UNANNOTATED

CHAPTER 27
Public Assistance

ARTICLE 1
General Provisions

27-1-1. Definitions.

As used in Articles 1 and 2 of Chapter 13 NMSA 1953, "department", "department of public welfare", "state department of public welfare", "New Mexico department of public welfare", "state board of public welfare", "board of public welfare", "state board", "state department", "health and social services department", "department of health and social services", "health and social services board", "board" and "human services department" mean the health care authority.

History: 1953 Comp., § 13-1-1, enacted by Laws 1977, ch. 252, § 16; 2024, ch. 39, § 60.

27-1-2. Powers of health care authority.

A. The health care authority is an agency of the state and shall at all times be under the exclusive control of this state. The management and control of the health care authority is vested in the secretary of health care authority.

B. Subject to the constitution of New Mexico, the health care authority has the power to:

(1) sue and, with the consent of the legislature, be sued;

(2) adopt and use a corporate seal;

(3) have succession in its corporate name;

(4) make contracts as authorized in Chapter 27 NMSA 1978 to carry out the purposes of that chapter;

(5) adopt, amend and repeal bylaws and rules;

(6) purchase, lease and hold real and personal property necessary or convenient for the carrying out of its powers and duties, to exercise the right of eminent

domain to acquire such real property in the same manner as the state now exercises that right and to dispose of any property acquired in any manner;

(7) have such powers as may be necessary or appropriate for the exercise of the powers specifically conferred upon it in Chapter 27 NMSA 1978;

(8) receive and have custody for protection and administration, disburse, dispose of and account for funds, commodities, equipment, supplies and any kind of property given, granted, loaned or advanced to the state for public assistance, public welfare, social security or any other similar purpose;

(9) enter into reciprocal agreements with public welfare agencies of other states relative to the provision for relief or assistance to transients and nonresidents;

(10) establish and administer programs of old age assistance and temporary assistance for needy families and persons with a visual impairment;

(11) establish and administer a program of services for children with a disability or who have a condition that may lead to a disability, and to supervise the administration of those services that are not administered directly by it;

(12) establish, extend and strengthen public welfare services for children; and

(13) establish and administer a program for general relief.

History: Laws 1937, ch. 18, § 3; 1941 Comp., § 73-103; 1953 Comp., § 13-1-3; 2007, ch. 46, § 16; 2024, ch. 39, § 61.

27-1-2.1. Temporary provision; subsidies to certain acute care facilities to cover revenue losses. (Repealed effective July 1, 2026.)

A. An eligible health care facility may apply annually to the health care authority department for quarterly subsidies to provide to sick and indigent persons in New Mexico:

(1) emergency medical services;

(2) inpatient services related to maternal, child and family health; or

(3) inpatient unit acute care.

B. An eligible health care facility shall only use a subsidy for the provision of care and services pursuant to Subsection A of this section and shall submit annually to the health care authority department a report demonstrating that the subsidy has been used to provide such care and services.

C. An eligible health care facility that has less than one hundred days of cash on hand in reserves shall provide the health care authority department with the following:

(1) upon initial application, a plan for the eligible health care facility to have one hundred days of cash on hand in reserves within five years without cutting the services it provides and providing those services to all patients, regardless of insurance coverage; and

(2) quarterly updates until the end of fiscal year 2026 regarding progress toward completing the plan pursuant to Paragraph (1) of this subsection.

D. An eligible health care facility that has more than one hundred days of cash on hand in reserves shall provide the health care authority department with the following:

(1) upon initial application, a plan for the eligible health care facility to maintain at least one hundred days of cash on hand in reserves without cutting the services it provides and providing those services to all patients, regardless of insurance coverage; and

(2) quarterly updates until the end of fiscal year 2026 regarding progress toward completing the plan pursuant to Paragraph (1) of this subsection.

E. An eligible health care facility that fails to provide the annual report or the quarterly updates to the health care authority department pursuant to this section shall not receive additional subsidies.

F. Over the course of fiscal years 2025 and 2026, the health care authority department shall not provide more than:

(1) three million two hundred thousand dollars ($3,200,000) to the Artesia general hospital;

(2) four million five hundred thirty-four thousand dollars ($4,534,000) to the Cibola general hospital;

(3) five million seven hundred thousand dollars ($5,700,000) to the Holy Cross hospital;

(4) two million five hundred thousand dollars ($2,500,000) to the miners' Colfax medical center;

(5) five million seven hundred thousand dollars ($5,700,000) to the Roosevelt general hospital;

(6) five million seven hundred thousand dollars ($5,700,000) to Rehoboth McKinley Christian health care services;

(7) two million seven hundred thousand dollars ($2,700,000) to the Sierra Vista hospital;

(8) five million seven hundred thousand dollars ($5,700,000) to the Union county general hospital;

(9) one million seven hundred thousand dollars ($1,700,000) to the Guadalupe county hospital;

(10) five million seven hundred thousand dollars ($5,700,000) to the Gila regional medical center; or

(11) one million eight hundred sixty-six thousand dollars ($1,866,000) to the Nor-Lea hospital district.

G. For the purposes of this section, "eligible health care facility" means the hospitals listed in Subsection F of this section.

History: Laws 2024, ch. 44, § 1.

27-1-3. Activities of health care authority.

The health care authority shall be charged with the administration of all the welfare activities of the state as provided in Chapter 27 NMSA 1978, except as otherwise provided for by law. The health care authority shall, except as otherwise provided by law:

A. administer old age assistance, temporary assistance for needy families, assistance to persons with a visual impairment or other physical disability and general relief;

B. administer all aid or services to children with a disability, including the extension and improvement of services for children with such a disability, insofar as practicable under conditions in this state, provide for locating children who have a disability or a condition that may become a disability, provide corrective and any other services and care and facilities for diagnosis, hospitalization and after-care for such children and supervise the administration of those services that are not administered directly by the health care authority;

C. formulate detailed plans, make rules and take action that is deemed necessary or desirable to carry out the provisions of Chapter 27 NMSA 1978 and that is not inconsistent with the provisions of that chapter;

D. cooperate with the federal government in matters of mutual concern pertaining to public welfare and public assistance, including the adoption of such methods of

administration as are found by the federal government to be necessary for the efficient operation of the plan for public welfare and assistance;

E. assist other departments, agencies and institutions of local, state and federal governments when so requested, cooperate with such agencies when expedient in performing services in conformity with the purposes of Chapter 27 NMSA 1978 and cooperate with medical, health, nursing and welfare groups, any state agency charged with the administration of laws providing for vocational rehabilitation of persons with a physical disability and organizations within the state;

F. act as the agent of the federal government in welfare matters of mutual concern in conformity with the provisions of Chapter 27 NMSA 1978 and in the administration of any federal funds granted to this state, to aid in furtherance of any such functions of the state government;

G. establish in counties or in districts, which may include two or more counties, local units of administration to serve as agents of the health care authority;

H. at its discretion, establish local offices of the health care authority for such territory as it may see fit and by rule prescribe the duties of the local office;

I. administer such other public welfare functions as may be assumed by the state after June 19, 1987;

J. carry on research and compile statistics relative to the entire public welfare program throughout the state, including all phases of dependency, defectiveness, delinquency and related problems, and develop plans in cooperation with other public and private agencies for the prevention as well as treatment of conditions giving rise to public welfare problems; and

K. inspect and require reports from all private institutions, boarding homes and agencies providing assistance, care or other direct services to persons who are elderly, who have a visual impairment, who have a physical or developmental disability or who are otherwise dependent.

Nothing contained in this section shall be construed to authorize the health care authority to establish or prescribe standards or regulations for or otherwise regulate programs or services to children in group homes as defined in Section 9-8-13 NMSA 1978 [repealed].

History: Laws 1937, ch. 18, § 4; 1941 Comp., § 73-104; 1953 Comp., § 13-1-4; Laws 1987, ch. 31, § 3; 2007, ch. 46, § 17; 2024, ch. 39, § 62.

27-1-3.1. Acute care bed usage; funding authorization.

The health care authority is authorized to accept and use federal grants or matching funds for the purpose of reimbursement to certain rural hospitals for using empty acute care beds for intermediate care and skilled nursing care, as defined in federal statutes and regulations, subject to federal approval and the availability of funds. The health care authority is authorized to use funds from existing appropriations for matching federal funds for the purposes of this section.

History: Laws 1980, ch. 83, § 1; 2024, ch. 39, § 63.

27-1-4. Status of assistance payments.

Payments received by a displaced person under the Relocation Assistance Act [42-3-1 NMSA 1978] shall not be considered as income or resources to any recipient of public assistance, and such payments shall not be deducted from the amount of aid to which the recipient would otherwise be entitled under the laws of this state.

History: 1953 Comp., § 13-1-20.2, enacted by Laws 1972, ch. 41, § 22.

27-1-5 to 27-1-7. Repealed.

27-1-8. State case registry.

A. The health care authority, acting as the state's child support enforcement agency pursuant to Title 4-D of the Social Security Act, shall establish a state case registry by October 1, 1998 that contains records with respect to:

(1) each case in which services are being provided on or after October 1, 1998 by the state Title 4-D agency; and

(2) each support order established or modified in the state on or after October 1, 1998, whether or not the order was obtained by the Title 4-D agency.

B. The records maintained by the state case registry shall use standardized data elements for parents, such as names, social security numbers and other uniform identification numbers like dates of birth and case identification numbers and contain such other information, such as case status, as the United States secretary of health and human services may require.

C. The Title 4-D agency and the administrative office of the courts shall work cooperatively to ensure that the requirements of Laws 1997, Chapter 237 are implemented in an effective, efficient and timely manner. The health care authority shall reimburse the administrative office of the courts for all costs incurred in furnishing the information. A cooperative agreement between the Title 4-D agency and the administrative office of the courts shall include costs to be charged by the administrative office of the courts for all work performed to conform to these requirements. The health care authority shall promptly provide the administrative office of the courts the data

elements and formats required under Subsection B of this section as soon as they become available to the authority.

D. The state case registry shall extract information from its automated system to share and compare information with and to receive information from other databases and information comparison services in order to obtain or provide information necessary to enable the Title 4-D agency or the United States secretary of health and human services or other state or federal agencies to carry out the Title 4-D program, subject to Section 6103 of the Internal Revenue Code of 1986. Such information comparison activities shall include the following:

(1) furnishing to the federal case registry of child support orders established (and update as necessary with information, including notice of expiration of orders) the minimum amount of information on child support cases recorded in the state case registry that is necessary to operate the federal registry, as specified by the United States secretary of health and human services in regulations;

(2) exchanging information with the federal parent locator service for the purposes specified in the State Directory of New Hires Act [50-13-1 to 50-13-4 NMSA 1978];

(3) exchanging information with New Mexico agencies and agencies of other states administering programs of temporary assistance for needy families and medicaid and other programs designated by the United States secretary of health and human services as necessary to perform state agency responsibilities under this section and under such programs; and

(4) exchanging information with other agencies of the state, agencies of other states and interstate information networks as necessary and appropriate to carry out or assist other states to carry out purposes of the Title 4-D program.

History: Laws 1997, ch. 237, § 1; 2024, ch. 39, § 64.

27-1-9. Locator information from interstate networks.

The state Title IV-D agency is authorized to have access to any system used by the state to locate an individual for purposes relating to motor vehicle or law enforcement.

History: Laws 1997, ch. 237, § 14.

27-1-10. Collection and use of social security numbers for use in child support enforcement.

A. For applicants or persons who have been assigned a social security number, the state shall have and use procedures requiring that the social security number of any:

(1) applicant for a professional license, commercial driver's license or occupational license be recorded on the application;

(2) applicant for a marriage license be collected and placed in the records maintained by the county clerk;

(3) person who is subject to a divorce decree, support order or paternity determination or acknowledgment be placed in the records relating to the matter; and

(4) person who has died be placed in the records relating to the death and be recorded on the death certificate.

B. The collection and use of social security numbers shall be made available to the human services department [health care authority department] for use in child support enforcement.

History: Laws 1997, ch. 237, § 15; 2013, ch. 144, § 1.

27-1-11. Expedited procedure.

The state Title IV-D agency shall have the authority to take the following actions relating to establishment of paternity or to establishment, modification or enforcement of support orders, without the necessity of obtaining an order from any other judicial or administrative tribunal, and to recognize and enforce the authority of state Title IV-D agencies of other states to take the following actions:

A. to order genetic testing for the purpose of paternity establishments;

B. to subpoena any financial or other information needed to establish, modify or enforce a support order and to impose penalties for failure to respond to such a subpoena. A subpoena issued by the state Title IV-D agency under this section shall be served upon the person to be subpoenaed or, at the option of the secretary of human services or the secretary's authorized representative, by certified mail addressed to the person at his last known address. The service of the subpoena shall be at least ten days prior to the required production of the information. If the subpoena is served by certified mail, proof of service is the affidavit of mailing. After service of a subpoena upon a person, if the person neglects or refuses to comply with the subpoena, the state Title IV-D agency may apply to the district court of the county where the subpoena was served or the county where the subpoena was responded to for an order compelling compliance. Failure of the person to comply with the district court's order shall be punishable as contempt;

C. to require all entities in the state, including for-profit, nonprofit and governmental employers to provide promptly, in response to a request by the state Title IV-D agency of that or any other state administering a program under this part, information on the

employment compensation, and benefits of any person employed by such entity as an employee or contractor and to sanction failure to respond to any such request;

D. to obtain access, subject to safeguards on privacy and information security, and subject to the nonliability of entities that afford such access, to information contained in the following records, including automated access in the case of records maintained in automated databases:

(1) records of other states and local government agencies, including:

(a) vital statistics, including records of marriage, birth and divorce;

(b) state and local tax and revenue records, including information on residence address, employer, income and assets;

(c) records concerning real and titled personal property;

(d) records of occupational and professional licenses and records concerning the ownership and control of corporations, partnerships and other business entities;

(e) employment security records;

(f) records of agencies administering public assistance programs;

(g) records of the motor vehicle division of the taxation and revenue department; and

(h) corrections records; and

(2) certain records held by private entities with respect to persons who owe or are owed support, or against or with respect to whom a support obligation is sought, consisting of:

(a) the names and addresses of such persons and the names and addresses of the employers of such persons, as appearing in customer records of public utilities and cable television companies, pursuant to an administrative subpoena; and

(b) information including information on assets and liabilities on such individuals held by financial institutions;

E. in cases in which support is subject to an assignment in order to comply with a requirement imposed pursuant to temporary assistance for needy families or medicaid, or to a requirement to pay through the state disbursement unit established pursuant to Section 454B of the Social Security Act, upon providing notice to obligor and obligee to direct the obligor or other payor to change the payee to the appropriate government entity;

F. to order income withholding;

G. in cases in which there is a support arrearage, to secure assets to satisfy the arrearage by:

(1) intercepting or seizing periodic or lump-sum payments from:

(a) a state or local agency, including unemployment compensation, workers' compensation and other benefits; and

(b) judgments, settlements and lotteries;

(2) attaching and seizing assets of the obligor held in financial institutions;

(3) attaching public and private retirement funds; and

(4) imposing liens and, in appropriate cases, to force sale of property and distribution of proceeds;

H. for the purpose of securing overdue support, to increase the amounts for arrearages, subject to such conditions or limitations as the state Title IV-D agency may provide;

I. the expedited procedures required shall include the following rules and authority, applicable with respect to all proceedings to establish paternity or to establish, modify or enforce support orders:

(1) each party to any paternity or child support proceeding is required, subject to privacy safeguards, to file with the tribunal and the state case registry upon entry of an order, and to update, as appropriate, information on location and identity of the party, including social security number, residential and mailing addresses, telephone number and driver's license number, and name, address and telephone number of employer; and

(2) in any subsequent child support enforcement action between the parties, upon sufficient showing that diligent effort has been made to ascertain the location of such a party, the tribunal may deem state due process requirements for notice and service of process to be met with respect to the party, upon delivery of written notice to the most recent residential or employer address filed with the tribunal;

J. procedures under which:

(1) the state agency and administrative or judicial tribunal with authority to hear child support and paternity cases exerts statewide jurisdiction over the parties; and

(2) in a state in which orders are issued by courts or administrative tribunals, a case may be transferred between local jurisdictions in the state without need for any additional filing by the petitioner, or service of process upon the respondent, to retain jurisdiction over the parties; and

K. the authority of the Title IV-D agency with regard to Subsections A through J of this section shall be subject to due process safeguards, including, as appropriate, requirements for notice, opportunity to contest the action and opportunity for an appeal on the record to an independent administrative or judicial tribunal. Such due process safeguards shall be developed and implemented by the Title IV-D agency in accordance with the administrative office of the courts and other affected agencies and individuals consistent with current policies and procedures for implementation of the human services department's [health care authority department's] regulations.

