

SENATE FLOOR SUBSTITUTE FOR
SENATE BILL 2

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

AN ACT

RELATING TO MEDICAID; PRESERVING ACCESS TO MEDICAID SERVICES;
PROVIDING DUE PROCESS TO MEDICAID PROVIDERS AND SUBCONTRACTORS;
PROVIDING FOR HEARING OFFICERS; ESTABLISHING PROCEDURES TO
RESOLVE OVERPAYMENT DISPUTES; PROVIDING FOR JUDICIAL REVIEW OF
A CREDIBLE ALLEGATION OF FRAUD DETERMINATION.

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 and Managed
Care Act"."

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

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

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

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

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

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

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

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

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

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

1 F. "fraud" means any act that constitutes fraud
 2 under state or federal law;

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

7 ~~[C.]~~ H. "medicaid" means the medical assistance
 8 program established pursuant to Title 19 of the federal Social
 9 Security Act and regulations issued pursuant to that act;

10 ~~[D.]~~ I. "medicaid provider" means a person
 11 [including a managed care organization, operating under
 12 contract with the department to provide] who provides medicaid-
 13 related services to recipients;

14 J. "overpayment" means an amount paid to a medicaid
 15 provider or subcontractor in excess of the medicaid allowable
 16 amount, including payment for any claim to which a medicaid
 17 provider or subcontractor is not entitled;

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

20 ~~[F.]~~ L. "recipient" means a person whom the
 21 department has determined to be eligible to receive medicaid-
 22 related services;

23 ~~[G.]~~ M. "secretary" means the secretary of human
 24 services; and

25 ~~[H.]~~ N. "subcontractor" means a person who

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1 contracts with a medicaid provider or a managed care
2 organization to provide medicaid-related services to
3 recipients."

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

6 "27-11-3. REVIEW OF MEDICAID [~~PROVIDERS~~] PROVIDER OR
7 MANAGED CARE ORGANIZATION--CONTRACT REMEDIES--PENALTIES.--

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

17 B. Upon not less than two days' written notice to a
18 medicaid provider or managed care organization, the secretary
19 may, consistent with the provisions of the Medicaid Provider
20 and Managed Care Act and rules issued pursuant to that act,
21 carry out an administrative investigation or conduct
22 administrative proceedings to determine whether a medicaid
23 provider or managed care organization has:

24 (1) materially breached its obligation to
25 furnish medicaid-related services to recipients, or any other

1 duty specified in its contract with the department;

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

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

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

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

20 (6) fraudulently procured or attempted to
21 procure any benefit from medicaid.

22 C. Subject to the provisions of Subsection D of
23 this section, after affording a medicaid provider or managed
24 care organization written notice of hearing not less than ten
25 days before the hearing date and an opportunity to be heard,

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1 and upon making appropriate administrative findings, the
2 secretary may take any or any combination of the following
3 actions against the medicaid provider or managed care
4 organization:

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

11 (2) issue an administrative order requiring
12 the medicaid provider or managed care organization to:

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

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

18 (c) provide any service that has been
19 denied;

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

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

1 (3) suspend or revoke the contract between the
 2 medicaid provider or managed care organization and the
 3 department pursuant to the terms of that contract.

4 D. If a contract between the department and a
 5 medicaid provider or managed care organization explicitly
 6 specifies a dispute resolution mechanism for use in resolving
 7 disputes over performance of that contract, the dispute
 8 resolution mechanism specified in the contract shall be used to
 9 resolve such disputes in lieu of the mechanism set forth in
 10 Subsection C of this section.

11 E. If a medicaid provider's or managed care
 12 organization's contract so specifies, the medicaid provider or
 13 managed care organization shall have the right to seek de novo
 14 review in district court of any decision by the secretary
 15 regarding a contractual dispute."

