrative law judge or as stipulated by the  
4 parties or as otherwise ordered by the presiding administrative  
5 law judge upon a showing of good cause. The evidentiary  
6 hearing of an expedited adjudicatory proceeding pursuant to  
7 this section shall not exceed ten business days in length and  
8 shall be conducted in accordance with Section 12-8-11 NMSA  
9 1978.

10 D. After affording the parties the opportunity to  
11 submit proposed findings and conclusions of law, and based  
12 solely upon the record in accordance with the Medicaid Managed  
13 Care and Provider Act and the Administrative Procedures Act,  
14 the presiding administrative law judge shall make findings of  
15 fact and conclusions of law on all material issues of fact, law  
16 or discretion, stating the basis for each. In addition, the  
17 presiding administrative law judge shall determine the amount  
18 of overpayment with respect to each disputed claim submitted  
19 for payment, if any. The findings of fact and conclusions of  
20 law of the presiding administrative law judge shall be made and  
21 served upon all parties of record within thirty calendar days  
22 following the presiding administrative law judge's receipt of  
23 the record.

24 E. The presiding administrative law judge's  
25 findings of fact and conclusions of law shall be binding on the

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1 department and constitute a final agency decision, which may be  
2 appealed pursuant to Section 39-3-1.1 NMSA 1978."

3 SECTION 8. A new section of the Medicaid Managed Care and  
4 Provider Act is enacted to read:

5 "[NEW MATERIAL] QUALIFICATIONS AND SELECTION OF  
6 ADMINISTRATIVE LAW JUDGE FOR EXPEDITED ADJUDICATORY  
7 PROCEEDINGS.--

8 A. The administrative law judge presiding over the  
9 expedited adjudicatory proceeding held pursuant to the Medicaid  
10 Managed Care and Provider Act shall:

11 (1) be licensed and in good standing to  
12 practice law in New Mexico or another state;

13 (2) have at least three years' cumulative  
14 experience in one or more of the following areas: the health  
15 insurance industry, the medicaid program, health care  
16 regulatory compliance, medical claims administration or health  
17 law;

18 (3) have at least five years' experience in  
19 commercial litigation demonstrating the ability to make a  
20 record in an adjudicatory proceeding suitable for judicial  
21 review;

22 (4) not currently be employed by or represent,  
23 or belong to a law firm that currently represents, the state or  
24 a medicaid managed care organization or third party  
25 administrator currently doing business with the department; and

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1 (5) not be related within the third degree of  
2 consanguinity to a person currently employed by an executive  
3 agency of the state, currently doing business with the state or  
4 currently employed by an organization doing business with the  
5 state.

6 B. The chief hearing officer of the administrative  
7 hearings office shall select an administrative law judge to  
8 preside over an expedited adjudicatory proceeding held pursuant  
9 to the Medicaid Managed Care and Provider Act and the  
10 Administrative Procedures Act."

11 SECTION 9. A new section of the Medicaid Managed Care and  
12 Provider Act is enacted to read:

13 "[NEW MATERIAL] COSTS OF EXPEDITED ADJUDICATORY  
14 PROCEEDING.--

15 A. The department shall be responsible for the  
16 costs of the administrative law judge.

17 B. Each party shall be responsible for its own  
18 costs related to the expedited adjudicatory proceeding,  
19 including costs associated with preparation for the hearing,  
20 discovery, depositions, subpoenas, service of process and  
21 witness expenses, travel expenses and investigation expenses  
22 and attorney fees.

23 C. The administrative law judge shall allow  
24 telephonic testimony of a witness if requested by a party."

25 SECTION 10. A new section of the Medicaid Managed Care

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1 and Provider Act is enacted to read:

2 "[NEW MATERIAL] RIGHTS OF MEDICAID PROVIDER OR  
3 SUBCONTRACTOR--TENTATIVE OR FINAL DETERMINATION OF  
4 OVERPAYMENT.--

5 A. A medicaid provider or subcontractor may  
6 challenge the accuracy of the department's audit, the  
7 credentials of the persons who participated in the audit or  
8 claims review or the good faith of a prepayment review of  
9 claims and may present evidence to dispute any matter or  
10 methodology forming the basis of a tentative or final  
11 determination of overpayment.

12 B. A medicaid provider or subcontractor may, but  
13 shall not be required to, conduct its own audit or sampling to  
14 challenge a tentative or final determination of overpayment."

15 SECTION 11. A new section of the Medicaid Managed Care  
16 and Provider Act is enacted to read:

17 "[NEW MATERIAL] RELEASE OF SUSPENDED PAYMENT FOR SERVICES  
18 PREVIOUSLY RENDERED--PREPAYMENT REVIEW--REMEDIAL TRAINING AND  
19 EDUCATION--TEMPORARY ASSISTANCE.--

20 A. The department shall release a suspended payment  
21 to a medicaid provider or subcontractor that is the subject of  
22 a referral based upon a determination of a credible allegation  
23 of fraud for services previously rendered if the medicaid  
24 provider or subcontractor posts a surety bond in the amount of  
25 the suspended payment, which posting shall be deemed good cause

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1 not to suspend payment.