History: Laws 1997, ch. 237, § 16.

27-1-12. Work requirement for persons owing past-due child support.

The state Title IV-D agency must have and use procedures under which the state has the authority, in any case in which an individual owes past-due support with respect to a child receiving assistance under a state program funded under temporary assistance for needy families, to issue an order or to request that a court or an administrative process established pursuant to state law issue an order that requires the individual to:

A. pay such support in accordance with a plan approved by the court, or at the option of the state, a plan approved by the state Title IV-D agency; or

B. if the individual is subject to such a plan and is not incapacitated, participate in such work activities as the court, or at the option of the state, the state Title IV-D agency, deems appropriate.

History: Laws 1997, ch. 237, § 22.

27-1-13. Financial institution data matches.

A. "Financial institution" means:

(1) a depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. 1813(c));

(2) an institution-affiliated party, as defined in Section 3(u) of that act (12 U.S.C. 1813(u));

(3) any federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. 1752), including an institution-affiliated party of such a credit union, as defined in Section 206(r) of that act (12 U.S.C. 1786(r)); and

(4) any benefit association, insurance company, safe deposit company, money-market mutual fund or similar entity authorized to do business in the state.

B. "Account" means a demand deposit account, checking or negotiable withdrawal order account, savings account, time deposit account or money-market mutual fund account.

C. "Past-due support" means the amount of support determined under a court order or an order of an administrative process established under state law for support and maintenance of a child or of a child and the parent with whom the child is living that has not been paid.

D. The health care authority, acting as the state's child support enforcement agency pursuant to Title 4-D of the Social Security Act, shall enter into agreements with financial institutions doing business in the state to develop and operate, in coordination with such financial institutions, a data match system to be operational by October 1, 2000, using automated data exchanges to the maximum extent feasible, in which each such financial institution is required to provide the information.

E. The health care authority shall establish standard procedures and formats for the financial institutions. Such procedures shall include administrative due process for child support obligors before funds or assets may be seized by the health care authority.

F. Each financial institution in New Mexico shall provide to the health care authority for each calendar quarter the name, record address, social security number or other taxpayer identification number and other identifying information for each noncustodial parent who maintains an account at such institution and who owes past-due support, as identified by the authority, by name and social security number or other taxpayer identification number.

G. Upon receipt of a notice of lien or levy from the health care authority, financial institutions shall encumber and surrender assets held by the institution on behalf of any noncustodial parent who is subject to a child support lien.

H. The health care authority may establish and pay a reasonable fee to a financial institution for conducting the data match provided for in this section, not to exceed the actual costs incurred by such financial institutions.

I. A financial institution shall not be liable under any state law to any person for disclosing of information to the health care authority under this section or for freezing or surrendering any assets held by the financial institution in response to a notice of lien or

seizure issued by the authority or for any other action taken in good faith to comply with the requirements of this section.

J. A state child support enforcement agency that obtains a financial record of a person from a financial institution may disclose the financial record only for the purpose of, and to the extent necessary in, establishing, modifying or enforcing a child support obligation of the person.

History: Laws 1997, ch. 237, § 33; 2024, ch. 39, § 65.

27-1-14. Enforcement of orders for health care.

A. All Title IV-D agency cases shall include a provision for the health care coverage of each child. In the case in which a medical support obligor parent provides such coverage and changes employment and the new employer provides such coverage, the state Title IV-D agency shall transfer notice of the provision to the employer, which notice shall operate to enroll each child in the medical support obligor's health plan unless the medical support obligor successfully contests the notice.

B. For purposes of this section, "medical support obligor" means a person owing a duty to provide health support, or against whom a proceeding for the enforcement of such a duty of support is commenced or for registration of a support order that includes provisions for such support for each minor child.

History: Laws 1997, ch. 237, § 34; 2007, ch. 165, § 1.

27-1-15. Repealed.

History: Laws 2005, ch. 160, § 1; repealed by Laws 2006, ch. 26, § 4.

27-1-16. Brain injury services fund created.

A. The "brain injury services fund" is created as a nonreverting fund in the state treasury. The fund shall be invested in accordance with the provisions of Section 6-10-10 NMSA 1978, and all income earned on the fund shall be credited to the fund.

B. The brain injury services fund shall be used to institute and maintain a statewide brain injury services program designed to increase the independence of persons with brain injuries.

C. The health care authority shall adopt all rules and policies necessary to administer a statewide brain injury services program. The authority shall coordinate with and seek advice from the brain injury advisory council to ensure that the statewide brain injury services program is appropriate for persons with brain injuries.

D. All money credited to the brain injury services fund shall be appropriated to the health care authority to carry out the provisions of this section.

E. Disbursements from the brain injury services fund shall be made upon warrant drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of health care authority.

F. For the purposes of this section, "brain injury":

(1) means an injury to the brain of traumatic or acquired origin, including an open or closed head injury caused by:

(a) an insult to the brain from an outside physical force;

(b) anoxia;

(c) electrical shock;

(d) shaken baby syndrome;

(e) a toxic or chemical substance;

(f) near-drowning;

(g) infection;

(h) a tumor;

(i) a vascular lesion; or

(j) an event that results in either temporary or permanent, partial or total impairments in one or more areas of the brain that results in total or partial functional disability, including: 1) cognition; 2) language; 3) memory; 4) attention; 5) reasoning; 6) abstract thinking; 7) judgment; 8) problem solving; 9) sensory perception and motor abilities; 10) psychosocial behavior; 11) physical functions; 12) information processing; or 13) speech; and

(2) does not apply to an injury that is:

(a) congenital;

(b) degenerative;

(c) induced by birth trauma;

(d) induced by a neurological disorder related to the aging process; or

(e) a chemically caused brain injury that is a result of habitual substance abuse.

History: Laws 2013, ch. 44, § 1; 2014, ch. 36, § 1; 2024, ch. 39, § 66.

ARTICLE 2
Public Assistance Act

27-2-1. Short title.

Sections 27-2-1 through 27-2-34 NMSA 1978 may be cited as the "Public Assistance Act".

History: 1953 Comp., § 13-17-1, enacted by Laws 1973, ch. 376, § 1; 2013, ch. 139, § 1.

27-2-2. Definitions.

As used in the Public Assistance Act:

A. "authority" or "department" means the health care authority;

B. "board" means the authority;

C. "director" means the secretary;

D. "local office" means the county or district office of the authority;

E. "medicaid advisory committee" means the body, established by federal law, that advises the New Mexico medicaid program on policy development and program administration;

F. "medicaid forward plan" means a health care coverage plan that leverages the medicaid program to provide a state-administered health care coverage option;

G. "public welfare" or "public assistance" means any aid or relief granted to or on behalf of an eligible person under the Public Assistance Act and rules issued pursuant to that act;

H. "applicant" means a person who has applied for assistance or services under the Public Assistance Act;

I. "recipient" means a person who is receiving assistance or services under the Public Assistance Act;

J. "federal act" means the federal Social Security Act, as may be amended from time to time, and regulations issued pursuant to that act; and

K. "secretary" means the secretary of health care authority.

History: 1953 Comp., § 13-17-2, enacted by Laws 1973, ch. 376, § 2; 1977, ch. 252, § 21; 1978 Comp., § 27-2-2; 1987, ch. 78, § 1; 1991, ch. 155, § 1; 2023, ch. 198, § 1; 2024, ch. 39, § 67.

27-2-3. Standard of need; income determination.

A. Consistent with the federal act and subject to the availability of federal and state funds, the board shall adopt a standard of need which shall establish a reasonable level of subsistence.

B. Consistent with the federal act, the board shall define by regulation exempt and nonexempt income and resources. Medical expenses shall not be deducted from either income or resources in determining eligibility.

History: 1953 Comp., § 13-17-3, enacted by Laws 1973, ch. 376, § 3; 1975, ch. 187, § 3.

27-2-4. Eligibility requirements.

Consistent with the federal act, a person is eligible for public assistance grants under the Public Assistance Act if:

A. pursuant to Section 27-2-3 NMSA 1978, the total amount of the person's nonexempt income is less than the applicable standard of need;

B. nonexempt specific and total resources are less than the level of maximum permissible resources established by the department;

C. the person meets all qualifications for one of the public assistance programs authorized by the Public Assistance Act;

D. within two years immediately prior to the filing of an application for assistance, the person has not made an assignment or transfer of real property unless the person has received a reasonable return for the real property or, if the person has not received a reasonable return, the person is willing to attempt to obtain such return and, if that attempt proves futile, the person is willing to attempt to regain title to the property;

E. the person is not an inmate of any public nonmedical institution at the time of receiving assistance, except that an inmate may be eligible for medical assistance programs administered by the medical assistance division of the department; and

F. the person is a resident of New Mexico.

History: 1953 Comp., § 13-17-4, enacted by Laws 1973, ch. 376, § 4; 1975, ch. 187, § 4; 2015, ch. 127, § 1.

27-2-5, 27-2-6. Repealed.

27-2-6.1. Supplemental postnatal assistance.

The department shall establish a program of supplemental postnatal assistance for those developmentally or intellectually disabled persons who during pregnancy received temporary assistance for needy families but whose assistance was revoked upon relinquishment of the newly born child for adoption. The supplemental postnatal assistance provided for in this section shall be at the same rate as temporary assistance for needy families, but supplemental postnatal assistance shall not exceed a period of sixty days. The department shall promulgate rules to carry out the provisions of this section.

History: 1978 Comp., § 27-2-6.1, enacted by Laws 1978, ch. 30, § 1; 2023, ch. 113, § 3.

27-2-6.2. Repealed.

27-2-7. General assistance program; qualifications and payments.

A. Subject to the availability of state funds, public assistance shall be provided under a general assistance program to or on behalf of eligible persons who:

(1) are under eighteen years of age and meet all eligibility conditions for the New Mexico Works Act [27-2B-1 NMSA 1978] except the relationship to the person with whom they are living;

(2) are over the age of eighteen and are disabled, according to rules of the department, and are not receiving cash assistance or services pursuant to the New Mexico Works Act;

(3) meet the qualifications under other rules for the general assistance program as the department shall establish; or

(4) are lawful resident immigrants who would otherwise be eligible for cash assistance or services pursuant to the New Mexico Works Act except that they began residing in the United States after August 22, 1996.

B. General assistance program payments may be made directly to the recipient or to the vendor of goods or services provided to the recipient. The department may by rule limit the grants that are made to general assistance recipients.

C. Whenever the department makes an adjustment in the standard of need for the New Mexico Works Act, subject to the availability of state funds, it shall make a commensurate adjustment in the standard of need for the general assistance program.

History: 1953 Comp., § 13-17-10, enacted by Laws 1973, ch. 376, § 10; 1977, ch. 201, § 1; 1998, ch. 8, § 27; 1998, ch. 9, § 27.

27-2-7.1. Eligible person entitled to information.

A recipient shall be provided with information about expiration of medicaid or general assistance benefits when the recipient or the recipient's guardian, custodian or other authorized representative files a request for such information with the human services department [health care authority department]. The department shall respond to the request within five business days of receipt of the request made on a form the department shall devise and make available to a recipient. The response shall be by physical mail, electronic mail or facsimile or by access into a department-authorized web site.

History: Laws 2007, ch. 88, § 1.

27-2-8. Repealed.

27-2-9. Payment for hospital care.

A. Consistent with the federal act, the department shall provide necessary hospital care for recipients of public assistance other than those eligible under the general assistance program authorized by Section 10 [27-2-7 NMSA 1978] of the Public Assistance Act. The rate of payment for in-patient hospital services shall be based either on the reasonable cost or the customary cost of such services, whichever is less. In determining reasonable cost under this section, the board shall adopt regulations establishing a formula consistent with the federal act. The department shall apply that formula to determine the amount to which each hospital is entitled as reimbursement for providing in-patient hospital services.

B. To receive reimbursement for providing in-patient hospital services, a hospital shall file annually with the department such information as the department may reasonably require to determine reasonable costs or the hospital's customary cost of in-patient hospital services.

C. Any hospital entitled to reimbursement for in-patient hospital services shall be entitled to a hearing, pursuant to regulations of the board consistent with applicable

state law, if the hospital disagrees with the department's determination of the reimbursement the hospital is to receive.

History: 1953 Comp., § 13-17-12, enacted by Laws 1973, ch. 376, § 13.

27-2-9.1. Administration of shelter care supplement.

A. A shelter care supplement shall be provided to those persons who are recipients of supplemental security income under Title 16 of the federal Social Security Act and who reside in shelter care homes licensed by the authority.

B. The authority is authorized to determine eligibility, compute payment, make payments and otherwise administer the shelter care supplement program.

C. The amount of the shelter care supplement payment shall be established by the secretary subject to the availability of general funds.

History: Laws 1979, ch. 401, § 1; 1983, ch. 174, § 1; 2024, ch. 39, § 68.

27-2-10. Food stamp program.

The income support division of the human services department [health care authority department]:

A. is authorized to establish a food stamp program to carry out the federal Food Stamp Act, as may be amended from time to time, and regulations issued pursuant to that act, subject to the continuation of the federal food stamp program and the availability of federal funds; and

B. shall by January 30 of each calendar year notify the taxation and revenue department of the location of food stamp offices in New Mexico for inclusion in a notice sent with an income tax refund or other notice to a taxpayer whose income is within one hundred thirty percent of federal poverty guidelines.

History: 1953 Comp., § 13-17-13, enacted by Laws 1973, ch. 376, § 14; 2005, ch. 138, § 2.

27-2-11. Scope of assistance programs.

Any public assistance program conducted by the department under the federal act is effective in all political subdivisions if the federal act so requires.

History: 1953 Comp., § 13-17-14, enacted by Laws 1973, ch. 376, § 15.

27-2-12. Medical assistance programs.

A. Consistent with the federal act and subject to the appropriation and availability of federal and state funds, the medical assistance division of the department may by rule provide medical assistance, including the services of licensed doctors of oriental medicine, licensed chiropractic physicians, licensed dental therapists and licensed dental hygienists in collaborating practice, to persons eligible for public assistance programs under the federal act.

B. Subject to appropriation and availability of federal, state or other funds received by the state from public or private grants or donations, the medical assistance division of the department may by rule provide medical assistance, including assistance in the payment of premiums for medical or long-term care insurance, to children up to the age of twelve if not part of a sibling group; children up to the age of eighteen if part of a sibling group that includes a child up to the age of twelve; and pregnant women who are residents of the state of New Mexico and who are ineligible for public assistance under the federal act. The department, in implementing the provisions of this subsection, shall:

(1) establish rules that encourage pregnant women to participate in prenatal care; and

(2) not provide a benefit package that exceeds the benefit package provided to state employees.

History: 1953 Comp., § 13-17-15, enacted by Laws 1973, ch. 376, § 16; 1991, ch. 144, § 1; 1993, ch. 158, § 1; 2003, ch. 343, § 1; 2006, ch. 2, § 1; 2019, ch. 107, § 15.