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

18 "27-11-4. RETENTION AND PRODUCTION OF RECORDS.--

19 A. Medicaid providers, managed care organizations
 20 and their subcontractors shall retain, for a period of at least
 21 six years from the date of creation, all medical and business
 22 records that are necessary to verify the:

23 (1) treatment or care of any recipient for
 24 which the medicaid provider, managed care organization or
 25 subcontractor received payment from the department to provide

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1 that benefit or service;

2 (2) services or goods provided to any
3 recipient for which the medicaid provider, managed care
4 organization or subcontractor received payment from the
5 department to provide that benefit or service;

6 (3) amounts paid by medicaid or the medicaid
7 provider or managed care organization on behalf of any
8 recipient; and

9 (4) records required by medicaid under any
10 contract between the department and the medicaid provider or
11 managed care organization.

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

22 C. Failure to provide copies or to permit
23 inspection of records requested pursuant to this section shall
24 constitute a violation of the Medicaid Provider and Managed
25 Care Act within the meaning of Paragraph (3) of Subsection B of

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1 Section 27-11-3 NMSA 1978."

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

4 "[NEW MATERIAL] DETERMINATION OF OVERPAYMENTS OR CREDIBLE
5 ALLEGATION OF FRAUD--AUDIT FINDINGS--SAMPLING--EXTRAPOLATION
6 LIMITED--NOTICE OF RIGHT TO INFORMAL CONFERENCE AND EXPEDITED
7 ADJUDICATORY PROCEEDING.--

8 A. The department may audit a medicaid provider or
9 subcontractor for overpayment, using sampling for the time
10 period audited. If the department contracts for the audit, the
11 department shall contract only with an independent auditor
12 approved by the state auditor. Each audited claim shall be
13 reviewed by a person who is licensed, certified, registered or
14 otherwise credentialed in New Mexico as to the matters such
15 person reviews, including coding or specific clinical practice.

16 B. The department shall not extrapolate audit
17 findings unless a medicaid provider's or subcontractor's error
18 rate exceeds ten percent based upon an appropriate sampling and
19 a representative sample of claims computed by valid statistical
20 methods in accordance with the most recently published medicare
21 program integrity manual and using statistical software
22 approved by the United States department of health and human
23 services.

24 C. Prior to reaching either a final determination
25 of overpayment or a credible allegation of fraud, the

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1 department shall serve the medicaid provider or subcontractor
2 with a written preliminary finding of overpayment.

3 D. The preliminary finding of overpayment shall:

4 (1) state with specificity the factual and
5 legal basis for each claim forming the basis of an alleged
6 overpayment;

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

9 (3) notify the medicaid provider or
10 subcontractor that is the subject of a preliminary finding of
11 overpayment of its right to request, within thirty calendar
12 days of service of the preliminary finding of overpayment, an
13 informal conference with a representative of the department who
14 is knowledgeable about the department's preliminary finding of
15 overpayment and with a member of the audit team, if an audit
16 formed the basis of any alleged overpayment, to informally
17 address, resolve or dispute the department's preliminary
18 finding of overpayment.

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

25 SECTION 6. A new section of the Medicaid Provider and

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1 Managed Care Act is enacted to read:

2 "[NEW MATERIAL] INFORMAL CONFERENCE--CORRECTIVE ACTION--
3 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
8 preliminary determination of overpayment by the department on
9 the medicaid provider or subcontractor. Upon receipt of a
10 request for an informal conference, the department shall set a
11 date for the conference to occur no later than fourteen
12 business days following receipt of the request.

13 B. Within seven days following the informal
14 conference, a medicaid provider or subcontractor may submit a
15 proposed corrective action plan to the department to correct
16 clerical, typographical, scrivener's and computer errors or to
17 provide requested credentialing, licensure or training records
18 identified in audit findings. The department shall not
19 unreasonably withhold approval of the proposed corrective
20 action plan. A medicaid provider or subcontractor shall have
21 no less than thirty days from the date of approval of its
22 corrective action plan to provide additional information or
23 documentation to the department to attempt to address or
24 resolve a disputed preliminary finding of overpayment."

25 SECTION 7. A new section of the Medicaid Provider and

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1 Managed Care Act is enacted to read:

2 "[NEW MATERIAL] EXPEDITED ADJUDICATORY PROCEEDINGS--
3 REQUIREMENTS.--

4 A. A medicaid provider or subcontractor seeking an
5 expedited adjudicatory proceeding pursuant to the Medicaid
6 Provider and Managed Care Act shall serve the department and
7 the administrative hearings office with a written request for
8 such proceeding no later than thirty calendar days following
9 the service of a final determination of overpayment by the
10 department on the medicaid provider or subcontractor.