2 B. The provisions of this section shall not prevent  
3 the department from:

4 (1) conducting a good-faith prepayment review  
5 of claims for ongoing services rendered by the medicaid  
6 provider or subcontractor;

7 (2) requiring the medicaid provider or  
8 subcontractor or its employees to complete remedial training or  
9 education to prevent the submission of claims for payment to  
10 which the medicaid provider or subcontractor is not entitled;  
11 or

12 (3) requiring the medicaid provider or  
13 subcontractor to engage an independent third party approved by  
14 the department to temporarily manage or provide technical  
15 assistance to the medicaid provider or subcontractor.

16 C. The department shall release a suspended payment  
17 no later than ten business days following the earlier of:

18 (1) the posting of a surety bond by the  
19 medicaid provider or subcontractor in the amount of the  
20 suspended payment;

21 (2) notice from the attorney general that the  
22 attorney general will not pursue legal action against the  
23 medicaid provider or subcontractor arising out of the referral  
24 of the medicaid provider or subcontractor based on a  
25 determination of a credible allegation of fraud;

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1 (3) the date on which an administrative  
2 decision as to the basis for suspending such payments, or  
3 portion of such payments, in favor of the medicaid provider or  
4 subcontractor becomes final; or

5 (4) the date on which a judicial decision as  
6 to the basis for suspending such payments, or portion of such  
7 payments, in favor of the medicaid provider or subcontractor  
8 becomes final and not subject to further appeal."

9 SECTION 12. A new section of the Medicaid Managed Care  
10 and Provider Act is enacted to read:

11 "[NEW MATERIAL] MAINTENANCE OF SERVICES--PAYMENT FOR  
12 ONGOING SERVICES.--

13 A. Following the referral of a medicaid provider or  
14 contractor based on a determination of a credible allegation of  
15 fraud, and during the pendency of a dispute between the  
16 department and a medicaid provider or subcontractor regarding  
17 an alleged overpayment, including an overpayment based in whole  
18 or in part on a credible allegation of fraud, the department  
19 shall not terminate or deny the medicaid provider's or  
20 subcontractor's continued participation in the state's medicaid  
21 program if the medicaid provider or subcontractor:

22 (1) submits to a good-faith prepayment review  
23 of claims for ongoing services;

24 (2) demonstrates that its employees have  
25 completed remedial training or education required by the

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1 department to prevent the submission of claims for payment to  
2 which the medicaid provider or subcontractor is not entitled;  
3 and

4 (3) engages an independent third party  
5 approved by the department to temporarily manage or provide  
6 technical assistance to the medicaid provider or subcontractor  
7 following the referral or during the pendency of the dispute.

8 B. The department shall not unreasonably withhold  
9 approval of a third party proposed by the medicaid provider or  
10 subcontractor pursuant to Paragraph (3) of Subsection A of this  
11 section.

12 C. A medicaid provider or subcontractor that  
13 complies with the requirements of Subsection A of this section  
14 shall be reimbursed for each clean claim for ongoing services  
15 within ten calendar days of receipt if submitted electronically  
16 or thirty calendar days if submitted manually."

17 SECTION 13. A new section of the Medicaid Managed Care  
18 and Provider Act is enacted to read:

19 "[NEW MATERIAL] DISPOSITION OF RECOVERED MEDICAID FUNDS.--

20 A. Overpayments collected pursuant to the Medicaid  
21 Managed Care and Provider Act on behalf of the state shall be  
22 remitted to the state treasurer for deposit in the general fund  
23 to be used for the state's medicaid program.

24 B. The department shall not pay any portion of  
25 funds recovered by the state from a medicaid managed care

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1 organization or a medicaid provider or subcontractor to any  
2 other person unless expressly authorized or required to do so  
3 by state or federal law."

4 SECTION 14. A new section of the Medicaid Managed Care  
5 and Provider Act is enacted to read:

6 "[NEW MATERIAL] CREDIBLE ALLEGATION OF FRAUD--JUDICIAL  
7 REVIEW--SUBSTANTIAL EVIDENCE REQUIRED.--

8 A. A credible allegation of fraud determination by  
9 the department shall be deemed a final agency decision and may  
10 be appealed pursuant to Section 39-3-1.1 NMSA 1978.