27-2-12.1. Repealed.

27-2-12.2. Medical assistance program; eligibility of married individuals.

For the purpose of determining medical assistance for institutional care program eligibility under the Public Assistance Act, the community spouse resource allowance for a community spouse as defined and authorized by the federal Medicare Catastrophic Coverage Act of 1988 shall be a minimum of thirty thousand dollars ($30,000).

History: Laws 1987, ch. 16, § 1; 1989, ch. 74, § 1.

27-2-12.3. Medicaid reimbursement; equal pay for equal physicians', dentists', optometrists', podiatrists' and psychologists' services.

The human services department [health care authority department] shall establish a rate for the reimbursement of physicians, dentists, optometrists, podiatrists and

psychologists for services rendered to medicaid patients that provides equal reimbursement for the same or similar services rendered without respect to the date on which such physician, dentist, optometrist, podiatrist or psychologist entered into practice in New Mexico, the date on which the physician, dentist, optometrist, podiatrist or psychologist entered into an agreement or contract to provide such services or the location in which such services are to be provided in the state; provided, however, that the requirements of this section shall not apply when the human services department [health care authority department] contracts with entities pursuant to Section 27-2-12.6 NMSA 1978 to negotiate a rate for the reimbursement for services rendered to medicaid patients in the medicaid managed care system.

History: 1978 Comp., § 27-2-12.2, enacted by Laws 1987, ch. 269, § 1; 1996, ch. 70, § 1.

27-2-12.4. Long-term care facilities; noncompliance with standards and conditions; sanctions.

A. In addition to any other actions required or permitted by federal law or regulation, the authority shall impose a hold on state medicaid payments to a long-term care facility thirty days after the authority makes an on-site visit that the long-term care facility is not in substantial compliance with the standards or conditions of participation promulgated by the United States department of health and human services pursuant to which the facility is a party to a medicaid provider agreement, unless the substantial noncompliance has been corrected within that thirty-day period or the facility's medicaid provider agreement is terminated or not renewed based in whole or in part on the noncompliance. The written notice shall cite the specific deficiencies that constitute noncompliance.

B. The authority shall remove the payment hold imposed under Subsection A of this section when after an on-site visit, the authority certifies in writing that the long-term care facility is in substantial compliance with the standards or conditions of participation pursuant to which the facility is a party to a medicaid provider agreement.

C. The authority shall not reimburse any long-term care facility during the payment hold period imposed pursuant to Subsection A of this section for any medicaid recipient-patients who are new admissions and who are admitted on or after the day the hold is imposed and prior to the day the hold is removed.

D. If a long-term care facility is certified in writing to be in noncompliance pursuant to Subsection A of this section for the second time in any twelve-month period, the authority shall cancel or refuse to execute the long-term care facility's medicaid provider agreement for a two-month period, unless it can be demonstrated that harm to the patients would result from this action or that good cause exists to allow the facility to continue to participate in the medicaid program. The provisions of this subsection are subject to appeal procedures set forth in federal regulations for nonrenewal or termination of a medicaid provider agreement.

E. A long-term care facility shall not charge medicaid recipient-patients, their families or their responsible parties to recoup any payments not received because of a hold on medicaid payments imposed pursuant to this section.

F. This section shall not be construed to affect any other provisions for medicaid provider agreement termination, nonrenewal, due process and appeal pursuant to federal law or regulation.

G. As used in this section:

(1) "day" means a twenty-four hour period beginning at midnight and ending one second before midnight;

(2) "long-term care facility" means an intermediate care facility or skilled nursing facility that is licensed by the authority and is medicaid certified;

(3) "new admissions" means medicaid recipients who have never been in the long-term care facility or, if previously admitted, had been discharged or had voluntarily left the facility. The term does not include:

(a) persons who were in the long-term care facility before the effective date of the hold on medicaid payments and became eligible for medicaid after that date; and

(b) persons who, after a temporary absence from the facility, are readmitted to beds reserved for them in accordance with federal regulations; and

(4) "substantial compliance" means the condition of having no cited deficiencies or having only those cited deficiencies that:

(a) are not inconsistent with any federal statutory requirement;

(b) do not interfere with adequate patient care;

(c) do not represent a hazard to the patients' health or safety;

(d) are capable of correction within a reasonable period of time; and

(e) are ones that the long-term care facility is making reasonable plans to correct.

History: Laws 1987, ch. 214, § 1; 2024, ch. 39, § 69.

27-2-12.5. Medicaid-certified nursing facilities; retroactive eligibility; refunds; penalty.

A. Medicaid payment for a medicaid-eligible patient shall be accepted by a medicaid-certified nursing facility from the first month of medicaid eligibility, regardless of whether the eligibility is retroactive. The nursing facility shall refund to the patient or responsible party all out-of-pocket money except for required medical-care credits paid to the nursing facility for that patient's care on and after the date of medicaid eligibility for services covered by the medicaid program. Within thirty days after notification by the human services department [health care authority department] of the patient's medicaid eligibility, the nursing facility shall make any necessary refund to the patient or responsible party required under this section.

B. In any cause of action brought against a nursing facility because of its failure to make a refund to the patient or responsible party as required under Subsection A of this section, the patient or responsible party may be awarded triple the amount of the money not refunded or three hundred dollars ($300), whichever is greater, and reasonable attorneys' fees and court costs.

History: Laws 1989, ch. 83, § 1; 1991, ch. 211, § 1.

27-2-12.6. Medicaid payments; managed care.

A. The department shall provide for a statewide, managed care system to provide cost-efficient, preventive, primary and acute care for medicaid recipients by July 1, 1995.

B. The managed care system shall ensure:

(1) access to medically necessary services, particularly for medicaid recipients with chronic health problems;

(2) to the extent practicable, maintenance of the rural primary care delivery infrastructure;

(3) that the department's approach is consistent with national and state health care reform principles; and

(4) to the maximum extent possible, that medicaid-eligible individuals are not identified as such except as necessary for billing purposes.

C. The department may exclude nursing homes, intermediate care facilities for individuals with developmental or intellectual disabilities, medicaid in-home and community-based waiver services and residential and community-based mental health services for children with serious emotional disorders from the provisions of this section.

History: Laws 1994, ch. 62, § 22; 2023, ch. 113, § 4.

27-2-12.7. Medicaid; health care authority employees; standards of conduct; enforcement.

A. As used in this section:

(1) "business" means a corporation, partnership, sole proprietorship, firm, organization or individual carrying on a business;

(2) "authority" or "department" means the health care authority;

(3) "employee" means a person who has been appointed to or hired for an authority office connected with the administration of medicaid funds and who receives compensation in the form of salary;

(4) "employee with responsibility" means an employee who is directly involved in or has a significant part in the medicaid decision-making, regulatory, procurement or contracting process; and

(5) "financial interest" means an interest held by a person, the person's spouse or minor child that is:

(a) an ownership interest in business; or

(b) an employment or prospective employment for which negotiations have already begun.

B. No employee with responsibility shall, for twenty-four months following the date on which the employee ceases to be an employee, act as agent or attorney for another person or business in connection with a judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to the medicaid program with respect to which the employee made an investigation, rendered a ruling or was otherwise substantially and directly involved during the last year the employee was an employee and that was actually pending under the employee's responsibility within that period.

C. The secretary, income support division director or medical assistance division director or their deputies shall not, for twelve months following the date on which that person ceases to be an employee, participate with respect to a judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to the medicaid program and pending before the authority.

D. An employee with responsibility shall not participate in any manner with respect to a judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to the medicaid program and involving the employee's spouse, minor child or a business in which the employee has a financial interest unless prior to the participation:

(1) full disclosure of the employee's relationship or financial interest is made in writing to the secretary; and

(2) a written determination is made by the secretary that the disclosed relationship or financial interest is too remote or inconsequential to affect the integrity of the services of the employee.

E. Violation of any of the provisions of this section by an employee is grounds for dismissal, demotion or suspension. A former employee who violates a provision of this section is subject to assessment by the authority of a civil money penalty of two hundred fifty dollars ($250) for each violation. The authority shall promulgate rules to provide for an administrative appeal of an assessment imposed.

History: Laws 1980, ch. 86, § 1; 1978 Comp., § 10-16-16, recompiled as 1978 Comp., § 27-2-12.7 by Laws 1997, ch. 112, § 10; 2024, ch. 39, § 70.

27-2-12.8. Mammograms for medicaid recipients.

In providing coverage for mammograms under the medicaid program, the department shall ensure that:

A. patients will not be routinely solicited for mammograms; and that mammograms will only be performed based on nationally recognized standards; and

B. any fee for service payment that shall be made on behalf of the medicaid program for a mammogram of a medicaid recipient shall be consistent with and not exceed the usual and customary charge that reflects the reasonable fair market value of the cost of a mammogram.

History: Laws 1997, ch. 264, § 1.

27-2-12.9. Medicaid; personal spending allowances; increases.

For fiscal year 2001, the medicaid personal spending allowance shall be forty-five dollars ($45.00) per month for each eligible recipient. Thereafter, the medicaid personal spending allowance shall be increased at the beginning of each fiscal year by the annual percentage increase in the consumer price index for all urban consumers for all items for the preceding calendar year.

History: Laws 2000, ch. 9, § 1.

27-2-12.10. Clinical nurse specialists.

The department shall recognize clinical nurse specialists as mid-level providers in the medicaid program provided that the clinical nurse specialists comply with the requirements for licensure pursuant to the Nursing Practice Act [Chapter 61, Article 3

NMSA 1978] and that the services provided by the clinical nurse specialists are covered and reimbursable in accordance with Title 19 or Title 21 of the federal act.

History: Laws 2001, ch. 304, § 1.

27-2-12.11. Prescription drug waiver program; purpose; eligibility.

Subject to the availability of state funds and consistent with the federal Social Security Act, the human services department [health care authority department] shall create a medicaid waiver program and may by regulation provide prescription drugs to persons whose incomes are less than one hundred eighty-five percent of the federal poverty level and who:

A. are sixty-five years of age or older; or

B. have been determined to be disabled under the criteria established under the federal social security administration's disability determination rules as applied by the department.

History: Laws 2003, ch. 34, § 1 and by Laws 2003, ch. 278, § 1.

27-2-12.12. Human services department [health care authority department]; managed care contract credentialing provisions.

The human services department [health care authority department] shall negotiate with medicaid contractors to ensure that the contractors' credentialing requirements are coordinated with other credentialing processes required of individual providers.

History: Laws 2003, ch. 235, § 4.

27-2-12.13. Medicaid reform; program changes.

A. The department shall carry out the medicaid program changes as recommended by the medicaid reform committee that was established pursuant to Laws 2002, Chapter 96, as follows:

(1) develop a uniform preferred drug list for the state's medicaid prescription drug benefit and integrate all medicaid programs or services administered by the medical assistance division of the department to its use;

(2) work with other agencies to integrate the use of the uniform preferred drug list as described in Paragraph (1) of this subsection to other health care programs, including the department of health, the publicly funded health care agencies of the Health Care Purchasing Act [13-7-1 NMSA 1978], state agencies that purchase

prescription drugs and other public or private purchasers of prescription drugs with whom the state can enter into an agreement for the use of a uniform preferred drug list;

(3) identify entities that are eligible to participate in the federal drug pricing program under Section 340b of the federal Public Health Service Act. The department shall make a reasonable effort to assist the eligible entities to enroll in the program and to purchase prescription drugs under the federal drug pricing program. The department shall ensure that entities enrolled in the federal drug pricing program are reimbursed for drugs purchased for use by medicaid recipients at acquisition cost and that the purchases are not included in a rebate program;

(4) work toward the development of a prescription drug purchasing cooperative to combine the buying power of the state's medicaid program, the publicly funded health care agencies of the Health Care Purchasing Act, the department of health, the corrections department and other potential public or private purchasers, including other states, to obtain the best price for prescription drugs. The administration and price negotiation of the prescription drug purchasing cooperative shall be consolidated under a single agency as determined by the governor;

(5) in consultation and collaboration with the department of health and medicaid providers and contractors, develop a program to expand the use of community health promoters. The community health promoters shall assist selected medicaid recipients in understanding the requirements of the medicaid program; ensuring that recipients are seeking and receiving primary and preventive health care services; following health care providers' orders or recommendations for medication, diet and exercise; and keeping appointments for examinations and diagnostic examinations;

(6) require that the managed care organizations provide or strengthen disease management programs for medical assistance recipients through closer coordination with and assistance to primary care and safety net providers and seek to adopt uniform key health status indicators. The department shall ensure that the managed care organizations make reasonable efforts and actively seek the expanded participation in disease management programs of primary care providers and other health care providers, particularly in underserved areas;

(7) ensure that case management services are provided to assist medicaid recipients in accessing needed medical, social and other services. The department shall require that managed care organizations provide or strengthen case management services through closer coordination with and assistance to primary care and safety net providers. The case management services shall be targeted to specific classes of individuals or individuals in specific areas where medicaid costs or utilization demonstrate a lack of health care management or coordination;

(8) design a pilot disease management program for the fee-for-service population. The department shall ensure that the disease management program is

based on key health status indicators, accountability for clinical benefits and demonstrated cost savings;

(9) continue the personal care option with increased consumer awareness of consumer-directed services as a choice in addition to consumer-delegated services;

(10) expand the program of all-inclusive care for the elderly to a rural or urban area with a population less than four hundred thousand to the extent resources are available;

(11) in conjunction with the department of health, the children, youth and families department and the state agency on aging [aging and long-term services department], coordinate the state's long-term care services, including health and social services and assessment and information and referral development for recipients through an appropriate transition process;

(12) develop a fraud and abuse detection and recovery plan that ensures cooperation, sharing of information and general collaboration among the medicaid fraud control unit of the attorney general, the managed care organizations, medicaid providers, consumer groups and the department to identify, prevent or recover medicaid reimbursement obtained through fraudulent or inappropriate means;

(13) work with other agencies to identify other state-funded health care programs and services that may be reimbursable under medicaid and to ensure that the programs and services meet the requirements for federal funding;

(14) in conjunction with Indian health service facilities or tribally operated health care facilities pursuant to Section 638 of the Indian Self-Determination and Education Assistance Act, medicaid managed care organizations and medicaid providers, ensure that Indian health service facilities and tribally operated facilities are utilized to the extent possible for services that are eligible for a one hundred percent federal medical assistance percentage match;

(15) review the payment methodologies for eligible federally qualified health centers that provide the maximum allowable medicaid reimbursement;

(16) ensure that primary care clinics engaged in medicaid-related outreach and enrollment activities are appropriately reimbursed under medicaid;

(17) assess a premium on selected medicaid recipients who meet criteria as determined by the department;

(18) assess tiered co-payments on emergency room services in amounts comparable to those assessed for the same services by commercial health insurers or health maintenance organizations, except that no co-payment shall be imposed if the patient is admitted as a hospital inpatient as a result of the emergency room evaluation.

The emergency room provider shall make a good faith effort to collect the co-payment from the patient. The co-payment shall apply to medicaid recipients in the managed care system or the fee-for-service system;

(19) assess tiered co-payments on selected higher-cost prescription drugs to provide incentives for greater use of generic prescription drugs when there is a generic or lower-cost equivalent available;

(20) assess a co-payment on the purchase of selected prescription drugs that are not on the uniform preferred drug list as described in Paragraph (1) of this subsection;

(21) consider the impact of cost-sharing requirements on medicaid recipients' access to health care. The department shall ensure that premiums and co-payments described in Paragraphs (17) through (20) of this subsection are in compliance with federal requirements;

(22) provide vision benefits for adults that do not exceed one routine eye exam and one set of corrective lenses in a twelve-month period or more than one frame for corrective lenses in a twenty-four-month period, except as medically warranted;

(23) review its prescription drug policies to ensure that pharmacists have the flexibility for and are not discouraged from using generic prescription drugs when there is a generic or lower-cost equivalent available; and

(24) review its nursing home eligibility criteria to ensure that consideration of income, trusts and other assets are the maximum permissible under federal law.