11 B. The chief hearing officer of the administrative
12 hearings office shall appoint or contract with a hearing
13 officer qualified pursuant to Section 8 of the this 2018 act no
14 later than thirty calendar days after service upon the
15 administrative hearings office of a request for an expedited
16 adjudicatory proceeding pursuant to the Medicaid Provider and
17 Managed Care Act by a medicaid provider or subcontractor.

18 C. The expedited adjudicatory proceeding requested
19 by a medicaid provider or subcontractor in accordance with the
20 Medicaid Provider and Managed Care Act shall commence no later
21 than thirty calendar days following the appointment of the
22 hearing officer or as stipulated by the parties or as otherwise
23 ordered by the hearing officer upon a showing of good cause.

24 The evidentiary hearing of an expedited adjudicatory proceeding
25 pursuant to this section shall not exceed ten business days in

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1 length and shall be conducted in accordance with Section
2 12-8-11 NMSA 1978.

3 D. After affording the parties the opportunity to
4 submit proposed findings and conclusions of law, and based
5 solely upon the record in accordance with the Medicaid Provider
6 and Managed Care Act and the Administrative Procedures Act, the
7 hearing officer shall make findings of fact and conclusions of
8 law on all material issues of fact, law or discretion, stating
9 the basis for each. In addition, the hearing officer shall
10 determine the amount of overpayment with respect to each
11 disputed claim submitted for payment, if any. The findings of
12 fact and conclusions of law of the hearing officer shall be
13 made and served upon all parties of record within thirty
14 calendar days following the hearing officer's receipt of the
15 record.

16 E. The hearing officer's findings of fact and
17 conclusions of law shall be binding on the department and
18 constitute a final agency decision, which may be appealed
19 pursuant to Section 39-3-1.1 NMSA 1978."

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

22 "[NEW MATERIAL] QUALIFICATIONS AND SELECTION OF HEARING
23 OFFICER FOR EXPEDITED ADJUDICATORY PROCEEDINGS.--

24 A. The hearing officer presiding over the expedited
25 adjudicatory proceeding held pursuant to the Medicaid Provider

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1 and Managed Care Act shall:

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

4 (2) have at least three years' cumulative
5 experience in one or more of the following areas: the health
6 insurance industry, the medicaid program, health care
7 regulatory compliance, medical claims administration or health
8 law;

9 (3) have at least five years' experience in
10 commercial litigation demonstrating the ability to make a
11 record in an adjudicatory proceeding suitable for judicial
12 review;

13 (4) not currently be employed by or represent,
14 or belong to a law firm that currently represents, the state or
15 a medicaid provider or managed care organization or third party
16 administrator currently doing business with the department; and

17 (5) not be related within the third degree of
18 consanguinity to a person currently employed by an executive
19 agency of the state, currently doing business with the state or
20 currently employed by an organization doing business with the
21 state.

22 B. The chief hearing officer of the administrative
23 hearings office shall select the hearing officer to preside
24 over an expedited adjudicatory proceeding held pursuant to the
25 Medicaid Provider and Managed Care Act and the Administrative

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1 Procedures Act."

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

4 "[NEW MATERIAL] COSTS OF EXPEDITED ADJUDICATORY
5 PROCEEDING.--

6 A. Each party shall be responsible for its own
7 costs related to the expedited adjudicatory proceeding,
8 including costs associated with preparation for the hearing,
9 discovery, depositions, subpoenas, service of process and
10 witness expenses, travel expenses and investigation expenses
11 and attorney fees.

12 B. The hearing officer shall allow telephonic
13 testimony of a witness if requested by a party.

14 C. The department shall reimburse the
15 administrative hearings office for the costs of a contract
16 hearing officer."