11 B. A medicaid provider or subcontractor who is the  
12 subject of a referral to the attorney general for further  
13 investigation based on a credible allegation of fraud may seek  
14 judicial review, pursuant to Section 39-3-1.1 NMSA 1978, of the  
15 department's determination that the allegation of fraud is  
16 credible. The department shall show by substantial evidence  
17 that:

18 (1) it has not abused its discretion by  
19 failing to follow its own procedures; and

20 (2) the evidence relied upon to make its  
21 credible allegation of fraud determination was relevant,  
22 credible and material to the issue of fraud.

23 C. In a proceeding for judicial review under this  
24 section, the reviewing court shall not consider evidence  
25 acquired by the department after making its credible allegation

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1 of fraud determination."

2 SECTION 15. A new section of the Medicaid Managed Care  
3 and Provider Act is enacted to read:

4 "[NEW MATERIAL] AWARD OF COSTS, FEES AND INTEREST.--

5 A. If a medicaid provider or subcontractor is the  
6 prevailing party in any expedited adjudicatory or court  
7 proceeding brought by the medicaid provider or subcontractor  
8 pursuant to the Medicaid Managed Care and Provider Act on or  
9 after July 1, 2018 in connection with a tentative or final  
10 determination of overpayment or of credible allegation of  
11 fraud, the medicaid provider or subcontractor shall be entitled  
12 to:

13 (1) reasonable administrative costs incurred  
14 in connection with an expedited adjudicatory proceeding with  
15 the department;

16 (2) reasonable litigation costs incurred in  
17 connection with a court proceeding; and

18 (3) interest pursuant to Subsection F of this  
19 section.

20 B. As used in this section:

21 (1) "court proceeding" means any civil action  
22 brought in state district court;

23 (2) "reasonable administrative costs" means  
24 actual charges for:

25 (a) court reporter fees, service of

1 process fees and similar expenses;

2 (b) the services of expert witnesses;

3 (c) any study, analysis, report, test or  
4 project reasonably necessary for the preparation of the party's  
5 case; and

6 (d) fees and costs paid or incurred for  
7 the services of attorneys or of certified public accountants in  
8 connection with the expedited adjudicatory proceeding; and

9 (3) "reasonable litigation costs" means:

10 (a) reasonable court costs; and

11 (b) actual charges for: 1) filing fees,  
12 court reporter fees, service of process fees and similar  
13 expenses; 2) the services of expert witnesses; 3) any study,  
14 analysis, report, test or project reasonably necessary for the  
15 preparation of the party's case; and 4) fees and costs paid or  
16 incurred for the services of attorneys or certified public  
17 accountants in connection with the proceeding.

18 C. For purposes of this section:

19 (1) the medicaid provider or subcontractor is  
20 the prevailing party if it has:

21 (a) substantially prevailed with respect  
22 to the amount in controversy; or

23 (b) substantially prevailed with respect  
24 to most of the issues involved in the case or the most  
25 significant issue or set of issues involved in the case;

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1 (2) the medicaid provider or subcontractor  
2 shall not be treated as the prevailing party if, prior to July  
3 1, 2018, the department establishes or, on or after July 1,  
4 2018, the presiding administrative law judge finds that the  
5 position of the department in the proceeding was based upon a  
6 reasonable application of the law to the facts of the case.  
7 For purposes of this paragraph, the position of the department  
8 shall be presumed not to be based upon a reasonable application  
9 of the law to the facts of the case if:

10 (a) the department did not follow its  
11 own rules or procedures in making a tentative finding or final  
12 determination of overpayment; or

13 (b) the department's tentative finding  
14 or final determination of overpayment giving rise to the  
15 proceeding was not supported by substantial evidence at the  
16 time such finding or determination was made; and

17 (3) the determination of whether the medicaid  
18 provider or subcontractor is the prevailing party and the  
19 amount of reasonable administrative costs or reasonable  
20 litigation costs shall be made:

21 (a) by agreement of the parties;

22 (b) in an expedited adjudicatory  
23 proceeding, by the presiding administrative law judge; or

24 (c) in a court proceeding, by the court.

25 D. A decision or order granting or denying in whole

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1 or in part an award for reasonable administrative costs  
2 pursuant to Subsection A of this section by the presiding  
3 administrative law judge shall be reviewable in the same manner  
4 as a decision of an administrative hearing officer. An order  
5 granting or denying in whole or in part an award for reasonable  
6 litigation costs pursuant to Subsection A of this section in a  
7 court proceeding may be incorporated as a part of the decision  
8 or judgment in the court proceeding and shall be subject to  
9 appeal in the same manner as the decision or judgment.

10 E. No agreement for or award of reasonable  
11 administrative costs or reasonable litigation costs in any  
12 expedited adjudicatory or court proceeding pursuant to  
13 Subsection A of this section shall exceed the lesser of thirty  
14 percent of the amount of the settlement or judgment or one  
15 hundred thousand dollars (\$100,000). A medicaid provider or  
16 subcontractor awarded administrative or litigation costs  
17 pursuant to this section may not receive an award of attorney  
18 fees pursuant to any other statutory provision.