B. The department shall, to the extent possible, combine or coordinate similar initiatives in this section or in other medicaid reform committee recommendations to avoid duplication or conflict. The department shall give preference to those initiatives that provide significant cost savings while protecting the quality and access of medicaid recipients' health care services.

C. The department shall ensure compliance with federal requirements for implementation of the medicaid reform committee's recommendations. The department shall request a federal waiver as may be necessary to comply with federal requirements.

D. As used in this section:

(1) "case management" means services that ensure care coordination among the patient, the primary care provider and other providers involved in addressing the patient's health care needs, including care plan development, communication and monitoring;

(2) "community health promoters" means persons trained to promote health and health care access among low-income persons and medically underserved communities;

(3) "disease management" means health care services, including patient education, monitoring, data collection and reporting, designed to improve health outcomes of medicaid recipients in defined populations with selected chronic diseases;

(4) "drug purchasing cooperative" means a collaborative procurement process designed to secure prescription drugs at the most advantageous prices and terms;

(5) "fee-for-service" means a traditional method of paying for health care services under which providers are paid for each service rendered;

(6) "managed care system" refers to the program for medicaid recipients required by Section 27-2-12.6 NMSA 1978;

(7) "medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal act;

(8) "preferred drug list" means a list of prescription drugs for which the state will make payment without prior authorization or additional charge to the medicaid recipient and that is based on clinical evidence for efficacy and meets the department's cost-effectiveness criteria;

(9) "primary care clinics" means facilities that provide the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services, and includes federally qualified health centers or federally qualified health center look-alikes as defined in Section 1905 of the federal act and designated by the federal department of health and human services, community-based health centers, rural health clinics and other eligible programs under the Rural Primary Health Care Act [24-1A-1 NMSA 1978];

(10) "primary care provider" means a health care practitioner acting within the scope of his license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiates referrals to other health care practitioners and maintains the continuity of care when appropriate; and

(11) "waiver" means the authority granted by the secretary of the federal department of health and human services, upon the request of the state, that allows exceptions to the state medicaid plan requirements and allows a state to implement innovative programs or activities.

History: Laws 2003, ch. 315, § 1.

27-2-12.14. Brain injury; services authorized.

Subject to the availability of state funds and consistent with Title 19 of the federal Social Security Act, the department shall provide services to persons with brain injuries, with emphasis on long-term disability services provided through home- and community-based programs.

History: Laws 2005, ch. 243, § 1.

27-2-12.15. Medicaid, state children's health insurance program and state coverage initiative program medical home waiver; rulemaking; application for waiver or state plan amendment.

A. Subject to the availability of state funds and consistent with the federal Social Security Act, the department shall work with its contractors that administer the state's approved waiver programs to promote and, if practicable, develop a program called the "medical home program". The "medical home" is an integrated care management model that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate. Care within the medical home includes primary care, preventive care and care management services and uses quality improvement techniques and information technology for clinical decision support. Components of the medical home model may include:

(1) assignment of recipients to a primary care provider, clinic or practice that will serve as a medical home;

(2) promotion of the health commons model of service delivery, whereby the medical home tracks recipients' primary care, specialty, behavioral health, dental health and social services needs as much as practicable;

(3) health education, health promotion, peer support and other services that may integrate with health care services to promote overall health;

(4) health risk or functional needs assessments for recipients;

(5) a method for reporting on the effectiveness of the medical home model and its effect upon recipients' utilization of health care services and the associated cost of utilization of those services;

(6) mechanisms to reduce inappropriate emergency department utilization by recipients;

(7) financial incentives for the provision of after-hours primary care;

(8) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;

(9) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promotoras;

(10) strategies to prevent or delay institutionalization of recipients through the effective utilization of home- and community-based support services;

(11) a primary care provider for each recipient, who advocates for and provides ongoing support, oversight and guidance to implement an integrated, coherent, cross-disciplinary plan for ongoing health care developed in partnership with the recipient and including all other health care providers furnishing care to the recipient;

(12) implementation of evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based upon recipient-specific factors;

(13) use of comparative effectiveness to make a cost-benefit analysis of health care practices;

(14) use of health information technology, including remote supervision, recipient monitoring and recipient registries, to monitor and track the health status of recipients;

(15) development and use of safe and secure health information technology to promote convenient recipient access to personal health information, health services and web sites with tools for patient self-management;

(16) implementation of training programs for personnel involved in the coordination of care for recipients;

(17) implementation of equitable financial incentive and compensation systems for primary care providers and other staff engaged in care management and the medical home model; and

(18) any other components that the secretary determines will improve a recipient's health outcome and that are cost-effective.

B. For the purposes of this section, "primary care provider" means a medical doctor or physician assistant licensed under the Medical Practice Act [61-6-1 NMSA 1978] to practice medicine in New Mexico, an osteopathic physician licensed pursuant to Chapter 61, Article 10 NMSA 1978, an osteopathic physician's assistant licensed pursuant to the Osteopathic Physicians' Assistants Act [repealed], a pharmacist clinician

licensed or certified to prescribe and administer drugs that are subject to the New Mexico Drug, Device and Cosmetic Act [26-1-1 NMSA 1978]; or a certified nurse practitioner as defined in the Nursing Practice Act [61-3-1 NMSA 1978] who provides first contact and continuous care and who has the staff and resources to manage the comprehensive and coordinated health care of each individual under the primary care provider's care.

History: Laws 2009, ch. 143, § 1; 2010, ch. 43, § 1.

27-2-12.16. Medicaid recipients; cost-sharing payments for emergency medical services when non-emergency services are indicated.

A. Consistent with the federal act and subject to the appropriation and availability of federal and state funds, the department shall promulgate rules that require a recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a co-payment, premium payment or other cost-sharing payment for the high-cost medical service if:

(1) the hospital from which the recipient seeks service:

(a) performs an appropriate medical screening and determines that the recipient does not have a condition requiring emergency medical services;

(b) informs the recipient that the recipient does not have a condition requiring emergency medical services;

(c) informs the recipient that if the hospital provides the non-emergency service, the hospital may require the recipient to pay a co-payment, premium payment or other cost-sharing payment in advance of providing the service;

(d) informs the recipient of the name and address of a non-emergency medicaid provider that can provide the appropriate medical service without imposing a cost-sharing payment; and

(e) offers to provide the recipient with a referral to the non-emergency provider to facilitate scheduling of the service;

(2) after receiving the information and assistance from the hospital described in Paragraph (1) of this subsection, the recipient chooses to obtain emergency medical services despite having access to medically acceptable, lower-cost non-emergency medical services; and

(3) the recipient's household income is at least one hundred percent of the federal poverty level.

B. The cost-sharing payment for a high-cost medical service made pursuant to this section shall be:

(1) for a child whose household income is one hundred to one hundred fifty percent of the federal poverty level, six dollars ($6.00);

(2) for an adult whose household income is one hundred to one hundred fifty percent of the federal poverty level, twenty-five dollars ($25.00);

(3) for a child whose household income is greater than one hundred fifty percent of the federal poverty level, twenty dollars ($20.00); and

(4) for an adult whose household income is greater than one hundred fifty percent of the federal poverty level, fifty dollars ($50.00).

C. The department shall not seek a federal waiver or other authorization to carry out the provisions of Subsection A of this section that would prevent a medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room or waive any provision under Section 1867 of the federal act.

D. The department shall not reduce hospital payments to reflect the potential receipt of a co-payment or other payment from a recipient receiving medical services provided through a hospital emergency room.

E. The secretary shall apply for a grant pursuant to Subsection 1903(y) of the federal Deficit Reduction Act to establish a program to provide for non-emergency services to serve as an alternative to emergency rooms as providers of health care. This program shall establish partnerships with local community hospitals and shall focus on providing alternatives to emergency services for primary care for rural and underserved areas where medicaid recipients do not have regular access to primary care. As used in this section, "primary care" means the first level of basic physical or behavioral health care for an individual's health needs, including diagnostic and treatment services.

History: Laws 2009, ch. 263, § 1.

27-2-12.17. Qualified state long-term care insurance partnership program; establishment; rulemaking.

A. Consistent with the federal act and subject to the appropriation and availability of federal and state funds, the secretary shall amend the state medicaid plan to establish a qualified state long-term care insurance partnership program pursuant to Section 1917(b) of the federal act. The program shall:

(1) provide incentives for an individual to obtain or maintain qualified insurance to cover the cost of long-term care; and

(2) provide a mechanism for an individual to qualify for medical assistance for institutional care or a medical assistance home- and community-based long-term care program on the basis of countable resources. Pursuant to the qualified state long-term care insurance partnership program:

(a) an individual who otherwise qualifies for medical assistance for institutional care or a medical assistance home- and community-based long-term care program shall qualify on the basis of countable resources when the individual is the beneficiary of a qualified insurance policy, insurance plan, certificate of insurance or rider; and

(b) for purposes of determining eligibility, the individual's total countable resources shall be reduced by an amount equal to the qualified insurance benefits that are made to or on behalf of the individual.

B. The secretary shall consult with the superintendent of insurance in the adoption and promulgation of rules regarding the implementation and operation of the qualified state long-term care partnership insurance program. These rules shall provide for reciprocity with respect to individuals who have purchased qualified insurance in another state participating in a qualified state long-term care insurance partnership program and shall provide that the amount of that individual's countable resources shall be disregarded with respect to that qualified insurance.

C. As used in this section:

(1) "qualified insurance" means an insurance policy, insurance plan, certificate of insurance or rider that the superintendent has certified as qualified long-term care partnership program insurance pursuant to Section 4 [59A-23A-12 NMSA 1978] of this 2013 act; and

(2) "rider" means a long-term care coverage provision added to any type of insurance plan, insurance policy or certificate of insurance.

History: Laws 2013, ch. 139, § 2.

27-2-12.18. Medical assistance; prescription drugs; prior authorization request form; prior authorization protocols.

A. Beginning January 1, 2014, the department shall require its medicaid contractors to accept the uniform prior authorization form developed pursuant to Sections 2 [59A-2-9.8 NMSA 1978] and 3 [61-11-6.2 NMSA 1978] of this 2013 act. The department shall require its medicaid contractors to accept the uniform prior authorization form as

sufficient to request prior authorization for prescription drug benefits on behalf of recipients.

B. The department shall require its medicaid contractors to respond within three business days upon receipt of a uniform prior authorization form. The department shall require each of its medicaid contractors to deem a prior authorization as having been granted if the contractor has failed to respond to the prior authorization request within three business days.

History: Laws 2013, ch. 170, § 1.

27-2-12.19. Former foster-care recipients; medical assistance coverage until age twenty-six.

The department shall cover individuals who are residents of New Mexico and who are former recipients of foster care, regardless of the state where the foster care was received, until those individuals reach the age of twenty-six years.

History: Laws 2015, ch. 31, § 1.

27-2-12.20. Crisis triage center; medical assistance reimbursement.

A. In accordance with federal law, the secretary shall adopt and promulgate rules to establish a reimbursement rate for services provided to recipients of state medical assistance at a crisis triage center.

B. As used in this section, "crisis triage center" means a health facility that:

(1) is licensed by the authority; and

(2) provides stabilization of behavioral health crises and may include residential and nonresidential stabilization.

History: Laws 2015, ch. 61, § 2; 2018, ch. 34, § 2; 2024, ch. 39, § 71.

27-2-12.21. Medical assistance; pharmacy benefits; prescription synchronization.

A. In accordance with federal law, the secretary shall adopt and promulgate rules that allow a recipient to fill or refill a prescription for less than a thirty-day supply of a prescription drug and apply a prorated daily copayment or coinsurance, if applicable, for the fill or refill, if:

(1) the prescribing practitioner or the pharmacist determines the fill or refill to be in the best interest of the patient;

(2) the recipient requests or agrees to receive less than a thirty-day supply of the prescription drug; and

(3) the reduced fill or refill is made for the purpose of synchronizing the recipient's prescription drug fills.

B. Medical assistance coverage shall not:

(1) deny coverage for the filling of a chronic medication when the fill is made in accordance with a plan to synchronize multiple prescriptions for the recipient pursuant to Subsection A of this section established among the department or the recipient's managed care plan, the prescribing practitioner and a pharmacist. The medical assistance coverage shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization; and

(2) prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to Subsection A of this section. The medical assistance coverage shall pay in full a dispensing fee for a partially filled or refilled prescription for each prescription dispensed, regardless of any prorated copayment or coinsurance that the recipient may pay for prescription synchronization services.

History: Laws 2015, ch. 65, § 2.

27-2-12.22. Incarcerated persons; medicaid eligibility; county jail technical assistance; presumptive eligibility determiner training and certification.

A. Incarceration shall not be a basis to deny or terminate eligibility for medicaid.

B. Upon release from incarceration, a formerly incarcerated person shall remain eligible for medicaid until the person is determined to be ineligible for medicaid on grounds other than incarceration.

C. An incarcerated person who was not enrolled in medicaid upon the date that the person became incarcerated shall be permitted to submit an application for medicaid during the incarcerated person's period of incarceration.

D. The provisions of this section shall not be construed to abrogate:

(1) any deadline that governs the processing of applications for medicaid pursuant to existing federal or state law; or

(2) requirements under federal or state law that the authority be notified of changes in income, resources, residency or household composition.

E. The provisions of this section shall not require the authority to pay for services on behalf of any incarcerated person except as permitted by federal law.

F. A correctional facility shall:

(1) inform the authority when an eligible person is incarcerated;

(2) facilitate, with assistance from the authority, eligibility determinations for medicaid during the incarcerated person's incarceration or upon release;

(3) notify the authority upon an eligible person's release; and

(4) facilitate the authority's or any authority contractor's provision of care coordination pursuant to the provisions of Section 33-1-22 NMSA 1978.

G. Upon the written request of a county, the authority shall provide a behavioral health screening tool to facilitate screenings performed in accordance with the provisions of Subsection A of Section 33-1-22 NMSA 1978, technical assistance and training and certification of county jail presumptive eligibility determiners to a county jail.

H. The secretary shall adopt and promulgate rules consistent with this section.

I. As used in this section:

(1) "care coordination" means an assessment for health risks and the creation of a plan of care to address a person's comprehensive health needs, including access to physical health care and mental health services; substance use disorder treatment; and transportation services;

(2) "eligibility" means a finding by the authority that a person has met the criteria established in state and federal law and the requirements established by authority rules to enroll in medicaid;

(3) "incarcerated person" means a person, the legal guardian or conservator of a person or, for a person who is an unemancipated minor, the parent or guardian of the person, who is confined in any of the following correctional facilities:

(a) a state correctional facility;

(b) a privately operated correctional facility;

(c) a county jail;

(d) a privately operated jail;

(e) a detention facility that is operated under the authority of the children, youth and families department and that holds the person pending a court hearing; or

(f) a facility that is operated under the authority of the children, youth and families department and that provides for the care and rehabilitation of a person who is under eighteen years of age and who has committed an act that would be designated as a crime under the law if committed by a person who is eighteen years of age or older;

(4) "medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal Social Security Act and rules promulgated pursuant to that act; and

(5) "unemancipated minor" means a person who is under eighteen years of age and who:

(a) is not on active duty in the armed forces; and

(b) has not been declared by court order to be emancipated.

History: Laws 2015, ch. 127, § 2; 2018, ch. 74, § 1; 2024, ch. 39, § 72.

27-2-12.23. Medical assistance; prescription drug coverage; step therapy protocols; clinical review criteria; exceptions.