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

19 "[NEW MATERIAL] RIGHTS OF MEDICAID PROVIDER OR
20 SUBCONTRACTOR--PRELIMINARY OR FINAL DETERMINATION OF
21 OVERPAYMENT.--

22 A. A medicaid provider or subcontractor may
23 challenge:

24 (1) the department's preliminary or final
25 determination of overpayment as:

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1 (a) exceeding statutory authority;
2 (b) arbitrary or capricious;
3 (c) a failure to follow department
4 procedure; or

5 (d) not supported by substantial
6 evidence;

7 (2) the credentials of persons who
8 participated in the audit or claims review; or

9 (3) the methodology or accuracy of the
10 department's audit.

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

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

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

19 A. The department shall direct the release of a
20 suspended payment to a medicaid provider or subcontractor that
21 is the subject of a referral based upon a determination of a
22 credible allegation of fraud for services previously rendered
23 if the medicaid provider or subcontractor posts a surety bond
24 in the amount of the suspended payment, which posting shall be
25 deemed good cause not to suspend payment.

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

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

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

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

15 C. The department shall direct that the release of
16 a suspended payment occur no later than ten business days
17 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 Provider and
10 Managed Care 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 subcontractor based on a determination of a credible allegation
15 of 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 prepayment review of claims
23 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 Provider and
18 Managed Care Act is enacted to read:

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

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

24 B. The department shall not enter into a contract
25 to pay any portion of funds recovered by the state from a

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

4 SECTION 14. A new section of the Medicaid Provider and
5 Managed Care 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 Provider and
3 Managed Care 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 Provider and Managed Care Act on or
9 after July 1, 2018 in connection with a preliminary or final
10 determination of overpayment or a determination of credible
11 allegation of fraud, the medicaid provider or subcontractor
12 shall be entitled 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 preparation for and conduct of an
25 administrative proceeding, including:

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1 (a) court reporter fees, service of
2 process fees and similar expenses;

3 (b) the services of expert witnesses;

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

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

10 (3) "reasonable litigation costs" means:

11 (a) reasonable court costs; and

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

19 C. For purposes of this section:

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

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

24 (b) substantially prevailed with respect
25 to most of the issues involved in the case or the most

1 significant issue or set of issues involved in the case;

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

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

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

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

22 (a) by agreement of the parties;

23 (b) in an expedited adjudicatory
24 proceeding, by the hearing officer; or

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

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

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

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

24 (1) clean claim electronically submitted by
25 the medicaid provider or subcontractor and not paid within

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1 thirty days of receipt;

2 (2) clean claim manually submitted by medicaid

3 provider or subcontractor and not paid within forty-five days

4 of receipt; or

5 (3) claim for which additional information was

6 necessary to substantiate the claim and not paid within sixty

7 days of receipt of such additional information."

8 SECTION 16. A new section of the Medicaid Provider and

9 Managed Care Act is enacted to read:

10 "[NEW MATERIAL] APPLICABILITY OF ADMINISTRATIVE PROCEDURES

11 ACT.--

12 A. The department shall be subject to Sections

13 12-8-2, 12-8-10 through 12-8-13, 12-8-15 and 12-8-16 NMSA 1978

14 for expedited adjudicatory proceedings as provided by the

15 Medicaid Provider and Managed Care Act.

16 B. Sections 12-8-2, 12-8-10 through 12-8-13,

17 12-8-15 and 12-8-16 NMSA 1978 apply to Sections 5, 7 through 11

18 and 14 of this 2018 act."

19 SECTION 17. A new section of the Administrative Hearings

20 Office Act is enacted to read:

21 "[NEW MATERIAL] APPOINTMENT OF HEARING OFFICER FOR

22 EXPEDITED ADJUDICATORY PROCEEDINGS UNDER THE MEDICAID PROVIDER

23 AND MANAGED CARE ACT.--The chief hearing officer shall select a

24 hearing officer for expedited adjudicatory proceedings as

25 provided by the Medicaid Provider and Managed Care Act."

.209163.8

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1 SECTION 18. TEMPORARY PROVISION--REFERENCES IN LAW.--As
 2 of the effective date of this act, all references in law to the
 3 Medicaid Provider Act shall be deemed to be references to the
 4 Medicaid Provider and Managed Care Act.

5 SECTION 19. EFFECTIVE DATE.--The effective date of the
 6 provisions of this act is January 1, 2019.

underscoring = new
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