19 F. Interest on amounts owed to a prevailing  
20 medicaid provider or subcontractor shall accrue and be paid at  
21 the rate of one and one-half percent a month on the amount of  
22 a:

23 (1) clean claim electronically submitted by  
24 the medicaid provider or subcontractor and not paid within  
25 thirty days of receipt;

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1 (2) clean claim manually submitted by the  
2 medicaid provider or subcontractor and not paid within forty-  
3 five days of receipt; or

4 (3) claim for which additional information was  
5 necessary to substantiate the claim and not paid within sixty  
6 days of receipt of such additional information."

7 SECTION 16. A new section of the Medicaid Managed Care  
8 and Provider Act is enacted to read:

9 "[NEW MATERIAL] APPLICABILITY OF ADMINISTRATIVE PROCEDURES  
10 ACT.--

11 A. The department shall be subject to Sections  
12 12-8-2, 12-8-10 through 12-8-13, 12-8-15 and 12-8-16 NMSA 1978  
13 for expedited adjudicatory proceedings as provided by the  
14 Medicaid Managed Care and Provider Act.

15 B. Sections 12-8-2, 12-8-10 through 12-8-13,  
16 12-8-15 and 12-8-16 NMSA 1978 apply to Sections 5, 7 through 12  
17 and 15 of this 2018 act."

18 SECTION 17. A new section of the Administrative Hearings  
19 Office Act is enacted to read:

20 "[NEW MATERIAL] APPOINTMENT OF ADMINISTRATIVE LAW JUDGE  
21 FOR EXPEDITED ADJUDICATORY PROCEEDINGS UNDER THE MEDICAID  
22 MANAGED CARE AND PROVIDER ACT.--The chief hearing officer shall  
23 select an administrative law judge for expedited adjudicatory  
24 proceedings as provided by the Medicaid Managed Care and  
25 Provider Act."

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1           SECTION 18. Section 30-44-7 NMSA 1978 (being Laws 1989,  
2 Chapter 286, Section 7, as amended) is amended to read:

3           "30-44-7. MEDICAID FRAUD--DEFINED--INVESTIGATION--  
4 PENALTIES.--

5           A. Medicaid fraud consists of:

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

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

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

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

21                           (d) anything of value, intending to  
22 retain it and knowing it to be in excess of the rates  
23 established under the program for the provision of treatment,  
24 services or goods;

25                   (2) providing with intent that a claim be

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1       relied upon for the expenditure of public money:

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

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

7                       (c) merchandise that has been  
8       adulterated, debased or mislabeled or is outdated;

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

14                      (4) executing or conspiring to execute a plan  
15      or action to:

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

23                      (b) obtain by means of false or  
24      fraudulent representation or promise anything of value in  
25      connection with the delivery of or payment for health care

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

8 B. Unless accompanied by evidence of a culpable  
9 mental state, the following shall not constitute medicaid  
10 fraud:

11 (1) a failure to comply with service  
12 definitions or guidelines issued by the department or a  
13 medicaid managed care organization; or

14 (2) a breach of contractual terms or  
15 provisions.

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

22 ~~[G-]~~ D. Except as otherwise provided for in this  
23 section regarding the payment of fines by an entity, whoever  
24 commits medicaid fraud as described in Paragraph (2) or (4) of  
25 Subsection A of this section when the value of the benefit,

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1 treatment, services or goods improperly provided is:

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

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

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

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

18 (5) more than twenty thousand dollars  
19 (\$20,000) [~~shall be~~] is guilty of a second degree felony and  
20 shall be sentenced pursuant to the provisions of Section  
21 31-18-15 NMSA 1978.

22 [~~D-~~] E. Except as otherwise provided for in this  
23 section regarding the payment of fines by an entity, whoever  
24 commits medicaid fraud when the fraud results in physical harm  
25 or psychological harm to a recipient is guilty of a fourth

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1 degree felony and shall be sentenced pursuant to the provisions  
2 of Section 31-18-15 NMSA 1978.

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

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

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

20 ~~[H-]~~ I. The unit shall coordinate with the human  
21 services department, department of health and children, youth  
22 and families department to develop a joint protocol  
23 establishing responsibilities and procedures, including prompt  
24 and appropriate referrals and necessary action regarding  
25 allegations of program fraud, to ensure prompt investigation of

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

12 SECTION 19. TEMPORARY PROVISION--REFERENCES IN LAW.--As  
13 of the effective date of this act, all references in law to the  
14 Medicaid Provider Act shall be deemed to be references to the  
15 Medicaid Managed Care and Provider Act.

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