A. By January 1, 2019, the secretary shall require any medical assistance plan for which any step therapy protocols are required to establish clinical review criteria for those step therapy protocols. The clinical review criteria shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:

(a) requiring members to: 1) disclose any potential conflicts of interest with health care plans, medical assistance plans, health maintenance organizations, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and

(b) using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;

(3) are based on high-quality studies, research and medical practice;

(4) are created pursuant to an explicit and transparent process that:

(a) minimizes bias and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) take into account the needs of atypical patient populations and diagnoses.

B. In the absence of clinical guidelines that meet the requirements of Subsection A of this section, peer-reviewed publications may be substituted.

C. When a medical assistance plan restricts coverage of a prescription drug for the treatment of any medical condition through the use of a step therapy protocol, a recipient and the practitioner prescribing the prescription drug shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. A medical assistance plan may use its existing medical exceptions process in accordance with the provisions of Subsections D through I of this section to satisfy this requirement. The process shall be made easily accessible for recipients and practitioners on the medical assistance plan's publicly accessible website.

D. A medical assistance plan shall expeditiously grant an exception to the medical assistance plan's step therapy protocol, based on medical necessity and a clinically valid explanation from the patient's prescribing practitioner as to why a drug on the plan's formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if:

(1) the prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(2) the prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) while under the recipient's current medical assistance plan, or under the recipient's previous health coverage, the recipient has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or

(4) the prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:

(a) cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;

(b) worsen a comorbid condition of the patient; or

(c) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

E. Upon the granting of an exception to a medical assistance plan's step therapy protocol, a medical assistance plan shall authorize continuing coverage for the prescription drug that is the subject of the exception request for no less than the duration of the therapeutic effect of the drug.

F. A medical assistance plan shall respond with its decision on a recipient's exception request within seventy-two hours of receipt. In cases where exigent circumstances exist, a medical assistance plan shall respond within twenty-four hours of receipt of the exception request. In the event the medical assistance plan does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted.

G. A medical assistance plan's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to department rules.

H. After a recipient has made an exception request in accordance with the provisions of this section, a medical assistance plan shall authorize continued coverage of a prescription drug that is the subject of the exception request pending the determination of the exception request.

I. The provisions of this section shall not be construed to prevent:

(1) a medical assistance plan from requiring a patient to try a biosimilar, interchangeable biologic or generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug; or

(2) a practitioner from prescribing a prescription drug that the practitioner has determined to be medically necessary.

J. As used in this section, "medical necessity" or "medically necessary" means health care services determined by a practitioner, in consultation with the medical assistance plan, to be appropriate or necessary, according to:

(1) any applicable, generally accepted principles and practices of good medical care;

(2) practice guidelines developed by the federal government or national or professional medical societies, boards or associations; or

(3) any applicable clinical protocols or practice guidelines developed by the medical assistance plan consistent with federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

History: Laws 2018, ch. 9, § 2; 2024, ch. 42, § 2.

27-2-12.24. Medical assistance; plan of care; participation required.

A. By January 1, 2020, the secretary shall require medical assistance plans to establish, in consultation with the department, hospitals, birthing centers, the children, youth and families department and the department of health, a process for the creation and implementation of a plan of care for a substance-exposed newborn and the relatives, parents, guardians or caretakers of a substance-exposed newborn as provided for in the Children's Code [Chapter 32A NMSA 1978].

B. As used in this section, "plan of care" means a plan created by a health care professional pursuant to the Children's Code that is intended to ensure the safety and well-being of a substance-exposed newly born child by addressing the treatment needs of the child and any of the child's parents, relatives, guardians, family members or caregivers to the extent those treatment needs are relevant to the safety of the child.

History: 1978 Comp., § 27-2-12.24, as enacted by Laws 2019, ch. 190, § 5

27-2-12.25. Prior authorization for gynecological or obstetrical ultrasounds prohibited.

A. The department shall prohibit its medicaid managed care and fee-for-service contractors from requiring prior authorization for gynecological or obstetrical ultrasounds.

B. Nothing in this section shall be construed to require payment for a gynecological or obstetrical ultrasound that is not:

(1) medically necessary; or

(2) a covered benefit.

C. As used in this section, "prior authorization" means advance approval that is required as a condition precedent to payment for medical care or related benefits rendered to a covered person, including prospective or utilization review conducted prior to the provision of covered medical care or related benefits.

History: Laws 2019, ch. 182, § 2

27-2-12.26. Qualified medicare beneficiary recipients; medicare part B coverage automatic enrollment.

A. The department shall provide for the automatic enrollment into medicare part B coverage of individuals:

(1) whom it deems eligible for participating in the qualified medicare beneficiary program; and

(2) who are not enrolled in medicare part B coverage.

B. By August 1, 2019, the secretary shall adopt and promulgate rules to provide for informing, in writing, applicants for and recipients of qualified medicare beneficiary coverage that, if they are enrolled in the qualified medicare beneficiary program and, at the time of enrollment they are not enrolled in medicare part B, they are eligible for automatic enrollment in medicare part B coverage, regardless of whether general or "open" enrollment of medicare part B beneficiaries is allowed under federal law at the time a qualified medicare beneficiary program recipient enrolls in the qualified medicare beneficiary program.

C. As used in this section:

(1) "medicare part B" means the supplemental medical insurance program provided under part B of Title 18 of the federal Social Security Act; and

(2) "qualified medicare beneficiary program" means the joint state-federal medical assistance program that provides for payment of recipients' premiums under part A of Title 18 of the federal Social Security Act and recipients' coinsurance and deductible amounts on services covered under medicare part B.

History: Laws 2019, ch. 136, § 1.

27-2-12.27. Medical assistance; managed care organization contracts; applicability of Prior Authorization Act.

The secretary shall ensure that contracts with managed care organizations to provide medical assistance to medicaid recipients are subject to and comply with the Prior Authorization Act.

History: Laws 2019, ch. 187, § 2.

27-2-12.28. Medical assistance; autism spectrum disorder.

A. The secretary shall ensure that medical assistance coverage provides coverage, which shall not be subject to age restrictions or dollar limits, for:

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and

(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

B. Coverage required pursuant to Subsection A of this section:

(1) shall be limited to treatment that is prescribed by the recipient's treating physician in accordance with a treatment plan;

(2) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(3) may be subject to other general exclusions and limitations of medical assistance coverage, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(4) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. The coverage required pursuant to Paragraph (1) of Subsection A of this section shall not be subject to any recipient cost-sharing.

D. The coverage required pursuant to Paragraph (2) of Subsection A of this section shall not be subject to cost-sharing provisions that are less favorable to a recipient than the cost-sharing provisions that apply to physical illnesses that are generally covered through medical assistance coverage, except as otherwise provided in Subsection B of this section.

E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include the:

(1) diagnosis;

(2) proposed treatment by types;

(3) frequency and duration of treatment;

(4) anticipated outcomes stated as goals;

(5) frequency with which the treatment plan will be updated; and

(6) signature of the treating physician.

F. This section shall not be construed as limiting benefits and coverage otherwise available to a recipient through medical assistance coverage.

G. As used in this section:

(1) "autism spectrum disorder" means:

(a) a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association; or

(b) a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American psychiatric association;

(2) "cost-sharing" means any deductible, copayment, coinsurance or other payment that a recipient is required to pay for medical assistance items or services provided through medical assistance coverage; and

(3) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain or restore to the maximum extent practicable the functioning of an individual.

History: Laws 2019, ch. 119, § 2.

27-2-12.29. Medical assistance; reimbursement for a one-year supply of covered prescription contraceptive drugs or devices.

A. In providing coverage for family planning services and supplies under the medical assistance program, the department shall ensure that a recipient is permitted to fill or refill a prescription for a one-year supply of a covered, self-administered contraceptive at one time, as prescribed.

B. Nothing in this section shall be construed to limit a recipient's freedom to choose or change the method of family planning to be used, regardless of whether the recipient has exhausted a previously dispensed supply of contraceptives.

History: Laws 2019, ch. 263, § 2.

27-2-12.30. Pharmacist prescriptive authority services; reimbursement parity.

A medical assistance program or its contractor shall reimburse a participating provider that is a certified pharmacist clinician or pharmacist certified to provide a prescriptive authority service who provides a service at the standard contracted rate that the medical assistance program reimburses, for the same service under that program, any licensed physician or physician assistant licensed pursuant to the Medical Practice Act [Chapter 61, Article 6 NMSA 1978] or any advanced practice certified nurse practitioner licensed pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978].

History: Laws 2020, ch. 58, § 2; 2021, ch. 54, § 10.

27-2-12.31. Heart artery calcium scan coverage.

A. In accordance with federal law, the secretary shall adopt and promulgate rules that provide medical assistance coverage for eligible enrollees to receive a heart artery calcium scan.

B. Medical assistance coverage provided pursuant to this section shall:

(1) be limited to the provision of a heart artery calcium scan to an eligible enrollee to be used as a clinical management tool;

(2) be provided every five years if an eligible enrollee has previously received a heart artery calcium score of zero; and

(3) not be required for future heart artery calcium scans if an eligible enrollee receives a heart artery calcium score greater than zero.

C. At its discretion or as required by law, a managed care organization providing medical assistance may offer or refuse coverage for further cardiac testing or procedures for eligible enrollees based upon the results of a heart artery calcium scan.

D. The provisions of this section shall not apply to short-term travel, accident-only or limited or specified-disease policies, plans or certificates of health insurance.

E. As used in this section:

(1) "eligible enrollee" means an enrollee who:

(a) is a person between the ages of forty-five and sixty-five; and

(b) has an intermediate risk of developing coronary heart disease as determined by a health care provider based upon a score calculated from an evidence-based algorithm widely used in the medical community to assess a person's ten-year cardiovascular disease risk, including a score calculated using a pooled cohort equation;

(2) "health care provider" means a physician, physician assistant, nurse practitioner or other health care professional authorized to furnish health care services within the scope of the professional's license; and

(3) "heart artery calcium scan" means a computed tomography scan measuring coronary artery calcium for atherosclerosis and abnormal artery structure and function.

History: Laws 2020, ch. 79, § 2.

27-2-12.32. Biomarker testing coverage.

A. In accordance with federal law, the secretary shall adopt and promulgate rules that provide medical assistance coverage for enrollees to receive biomarker testing.

B. A medical assistance plan providing coverage pursuant to this section shall be for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an enrollee's disease or condition when the test is supported by medical and scientific evidence, including:

(1) labeled indications for a United States food and drug administration-approved or -cleared test;

(2) indicated tests for a United States food and drug administration-approved drug;

(3) warnings and precautions on United States food and drug administration labels;

(4) federal centers for medicare and medicaid services national coverage determinations or medicare administrative contractor local coverage determinations; or

(5) nationally recognized clinical practice guidelines.

C. Medicaid contractors delivering services to enrollees shall provide biomarker testing at the same scope, duration and frequency as the medical assistance plan otherwise provides to enrollees.

D. A medical assistance plan providing coverage for biomarker testing pursuant to this section shall ensure that:

(1) coverage is provided in a manner that limits disruptions in care, including coverage for multiple biopsies or biospecimen samples; and

(2) a patient and a practitioner who prescribes biomarker testing have clear, readily accessible and convenient processes to request an appeal of a benefit denial by the insurer and that those processes are accessible on the medical assistance division of the department's website.

E. As used in this section:

(1) "biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. "Biomarker" includes gene mutations, characteristics of genes or protein expression;

(2) "biomarker testing" means analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker and includes single-analyte tests, multiplex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing; and

(3) "nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that are:

(a) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy; and

(b) used to establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

History: Laws 2023, ch. 138, § 2.

27-2-12.33. Study of the medicaid forward plan.

A. The secretary, in coordination with the superintendent of insurance and in consultation with the medicaid advisory committee, other stakeholders identified by the

secretary and representatives of Indian nations, tribes and pueblos that are located wholly or partially in New Mexico, shall study the following operational needs for and effects of implementing the medicaid forward plan and amending the New Mexico medicaid state plan, pursuant to the federal act to provide medical assistance to residents who are under age sixty-five, are not otherwise eligible for and enrolled in mandatory coverage under the New Mexico medicaid state plan and have a household income that exceeds one hundred thirty-three percent of the federal poverty level:

(1) the effects on the individual, group and self-insured health insurance markets, including the New Mexico health insurance exchange and the health benefits programs provided to state or local public employees or public school employees, of providing mandatory or optional medicaid coverage to individuals who would otherwise be eligible for health insurance through those markets;

(2) the effects on health care providers and health care facilities, including reimbursement rates needed to maximize access to health care services;

(3) the operational needs for administering the medicaid forward plan, including staffing and technical needs for enrollment and collection of premiums or cost-sharing;

(4) the funding plan, including necessary expenditures and total revenue generated;

(5) the fiscal effects on recurring and nonrecurring spending in the state budget; and

(6) the financial sustainability, including steps necessary for the department and the superintendent of insurance to apply for federal waivers to maximize federal funding and leverage those waivers to ensure affordability for enrollees in the medicaid forward plan.

B. The secretary's proposed program design for the medicaid forward plan shall be contingent on the results of the study and shall include:

(1) a financing plan, which shall include recommended appropriation of state funds, projected federal funds, savings directly or indirectly attributable to the program design, a sliding scale for premiums and cost-sharing based on household income for individuals eligible to enroll in the medicaid forward plan and other potential cost offsets;

(2) information about recommended reimbursement rates to maximize access to health care services under the medicaid forward plan;

(3) details about the department's operational needs for administering the medicaid forward plan; and

(4) information about federal waivers needed to maximize federal funding and ensure affordability and choice for enrollees.

C. By October 1, 2024, the secretary shall submit a report to the legislative finance committee and the legislative health and human services committee detailing the secretary's study of, and proposed program design for, the medicaid forward plan.

History: Laws 2023, ch. 198, § 2.

27-2-12.34. Community-based pharmacy reimbursement.

A. Each managed care organization that contracts with the department shall ensure that community-based pharmacy providers that provide services to medicaid recipients are reimbursed as follows:

(1) for the ingredient cost of a drug at a value that is at least equal to the national average drug acquisition cost for the prescription drug at the time that the drug is administered or dispensed, or if data for the national average drug acquisition is unavailable, the wholesale acquisition cost of the drug; and

(2) a professional dispensing fee.

B. The professional dispensing fee reimbursed to community-based pharmacy providers shall be no less than the professional dispensing fee reimbursed to community-based pharmacy providers for covered outpatient drugs in the medicaid fee-for-service program.

C. By January 1, 2025, and annually thereafter, the department shall compile a list of all community-based pharmacy providers in the state and publish the list on the department's website.

D. For the purposes of this section:

(1) "community-based pharmacy provider" means a pharmacy that is:

(a) open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written;

(b) located in the state or near the state border, if the border town is a primary source of prescription drugs for medicaid recipients residing in the border area; and

(c) not: 1) government-owned; 2) hospital-owned; 3) owned by a corporation that owns hospitals; 4) an extension of a medical practice or special facility; 5) owned by a corporate chain of pharmacies with stores outside of the state; or 6) a mail-order pharmacy;

(2) "ingredient cost" means the actual amount paid to a community-based pharmacy provider for a prescription drug, not including the professional dispensing fee or cost sharing;

(3) "managed care organization" means a person or entity eligible to enter into risk-based prepaid capitation agreements with the department to provide health care and related services;

(4) "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

(5) "medicaid recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;

(6) "national average drug acquisition cost" means the national average of prices at which pharmacies purchase a prescription drug from manufacturers or wholesalers; and

(7) "wholesale acquisition cost" means a manufacturer's list price for a prescription drug sold to wholesalers in the United States, not including discounts, rebates or reductions in price.

History: 1978 Comp., § 27-2-12.34, enacted by Laws 2024, ch. 35, § 1.

27-2-13. Conflict in federal and state laws.

Any section of the NMSA 1978 relating to public assistance which is in conflict with the provisions of the federal act or the federal Food Stamp Act, as may be amended from time to time, and federal regulations issued pursuant thereto, shall be suspended in its operation if the attorney general certifies that such conflict exists.

History: 1953 Comp., § 13-17-16, enacted by Laws 1973, ch. 376, § 17.

27-2-14. Continuing effect of regulations and standards.

Regulations and standards of the board and department adopted prior to the effective date of the Public Assistance Act are continued in full force and effect, unless modified or revoked.

History: 1953 Comp., § 13-17-17, enacted by Laws 1973, ch. 376, § 18.

27-2-15. Cooperation with the United States.

A. The authority is designated as the state agency to cooperate with the federal government in the administration of the provisions of Title 1, Title 4, Parts 2 and 3 of Title 5 and Title 10 of the federal Social Security Act. The authority shall cooperate with

the proper departments of the federal government and with all other departments of the state and local governments in the enforcement and administration of those provisions of the federal Social Security Act and rules adopted in accordance with that act in the manner prescribed in Chapter 27 NMSA 1978 or as otherwise provided by law.

B. The authority shall make reports in such form and containing such information as any agency or instrumentality of the United States with which it is cooperating may require and shall comply with such provisions as that agency or instrumentality may find necessary to assure the correctness and verification of the reports.

History: Laws 1937, ch. 18, § 9; 1941 Comp., § 73-109; 1953 Comp., § 13-1-9; 2024, ch. 39, § 73.

27-2-16. Compliance with federal law.

A. Subject to the availability of state funds, the authority may provide assistance to aged, blind or disabled persons in the amounts consistent with federal law to enable the state to be eligible for medicaid funding. Persons shall be determined to be aged, blind or disabled according to rules of the authority.

B. If drug product selection is permitted by Section 26-3-3 NMSA 1978, reimbursement by the medicaid program shall be limited to the wholesale cost of the lesser expensive therapeutic equivalent drug generally available in New Mexico plus a reasonable dispensing fee of at least three dollars sixty-five cents ($3.65).

History: 1953 Comp., § 13-17-18, enacted by Laws 1974, ch. 31, § 1; 1982, ch. 26, § 2; 1984, ch. 27, § 1; 2024, ch. 39, § 74.

27-2-17. Custodian of funds.

The authority is designated as the custodian of all money received by the state, which the authority is authorized to administer, from any appropriations made by the congress of the United States for the purpose of cooperating with the several states in the enforcement and administration of the provisions of the federal Social Security Act and all money received from any other source for the purposes set forth in Chapter 27 NMSA 1978. The authority is authorized to receive such money, provide for its proper custody and make disbursements of it under such rules as the authority may prescribe.

History: Laws 1937, ch. 18, § 10; 1941 Comp., § 73-110; 1953 Comp., § 13-1-10; 2024, ch. 39, § 75.

27-2-18 to 27-2-20. Repealed.

27-2-21. Assistance not assignable.

Assistance granted under this act shall not be transferable or assignable, at law or in equity, and none of the money paid or payable under this act shall be subject to execution, levy, attachment, garnishment or other legal process, or to the operation of any bankruptcy or insolvency law.

History: Laws 1937, ch. 18, § 11g; 1941 Comp., § 73-118; 1953 Comp., § 13-1-19.

27-2-22. Repealed.

27-2-23. Third party liability.

A. The income support division of the department shall make reasonable efforts to ascertain any legal liability of third parties who are or may be liable to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance pursuant to the provisions of Chapter 27 NMSA 1978.

B. When the department makes medical assistance payments on behalf of a recipient, the department is subrogated to any right of the recipient against a third party for recovery of medical expenses to the extent that the department has made payment.

C. Health insurers, including self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers or other parties, that are, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business with New Mexico, shall:

(1) provide, with respect to individuals who are eligible for or are provided medical assistance under the medicaid program, upon the request of the state, information to determine during what period the individual, the individual's spouse or the individual's dependents may be, or may have been, covered by a health insurer and the nature of the coverage provided by the health insurer, including the name, address and identifying number of the plan;

(2) accept New Mexico's right of recovery and the assignment to New Mexico of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the medicaid program;

(3) respond to any inquiry by New Mexico regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of such health care item or service; and

(4) agree not to deny a claim submitted by New Mexico solely on the basis of the date of submission of the claim by the provider, the type of the claim form or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

(a) the claim is submitted by New Mexico within the three-year period beginning on the date on which the item or service was furnished; and

(b) any action by New Mexico to enforce its rights with respect to such claim is commenced within six years of New Mexico's submission of such claim.

D. Nothing in this section shall be construed to preclude the application of common law principles in determining equitable reimbursement from any third-party source for New Mexico or a health insurer, including self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers or other parties.

History: 1953 Comp., § 13-1-20.1, enacted by Laws 1969, ch. 232, § 1; 2007, ch. 246, § 1.

27-2-23.1. Employee Retirement Income Security Act employee health benefit plans; clauses to exclude medicaid coverage prohibited.

No employee health benefit plan established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, that provides payments for health care on behalf of individuals residing in the state shall contain any provisions excluding or limiting coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee health benefit plan, because that individual is provided, or is eligible for, benefits under the medicaid program of this state pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.

History: 1978 Comp., § 27-2-23.1, enacted by Laws 1989, ch. 184, § 1.

27-2-24. [Federal government entitled to share recovery.]

The federal government shall be entitled to a share of any amounts recovered under the preceding two sections [27-2-22, 27-2-23 NMSA 1978] if required as a condition to federal financial participation. The federal government's share shall be limited to a percentage of the net recovery equal to the percentage of federal participation claimed by the state for the payments when originally made. The amount due the United States shall be paid promptly from the funds so collected to the United States government.

History: Laws 1937, ch. 18, § 11i; 1941, ch. 116, § 6; 1941 Comp., § 73-120; 1953 Comp., § 13-1-21; Laws 1969, ch. 232, § 2.

27-2-25. Funeral expenses.

A. On the death of:

(1) a recipient of financial assistance under Section 27-2-6 [repealed] or 27-2-7 NMSA 1978 or under the federal supplemental security income program; or

(2) a person living in a nursing home or an intermediate care facility, the payment for whose care is made in whole or in part pursuant to Title 19 of the federal Social Security Act; funeral expenses up to two hundred dollars ($200) shall be paid by the income support division of the authority if the deceased's available resources, as defined by rule of the division, are insufficient to pay the funeral expenses, the persons legally responsible for the support of the deceased are unable to pay the funeral expenses and no other person will undertake to pay those expenses.

B. No payment shall be made by the income support division when resources available from all sources to pay the funeral expenses total six hundred dollars ($600) or more. When the resources are less than six hundred dollars ($600), the division shall pay the difference between six hundred dollars ($600) and the resources, or two hundred dollars ($200), whichever is less.

History: Laws 1937, ch. 18, § 11j; 1941 Comp., § 73-121; 1953 Comp., § 13-1-22; Laws 1959, ch. 49, § 1; 1969, ch. 234, § 1; 1975, ch. 220, § 1; 2024, ch. 39, § 76.

27-2-26. Money received from other sources; duty and liability of funeral director.

Should any funeral director accept payment from sources other than the income support division of the authority for burial of a deceased person for whom a claim for burial expenses has been made to the division, the funeral director shall immediately notify the division of the payment. The division shall consider the payment in determining the amount of any funeral expense payment it makes. If the division has already made payment, the funeral director shall refund to the division any excess over the amount that the division would have paid had it known of the payment from other sources. If any funeral director fails to notify the division of any such payment from other sources, the funeral director shall be liable to the division in an amount double the amount paid or to be paid by the division.

History: 1953 Comp., § 13-1-22.1, enacted by Laws 1975, ch. 220, § 2; 2024, ch. 39, § 77.

27-2-27. Single state agency; powers and duties.

A. The authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title 4-D of the federal Social Security Act with the following duties and powers to:

(1) establish the paternity of a child in the case of the child born out of wedlock with respect to whom an assignment of support rights has been executed in favor of the authority;

(2) establish an order of support for children receiving aid from temporary assistance for needy families and, at the option of the authority, for the spouse or former spouse with whom such children are living, but only if a support obligation has been established with respect to such spouse or former spouse, for whom no order of support currently exists and seek modification, based upon the noncustodial parent's ability to pay, of existing orders in which the support order is inadequate to properly care for the child and the spouse or former spouse with whom the child is living;

(3) enforce as the real party in interest any existing order for the support of children who are receiving temporary assistance for needy families or of the spouse or former spouse with whom such children are living;

(4) provide services to non-aid families with dependent children in the establishment and enforcement of paternity and child support obligations, including locating the absent parent. For these services, the authority is authorized to establish and collect fees, costs and charges permitted or required by federal law or by regulations adopted pursuant to that federal law; and

(5) adopt rules for the disposition of unclaimed child, spousal or medical support payments.

B. In all cases handled by the authority pursuant to the provisions of this section, the child support enforcement division or an attorney employed by the division represent the authority, to the exclusion of any other party, in establishing, modifying and enforcing support obligations.

C. An attorney employed to provide the Title 4-D services represents only the authority's interests, and no attorney-client relationship shall exist between the attorney and another party.

D. The authority shall, at the time an application for child support services is made, inform the applicant that neither the Title 4-D agency nor the attorney who provides services under this section is the applicant's attorney and that the attorney who provides services under this section shall not provide legal representation to the applicant.

E. The authority may initiate an action or may intervene in an action involving child support.

F. The attorney employed by the authority pursuant to this section shall not act as a guardian ad litem for the applicant.

G. A court shall not disqualify the authority in a legal action filed pursuant to the Support Enforcement Act of the federal Social Security Act because the authority has previously provided services to a party whose interests are now adverse to the relief requested.

History: 1978 Comp., § 27-2-27, enacted by Laws 1981, ch. 90, § 1; 1982, ch. 12, § 1; 1984, ch. 98, § 1; 1995, ch. 46, § 1; 2003, ch. 283, § 2; 2004, ch. 41, § 1; 2024, ch. 39, § 78.

27-2-28. Liability for repayment of public assistance.

A. In cases where the authority has provided cash assistance to children in a household, the court shall award judgment in favor of the authority and against the noncustodial parents of the children for child support, calculated pursuant to Section 40-4-11.1 NMSA 1978, for all months in which the children received cash assistance benefits.

B. Equitable defenses available to the noncustodial parent in claims by the custodian for retroactive support or past due support shall not operate to deprive the authority of its right to request retroactive support or past due support for months during which the noncustodial parent's children received cash assistance benefits.

C. Amounts of support collected that are in excess of the amounts specified in Subsections A and B of this section shall be paid by the authority to the custodian of the child.

D. No agreement between any custodian of a child and a parent of that child, either relieving the parent of any duty of child or spousal support or responsibility or purporting to settle past, present or future support obligations, either as a settlement or prepayment, shall act to reduce or terminate any rights of the authority to recover from that parent for support provided, unless the authority has consented to the agreement in writing.

E. The noncustodial parent shall be given credit for any support actually provided, including housing, clothing, food or funds paid prior to the entry of any order for support. The noncustodial parent has the burden to prove that the noncustodial parent has provided any support.

F. An application for public assistance by any person constitutes an assignment by operation of law of any support rights the person is entitled to during the time the person's household receives public assistance, whether the support rights are owed to the applicant or to any family member for whom the applicant is applying for or receiving assistance. The assignment includes all support rights that accrue as long as the applicant receives public assistance.

G. By operation of law, an assignment to the authority of any and all rights of an applicant for or recipient of medical assistance under the medicaid program in New Mexico or supplemental security income through the social security administration:

(1) is deemed to be made of:

(a) any payment for medical care from any natural person, firm or corporation, including an insurance carrier; and

(b) any recovery for personal injury, whether by judgment or contract for compromise or settlement;

(2) shall be effective to the extent of the amount of medical assistance actually paid by the authority under the medicaid program; and

(3) shall be effective as to the rights of any other persons who are eligible for medical assistance and whose rights can legally be assigned by the applicant or recipient.

H. An applicant or recipient is required to cooperate fully with the authority in its efforts to secure the assignment and to execute and deliver any instruments and papers deemed necessary to complete the assignment by the authority.

History: 1978 Comp., § 27-2-28, enacted by Laws 1981, ch. 90, § 2; 1982, ch. 12, § 2; 1991, ch. 223, § 1; 1995, ch. 202, § 1; 2009, ch. 32, § 1; 2024, ch. 39, § 79.

27-2-29. Repealed.

27-2-29.1. Compensation under contingent fee contracts; suspense fund created.

A. To make disbursements and distributions pursuant to this section, the "health care authority reimbursement suspense fund" is created in the state treasury.

B. When pursuing a claim arising under Section 27-2-23 or 27-2-28 NMSA 1978, in addition to other available alternatives, the authority may contract with a person to represent the authority on a contingent fee basis if the contract:

(1) is approved by the attorney general;

(2) provides that all amounts received by the contractor as satisfaction of the claim shall be transferred to the authority and deposited into the health care authority reimbursement suspense fund to the credit of the authority; and

(3) provides that, upon the direction of the secretary, the compensation due to the contractor shall be disbursed from the suspense fund to the contractor.

C. After a disbursement to a contractor pursuant to Paragraph (3) of Subsection B of this section, the balance of each deposit into the health care authority reimbursement suspense fund shall be distributed to the general fund and shall be appropriated to the authority to reimburse the authority for the public assistance from which the claim arose and, if required, for reimbursing the federal government.

History: Laws 2010, ch. 80, § 1; 2024, ch. 39, § 80.

27-2-30. [Enforcement of support;] orders.

The court in term time or judge in vacation may make and enforce by attachment or otherwise such order to restrain the use or disposition of the property of the defendant to provide for the support of the dependents during the pendency of the suit as in his discretion may seem just and proper.

History: 1953 Comp., § 13-1-27.3, enacted by Laws 1965, ch. 66, § 3.

27-2-31. Judgments and proceeds.

Upon final hearing, judgment for the authority shall include all sums expended during the pendency of the action. When the authority recovers judgments under Chapter 27, Article 2 NMSA 1978, it may enforce, compromise or settle the judgments in any way considered by the authority to be in the public interest. Any proceeds of judgments or settlements shall be retained by the authority for its authorized activities and required reimbursements to the federal government.

History: 1953 Comp., § 13-1-27.4, enacted by Laws 1965, ch. 66, § 4; 2024, ch. 39, § 81.

27-2-32. Duty of agencies to cooperate.

All state, county and municipal agencies, departments, bureaus and divisions shall cooperate in the location of absent parents who are not fulfilling their obligation to support their children and shall on request supply the authority with all information on hand relative to the location, social security number, income and property of such absent parents, notwithstanding any other provision of law making the information confidential. The authority shall use such information only for the purpose of enforcing the support liability of such absent parents and shall not use the information or disclose it for any other purpose.

History: 1953 Comp., § 13-1-28, enacted by Laws 1969, ch. 182, § 3; 1981, ch. 90, § 3; 1985, ch. 105, § 14; 2024, ch. 39, § 82.

27-2-33. Repealed.

27-2-34. Limitations of act.

All assistance granted under this act shall be deemed to be granted and to be held subject to the provisions of any amending or repealing act that may hereafter be passed, and no recipient shall have any claim for compensation, or otherwise, by reason of his assistance being affected in any way by any amending or repealing act.

History: Laws 1937, ch. 18, § 22; 1941, ch. 116, § 7; 1941 Comp., § 73-132; 1953 Comp., § 13-1-35.

27-2-35 to 27-2-40. Repealed.

27-2-41. Short title.

Sections 27-2-41 through 27-2-47 NMSA 1978 may be cited as the "Indigent Catastrophic Illness Hospital Funding Act".

History: Laws 1990, ch. 93, § 1; 2024, ch. 39, § 83.

27-2-42. Legislative findings; purpose.

A. The legislature finds that twenty-five percent of New Mexicans have no health insurance. When such individuals suffer a catastrophic illness, the large hospital bills that are incurred can often result in indigency for that sick person and his family.

B. The purpose of the Indigent Catastrophic Illness Hospital Funding Act [27-2-41 to 27-2-47 NMSA 1978] is to reduce the impact of medical indigency on the cost of health care in New Mexico by providing for payment of some portion of large hospital bills incurred by medically indigent patients.

History: Laws 1990, ch. 93, § 2.

27-2-43. Definitions.

As used in the Indigent Catastrophic Illness Hospital Funding Act [27-2-41 to 27-2-47 NMSA 1978]:

A. "authority" or "department" means the health care authority;

B. "fund" means the indigent catastrophic illness hospital fund;

C. "hospital" means any general or special hospital that is licensed by the authority and that has annual gross charges for medicare, medicaid and indigent patients greater than ten percent of the hospital's total annual gross charges; and

D. "medically indigent patient" means a person who is a New Mexico resident who incurs hospital charges, who is not eligible for medicaid or medicare and whose family or household income does not exceed two hundred fifty percent of the federal poverty level.

History: Laws 1990, ch. 93, § 3; 2024, ch. 39, § 84.

27-2-44. Indigent catastrophic illness hospital fund created.

The "indigent catastrophic illness hospital fund" is created as a nonreverting fund in the state treasury. Money in the fund is appropriated to the authority to reimburse hospitals for eligible claims for hospital charges incurred by medically indigent patients and for paying administrative costs of the authority not to exceed three percent of the annual appropriation or other distribution or transfer to the fund. Money in the fund shall be invested as provided for other state funds and income earned on the fund shall be credited to the fund.

History: Laws 1990, ch. 93, § 4; 2024, ch. 39, § 85.

27-2-45. Hospitals; claims for payment.

A. A hospital may submit eligible claims to the department on or before April 1 of each year for payment from the fund by June 30 of each year in an amount determined pursuant to this section.

B. A claim submitted by a hospital for payment from the fund shall be deemed an eligible claim if it is for:

(1) uncovered hospital charges of five thousand dollars ($5,000) or more for an illness of a medically indigent patient;

(2) hospital charges incurred within the twelve months immediately prior to the applicable April 1 closing deadline; and

(3) an amount determined by subtracting from the base claim the medically indigent patient's deductible and then reducing the resulting balance, based on the hospital's medicare cost-to-charge ratio, to an amount equal to medicare allowable costs.

C. The department shall pay from the fund to each hospital the amount of each eligible claim if there is sufficient money in the fund. If there is not sufficient money in the fund to pay all eligible claims of hospitals for that year, the amount of each claim that shall be paid shall be an amount derived from multiplying the full amount of the eligible claim by the percentage derived from dividing the balance in the fund, after administrative costs have been subtracted, by the sum of the eligible claims.

History: Laws 1990, ch. 93, § 5.

27-2-46. Medically indigent patient deductible.

A medically indigent patient's deductible shall be an amount determined by the hospital that the medically indigent patient is able to pay the hospital in monthly installments over an eighteen-month period. That determination shall be made pursuant

to department rules and regulations and shall include, but not be limited to, consideration of the medically indigent patient's family size, household income and obligations.

History: Laws 1990, ch. 93, § 6.

27-2-47. Department; regulations.

The department shall adopt and promulgate by September 30, 1990 rules and regulations necessary to implement and administer the Indigent Catastrophic Illness Hospital Funding Act [27-2-41 to 27-2-47 NMSA 1978].

History: Laws 1990, ch. 93, § 7.

ARTICLE 2A
Medicaid Estate Recovery

27-2A-1. Short title.

Chapter 27, Article 2A NMSA 1978 may be cited as the "Medicaid Estate Recovery Act".

History: Laws 1994, ch. 87, § 1; 2024, ch. 39, § 86.

27-2A-2. Purpose of act.

The purpose of the Medicaid Estate Recovery Act is to authorize and require the department to seek recovery of medical assistance payments made by the department for certain individuals, under certain circumstances, as provided in Title XIX of the Social Security Act.

History: Laws 1994, ch. 87, § 2.

27-2A-3. Definitions.

As used in the Medicaid Estate Recovery Act:

A. "authority" or "department" means the health care authority;

B. "estate" means real and personal property and other assets of the individual subject to probate or administration pursuant to the provisions of the Uniform Probate Code [Chapter 45 NMSA 1978]; and

C. "medical assistance" means amounts paid by the department as medical assistance pursuant to Title 19 of the Social Security Act.

History: Laws 1994, ch. 87, § 3; 2024, ch. 39, § 87.

27-2A-4. Department to seek recovery of medical assistance payments restriction.

A. The department shall seek recovery from the estate of an individual:

(1) for medical assistance paid on behalf of an individual who was an inpatient in a nursing facility, intermediate care facility for individuals with developmental or intellectual disabilities or other medical institution if the individual was required, as a condition of receiving services in the facility or institution pursuant to the state plan, to spend for costs of services all but a minimal amount of the individual's income required for personal needs, and with respect to whom the department determined, after opportunity for a hearing in accordance with procedures established by the department, could not reasonably have been expected to have been discharged from the facility or institution to return home; and

(2) for medical assistance payments made for nursing facility services, home- and community-based services and related hospital and prescription drug services on behalf of an individual who was fifty-five years of age or older when the individual received medical assistance.

B. In the case of an individual who has participated in the state's qualified state long-term care insurance partnership program pursuant to Section 27-2-12.17 NMSA 1978, the department shall seek recovery of medical assistance paid on behalf of the individual only of the value of the individual's estate that exceeds the amount that the department has disregarded from the individual's countable resources pursuant to Paragraph (2) of Subsection A of Section 27-2-12.17 NMSA 1978 in making its eligibility determination for medical assistance for institutional care or a medical assistance home- and community-based long-term care program.

History: Laws 1994, ch. 87, § 4; 2013, ch. 139, § 3; 2023, ch. 113, § 5.

27-2A-5. Administration; recovery from estates.

A. The department shall administer the estate recovery program.

B. The department shall adopt and promulgate rules and regulations to implement the provisions of the Medicaid Estate Recovery Act.

C. The department may compromise, settle or waive recovery pursuant to the Medicaid Estate Recovery Act when deemed by the department to be in the best interests of the state.

History: Laws 1994, ch. 87, § 5.

27-2A-6. Hardship waiver.

The department shall waive the application of the provisions of the Medicaid Estate Recovery Act if application of the provisions would work an undue hardship as determined pursuant to regulations adopted and promulgated by the secretary of human services. The regulations shall include a provision for special consideration when an asset subject to recovery is the sole income-producing asset or is a homestead of modest value.

History: Laws 1994, ch. 87, § 6.

27-2A-7. Restrictions on recovery from estates.

Any recovery from an estate may be made only after the death of the decedent's surviving spouse, if any, and only at a time when the decedent has no surviving child who is less than twenty-one years of age or is blind or disabled as defined in 42 U.S.C. 1383C.

History: Laws 1994, ch. 87, § 7.

27-2A-8. Due process.

When the department determines it will seek to recover from an estate, it shall give written notice of that intent to the personal representative or successor in interest of the estate or the individual.

History: Laws 1994, ch. 87, § 8.

27-2A-9. Department exempt from bond requirement for personal representative.

If the department seeks appointment as a personal representative of a decedent to enforce its rights as a creditor of the decedent pursuant to the provisions of the Medicaid Estate Recovery Act, it is exempt from any requirement for posting a bond.

History: Laws 1994, ch. 87, § 9.

ARTICLE 2B
New Mexico Works Act

27-2B-1. Short title.

Chapter 27, Article 2B NMSA 1978 may be cited as the "New Mexico Works Act".

History: Laws 1998, ch. 8, § 1; 1998, ch. 9, § 1; 2009, ch. 186, § 1.

27-2B-2. Legislative findings; purpose of act.

A. The legislature finds that:

(1) the poverty rate in New Mexico is the highest in the nation and has exceeded more than twenty percent of the population for most of the past twenty-five years;

(2) having a job does not provide a guarantee of avoiding poverty as demonstrated by the high percentage of persons in the civilian labor force over sixteen years of age with reported incomes in 1989 that were below the poverty level; and

(3) the diversity of the state, with its residents living in rural and metropolitan areas, reservations and border areas, requires the state to adjust state policies governing economic and social programs for the poor and the working poor to reflect the particular needs of particular locales, not just to create a generic one-size-fits-all program.

B. The legislature finds that education and training are essential to long-term career development.

C. The legislature finds that employment improves the quality of life for parents and children by increasing family income, developing the discipline necessary for self-sufficiency and improving self-esteem, and thus, it is in the public interest to fundamentally alter the state's financial assistance program for needy families with children so both cash and services, including education, job training, child care and transportation provided in accordance with the New Mexico Works Act assist recipients to obtain and keep employment that is sufficient to sustain their families, ensure the dignity of those who receive assistance and strengthen families and families' support for their children.

D. The legislature finds that although most New Mexicans want to work, and in fact New Mexico has been cited as a "like to work" state, not all families can move quickly into the labor force and that regular assessments and key intervention and follow-up can help persons connect to the work force to obtain meaningful work and achieve self-sufficiency.

E. The legislature further finds that the federal act envisions that state and tribal governments will work together to serve participants residing in Indian country, and it is important that the state and the tribal governments work, government to government, to address the issues of availability and delivery of service to the twenty-two tribes and pueblos.

F. The purpose of the New Mexico Works Act is to increase family income through family employment and child support and, by viewing financial assistance as a support service to enable and assist parents to participate in employment rather than as an entitlement, to enable New Mexico to change the culture of the welfare office, both on the part of the department and on the part of the recipients, so that all parties can focus on addressing the barriers to participation in work activities and putting New Mexicans to work.

History: Laws 1998, ch. 8, § 2 and Laws 1998, ch. 9, § 2.

27-2B-3. Definitions.

As used in the New Mexico Works Act:

A. "applicant" means a person applying for cash assistance on behalf of a benefit group;

B. "benefit group" means a pregnant woman or a group of people that includes a dependent child, all of that dependent child's full, half or adopted siblings or stepsiblings living with the dependent child's parent or relative within the fifth degree of consanguinity and the parent with whom the children live;

C. "cash assistance" means cash payments funded by the temporary assistance for needy families block grant pursuant to the federal Social Security Act and by state funds;

D. "authority" or "department" means the health care authority;

E. "dependent child" means a natural child, adopted child, stepchild or ward who is:

(1) seventeen years of age or younger;

(2) eighteen years of age and is enrolled in high school; or

(3) between eighteen and twenty-two years of age and is receiving special education services regulated by the public education department;

F. "director" means the director of the income support division of the authority;

G. "earned income" means cash or payment in kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services;

H. "federal act" means the federal Social Security Act and rules promulgated pursuant to the Social Security Act;

I. "federal poverty guidelines" means the level of income defining poverty by family size published annually in the federal register by the United States department of health and human services;

J. "immigrant" means an alien as defined in the federal act;

K. "parent" means natural parent, adoptive parent or stepparent;

L. "participant" means a recipient of cash assistance or services or a member of a benefit group who has reached the age of majority;

M. "person" means an individual;

N. "secretary" means the secretary of health care authority;

O. "services" means child care assistance; payment for employment-related transportation costs; job search assistance; employment counseling; employment, education and job training placement; one-time payment for necessary employment-related costs; case management; or other activities whose purpose is to assist transition into employment;

P. "unearned income" means old age, survivors and disability insurance; railroad retirement benefits; veterans administration compensation or pension; military retirement; pensions, annuities and retirement benefits; lodge or fraternal benefits; shared shelter payments; settlement payments; individual Indian money; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income;

Q. "vehicle" means a conveyance for the transporting of persons to or from employment, for the activities of daily living or for the transportation of goods; "vehicle" does not include any boat, trailer or mobile home used as a principal place of residence; and

R. "vocational education" means an organized educational program that is directly related to the preparation of a person for employment in a current or emerging occupation requiring training other than a baccalaureate or advanced degree. Vocational education shall be provided by an educational or a training organization, such as a vocational-technical school, community college, post-secondary educational institution or proprietary school.

History: Laws 1998, ch. 8, § 3; 1998, ch. 9, § 3; 1999, ch. 273, § 1; 2001, ch. 295, § 1; 2001, ch. 326, § 1; 2003, ch. 311, § 2; 2003, ch. 432, § 2; 2007, ch. 350, § 1; 2009, ch. 186, § 2; 2024, ch. 39, § 88.

27-2B-4. Application; resource planning session; individual responsibility plans; participation agreement; review periods.

A. Application for cash assistance or services shall be made to the department. The application shall be in writing or reduced to writing in the manner and on the form prescribed by the department. The application shall be made under oath by an applicant having custody of or residing with a dependent child who is a benefit group member and shall contain a statement of the age of the child, residence, a complete statement of the amount of property in which the applicant has an interest, a statement of all income that the applicant and other benefit group members have at the time of the filing of the application and other information required by the department.

B. The department shall assist an applicant in completing the application for cash assistance or services and shall evaluate an applicant to determine eligibility for all department programs for which the applicant is eligible. The department shall process all expedited food stamp applications within two business days of submission, and the department shall deliver expedited food stamps to an eligible applicant within seven days of the application.

C. At the time of application for cash assistance and services, an applicant and the department shall identify everyone who is to be counted in the benefit group. Once an application is approved, the participant shall advise the department if there are any changes in the membership of the benefit group.

D. No later than thirty days after an application is filed, the department shall provide to an applicant a resource planning session to ascertain the applicant's immediate needs, assess financial and nonfinancial options, make referrals and act on the application.

E. No later than five days after an application is approved, the department shall provide reimbursement for child care.

F. Whenever the department receives an application for assistance, a verification and record of the applicant's circumstances shall promptly be made to ascertain the facts supporting the application and to obtain other information required by the department. The verification may include a visit to the home of the applicant, as long as the department gives adequate prior notice of the visit to the applicant.

G. No later than fifteen days after an application is approved, the department shall assess the education, skills, prior work experience and employability of the participant.

H. After the initial assessment of skills, the department shall work with the participant to develop an individual responsibility plan that:

(1) sets forth an employment goal for the participant and a plan for moving the participant into employment;

(2) sets forth obligations of the participant that may include a requirement that the participant attend school, maintain certain grades and attendance, keep the

participant's school-age children in school, immunize the participant's children or engage in other activities that will help the participant become and remain employed;

(3) is designed to the greatest extent possible to move the participant into whatever employment the participant is capable of handling and to provide additional services as necessary to increase the responsibility and amount of work the participant will handle over time;

(4) describes the services the department may provide so that the participant may obtain and keep employment; and

(5) may require the participant to participate in appropriate services, such as substance abuse, domestic violence or mental health services.

I. The participant and the department shall sign the participant's individual responsibility plan. The department shall not allow a participant to decline to participate in developing an individual responsibility plan. The department shall not waive the requirement that a participant develop an individual responsibility plan. The department shall emphasize the importance of the individual responsibility plan to the participant.

J. If a participant does not develop an individual responsibility plan, refuses to sign an individual responsibility plan or refuses to attend semiannual reviews of an individual responsibility plan, the participant shall be required to enter into a conciliation process pursuant to Subsection C of Section 27-2B-14 NMSA 1978. If the participant persists in noncompliance with the individual responsibility plan process after the conciliation process, the participant shall be subject to sanctions pursuant to Section 27-2B-14 NMSA 1978.

K. The participant shall also sign a participation agreement that designates the number of hours that the participant must participate in work activities to meet participation standards.

L. The department shall review the current financial eligibility of a benefit group when the department reviews food stamp eligibility.

M. The department shall meet semiannually with a participant to review and revise the participant's individual responsibility plan.

N. The department shall develop a complaint procedure to address issues pertinent to the delivery of services and other issues relating to a participant's individual responsibility plan.

History: Laws 1998, ch. 8, § 4 and Laws 1998, ch. 9, § 4; 1999, ch. 71, § 1; 1999, ch. 273, § 2; 1999, ch. 280, § 1; 2001, ch. 295, § 2; 2001, ch. 326, § 2; 2007, ch. 350, § 2.

27-2B-5. Work requirements; work participation rates.

A. The following qualify as work activities:

(1) unsubsidized employment, including self-employment;

(2) subsidized private sector employment, including self-employment;

(3) subsidized public sector employment;

(4) work experience;

(5) on-the-job training;

(6) job search and job readiness;

(7) community service programs;

(8) vocational education;

(9) job skills training activities directly related to employment;

(10) education directly related to employment;

(11) satisfactory attendance at a secondary school or course of study leading to a high school equivalency credential in the case of a participant who has not completed secondary school or received such a certificate; and

(12) the provision of child care services to a participant who is participating in a community service program.

B. The department shall recognize community service programs and job training programs that are operated by an Indian nation, tribe or pueblo.

C. The department may not require a participant to work more than four hours per week over the work requirement rate set pursuant to the federal act.

D. The department shall require a parent, caretaker or other adult who is a member of a benefit group to engage in a work activity.

E. Where best suited for the participant to address barriers, the department may require the following work activities:

(1) participating in parenting classes, money management classes or life skills training;

(2) participating in a certified alcohol or drug addiction program;

(3) in the case of a homeless benefit group, finding a home;

(4) in the case of a participant who is a victim of domestic violence residing in a domestic violence shelter or receiving counseling or treatment or participating in criminal justice activities directed at prosecuting the domestic violence perpetrator for no longer than twenty-four weeks; and

(5) in the case of a participant who does not speak English, participating in a course in English as a second language.

F. Subject to the availability of funds, the department in cooperation with the workforce solutions department, Indian affairs department and other appropriate state agencies may develop projects to provide for the placement of participants in work activities, including the following:

(1) participating in unpaid internships with private and government entities;

(2) refurbishing publicly assisted housing;

(3) volunteering at a head start program or a school;

(4) weatherizing low-income housing; and

(5) restoring public sites and buildings, including monuments, parks, fire stations, police buildings, jails, libraries, museums, auditoriums, convention halls, hospitals, buildings for administrative offices and city halls.

G. If a participant is engaged in full-time vocational education studies or an activity set out in Paragraphs (9) through (11) of Subsection A of this section, the participant shall engage in another work activity at the same time. Additionally, for two-parent families that receive federally funded child-care assistance, the participant's spouse shall engage in a work activity set out in Paragraphs (1) through (5) or (7) of Subsection A of this section unless the participant suffers from a temporary or complete disability that bars the participant from engaging in a work activity or the participant is barred from engaging in a work activity because the participant provides sole care for a person with a disability.

H. A participant engaged in vocational education studies shall make reasonable efforts to obtain a loan, scholarship, grant or other assistance to pay for costs and tuition, and the department shall disregard those amounts in the eligibility determination.

I. For as long as the described conditions exist, the following are exempt from the work requirement:

(1) a participant barred from engaging in a work activity because the participant has a temporary or permanent disability;

(2) a participant over age sixty;

(3) a participant barred from engaging in a work activity because the participant provides the sole care for a person with a disability;

(4) a single custodial parent caring for a child less than twelve months old for a lifetime total of twelve months;

(5) a single custodial parent caring for a child under six years of age if the parent is unable to obtain child care for one or more of the following reasons:

(a) unavailability of appropriate child care within a reasonable distance from the parent's home or work as defined by the children, youth and families department;

(b) unavailability or unsuitability of informal child care by a relative under other arrangements as defined by the children, youth and families department; or

(c) unavailability of appropriate and affordable formal child-care arrangements as defined by the children, youth and families department;

(6) a pregnant woman during her last trimester of pregnancy;

(7) a participant prevented from working by a temporary emergency or a situation that precludes work participation for thirty days or less;

(8) a participant who demonstrates by reliable medical, psychological or mental reports, court orders or police reports that family violence or threat of family violence effectively bars the participant from employment; and

(9) a participant who demonstrates good cause of the need for the exemption.

J. As a condition of the exemptions identified in Subsection I of this section, the department may establish participation requirements specific to the participant's condition or circumstances, such as substance abuse services, mental health services, domestic violence services, pursuit of disability benefits, job readiness or education directly related to employment. The activities are established to improve the participant's capacity to improve income and strengthen family support.

History: Laws 1998, ch. 8, § 5 and Laws 1998, ch. 9, § 5; 1999, ch. 269, § 1; 2007, ch. 46, § 18; 2007, ch. 350, § 3; 2015, ch. 122, § 14.

27-2B-5.1. Work activities; workers' compensation coverage.

A. For the purposes of the Workers' Compensation Act [52-1-1 NMSA 1978]:

(1) cash assistance and services paid to participants engaged in any work activity described in Section 27-2B-5 NMSA 1978 shall not be considered wages and shall not be deemed to create an employer-employee or co-employer-employee relationship between the participant and the state; and

(2) payment of a wage subsidy to an employer of a participant shall not be deemed to be payment of wages by the state and shall not be deemed to create an employer-employee or co-employer-employee relationship between the participant and the state.

B. Workers' compensation claims by participants shall be separately recorded and maintained in the calculation of the experience modification factor used to calculate premiums for the participating employer so that the experience modification factor attributable to claims by participants can be separated from the remainder of the employer's experience modification factor.

C. The separately calculated experience modification factor for the first year of employment of each participant shall not be considered as part of the experience modification factor of any employer. The superintendent of insurance shall promulgate rules to implement this section.

D. The department shall ensure that participants undergo safety training prior to employment.

E. Participants in an unpaid work activity described in Section 27-2B-5 NMSA 1978 shall be considered trainees and shall not be eligible for workers' compensation benefits.

History: Laws 1999, ch. 181, § 2.

27-2B-5.2. Work program; public schools.

The department and the state department of public education may establish a work program for participants to engage in a work activity pursuant to Subsection A of Section 27-2B-5 NMSA 1978 at public schools.

History: Laws 1999, ch. 27, § 1.

27-2B-6. Durational limits.

A. Pursuant to the federal act, on or after July 1, 1997 a participant may receive federally funded cash assistance or state-funded cash assistance and services pursuant to the New Mexico Works Act for up to sixty months.

B. During a participant's semiannual review, the department shall examine the participant's progress to determine if the participant has successfully completed an

educational or training program or increased the number of hours the participant is working as required by the federal act. The department may refer the participant to alternative work activities or provide additional services to address barriers to employment facing the participant.

C. Up to twenty percent of the population of participants may be exempted from the sixty-month durational limit set out in Subsection A of this section because of hardship or because those participants are battered or subject to extreme cruelty.

D. For the purposes of this section, a participant has been battered or subjected to extreme cruelty if the participant can demonstrate by reliable medical, psychological or mental reports, court orders or police reports that the participant has been subjected to and currently is affected by:

(1) physical acts that result in physical injury;

(2) sexual abuse;

(3) being forced to engage in nonconsensual sexual acts or activities;

(4) threats or attempts at physical or sexual abuse;

(5) mental abuse; or

(6) neglect or deprivation of medical care except when the deprivation is based by mutual consent on religious grounds.

E. For the purposes of this section, a hardship exception applies to a person who demonstrates through reliable medical, psychological or mental reports, social security administration records, court orders, police reports or department records that the person is a person:

(1) who is barred from engaging in a work activity because the person has a temporary or permanent disability;

(2) who is the sole provider of home care to a family member who is ill or has a disability;

(3) whose ability to be gainfully employed is affected by domestic violence;

(4) whose application for supplemental security income is pending in the application or appeals process and who:

(a) meets the criteria of Paragraph (1) of this subsection; or

(b) was granted a waiver from the work requirement or was granted a limited participation requirement pursuant to Paragraph (1) of Subsection I of Section 27-2B-5 NMSA 1978 in the last twenty-four months; or

(5) who otherwise qualifies for a hardship exception as defined by the department.

F. Pursuant to the federal act, the department shall not count a month of receipt of cash assistance or services toward the sixty-month durational limit if during the time of receipt the participant:

(1) was a minor and was not the head of a household or married to the head of a household; or

(2) lived in Indian country, as defined in the federal act, if the most reliable data available with respect to the month indicate that at least fifty percent of the adults living in Indian country or in the village were not employed.

History: Laws 1998, ch. 8, § 6 and Laws 1998, ch. 9, § 6; 2001, ch. 295, § 3; 2001, ch. 326, § 3; 2003, ch. 311, § 3; 2003, ch. 432, § 3; 2007, ch. 46, § 19; 2007, ch. 350, § 4.

27-2B-7. Financial standard of need.

A. The secretary shall adopt a financial standard of need based upon the availability of federal and state funds and based upon appropriations by the legislature of the available federal temporary assistance for needy families grant made pursuant to the federal act in the following categories:

(1) cash assistance;

(2) child care services;

(3) other services; and

(4) administrative costs.

The legislature shall determine the actual percentage of each category to be used annually of the federal temporary assistance for needy families grant made pursuant to the federal act. Within the New Mexico works program, the department may provide cash assistance or services to specific categories of benefit groups from general funds appropriated to cash assistance or services. The department may exclude these funds from temporary assistance for needy families maintenance of effort. The department shall identify alternative state spending to claim as maintenance of effort and make necessary arrangements to allow reporting of that spending.

B. The following income sources are exempt from the gross income test, the net income test and the cash payment calculation:

(1) medicaid;

(2) food stamps;

(3) government-subsidized foster care payments if the child for whom the payment is received is also excluded from the benefit group;

(4) supplemental security income;

(5) government-subsidized housing or housing payments;

(6) federally excluded income;

(7) educational payments made directly to an educational institution;

(8) government-subsidized child care;

(9) earned income that belongs to a person seventeen years of age or younger who is not the head of household;

(10) child support passed through to the participant by the child support enforcement division of the department in the following amounts:

(a) fifty dollars ($50.00) per month through December 31, 2008; and

(b) no later than January 1, 2009, a minimum of one hundred dollars ($100) for one child and two hundred dollars ($200) for two or more children as based on the availability of state or federal funds;

(11) earned income deposited in an individual development account by a member of the benefit group or money received as matching funds for allowable uses by the owner of the individual development account pursuant to the Individual Development Account Act [58-30-1 NMSA 1978]; and

(12) other income sources as determined by the department.

C. The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

D. For a benefit group to be eligible to participate:

(1) gross countable income that belongs to the benefit group must not exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group; and

(2) net countable income that belongs to the benefit group must not equal or exceed the financial standard of need after applying the disregards set out in Paragraphs (1) through (4) of Subsection E of this section.

E. Subject to the availability of state and federal funds, the department shall determine the cash payment of the benefit group by applying the following disregards to the benefit group's earned income and then subtracting that amount from the benefit group's financial standard of need:

(1) one hundred twenty-five dollars ($125) of monthly earned income and one-half of the remainder, or for a two-parent family, two hundred twenty-five dollars ($225) of monthly earned income and one-half of the remainder for each parent;

(2) monthly payments made for child care at a maximum of two hundred dollars ($200) for a child under two years of age and at a maximum of one hundred seventy-five dollars ($175) for a child two years of age or older;

(3) costs of self-employment income; and

(4) business expenses.

F. In addition to the disregards specified in Subsection E of this section, and between June 28, 2007 and June 30, 2008, or until implementation of the employment retention and advancement bonus program described in Subsection G of this section, the department shall apply the following income disregards to the benefit group's earned income and then subtract that amount from the benefit group's financial standard of need:

(1) for the first two years of receiving cash assistance or services, if a participant works over the work requirement rate set by the department pursuant to the New Mexico Works Act, one hundred percent of the income earned by the participant beyond that rate; and

(2) for the first two years of receiving cash assistance or services, for a two-parent benefit group in which one parent works more than thirty-five hours per week and the other works more than twenty-four hours per week, one hundred percent of income earned by each participant beyond the work requirement rate set by the department.

G. No later than July 1, 2008, New Mexico employment incentives shall be as follows:

(1) the department shall implement an employment retention and advancement bonus program based on availability of state or federal funds that includes financial incentives to encourage a participant to:

(a) leave the New Mexico works program and move into an employment retention and advancement bonus incentive program;

(b) maintain a minimum of thirty hours per week employment; and

(c) leave the employment retention and advancement bonus incentive program due to increased earnings above the income eligibility standard and continue employment;

(2) the employment retention and advancement bonus incentive program shall provide a cash bonus and employment services to a former participant who, upon application:

(a) is currently engaged in paid work for a minimum of thirty hours per week;

(b) has received cash assistance for at least three months and one of the last three months;

(c) has had a gross income of less than one hundred fifty percent of the federal poverty guidelines; and

(d) has participated in the employment retention and advancement bonus incentive program for no longer than eighteen months;

(3) for continued eligibility in the employment retention and advancement bonus incentive program, a participant shall:

(a) be engaged in paid work for thirty hours per week for at least one of the past three months;

(b) be engaged in paid work for thirty hours per week for at least four of the past six months;

(c) have had gross income less than one hundred fifty percent of the federal poverty guidelines; and

(d) have participated in the program no more than eighteen months;

(4) the department shall provide employment services to assist participants in gaining access to available work supports, maintain employment and advance to higher-paying employment; and

(5) the department shall:

(a) establish the amount of bonus to be paid to participants in the employment retention and advancement bonus program based on availability of state and federal funds;

(b) propose rules to implement the employment retention and advancement bonus incentive program of this subsection no later than January 1, 2008; and

(c) begin implementation of the employment retention and advancement bonus incentive program of this subsection no later than July 1, 2008.

H. The department may recover overpayments of cash assistance on a monthly basis not to exceed fifteen percent of the financial standard of need applicable to the benefit group.

I. Based upon the availability of funds and in accordance with the federal act, the secretary may establish a separate temporary assistance for needy families cash assistance program that may waive certain New Mexico Works Act requirements due to a specific situation.

J. Subject to the availability of state and federal funds, the department may limit the eligibility of benefit groups that are eligible because a legal guardian is not included in the benefit group.

History: Laws 1998, ch. 8, § 7; 1998, ch. 9, § 7; 1999, ch. 54, § 1; 2001, ch. 295, § 4; 2001, ch. 326, § 4; 2003, ch. 362, § 13; 2006, ch. 96, § 14; 2007, ch. 349, § 14; 2007, ch. 350, § 5; 2009, ch. 186, § 3.

27-2B-7.1. Repealed.

History: Laws 2003, ch. 160, § 1; repealed by Laws 2007, ch. 350, § 11.

27-2B-8. Resources.

A. Liquid and nonliquid resources owned by the benefit group shall be counted in the eligibility determination.

B. A benefit group may at a maximum own the following resources:

(1) two thousand dollars ($2,000) in nonliquid resources;

(2) one thousand five hundred dollars ($1,500) in liquid resources, excluding funds deposited in an individual development account established pursuant to the Individual Development Account Act or a qualified tuition program, as defined in Section 529 of the Internal Revenue Code of 1986;

(3) the value of the principal residence of the participant;

(4) the value of burial plots and funeral contracts for family members; and

(5) the value of work-related equipment up to one thousand dollars ($1,000).

C. Vehicles owned by the benefit group shall not be considered in the determination of resources attributed to the benefit group.

History: Laws 1998, ch. 8, § 8 and Laws 1998, ch. 9, § 8; 2001, ch. 295, § 5; 2001, ch. 326, § 5; 2003, ch. 311, § 4; 2003, ch. 432, § 4; 2006, ch. 96, § 15; 2007, ch. 349, § 15; 2019, ch. 225, § 1.

27-2B-9. Mandatory school attendance.

If a minor member of a benefit group has three unexcused absences from school during a grading period, his parent shall notify the department of the absences within fourteen days. The department may impose a sanction on the benefit group that reduces the cash assistance by the amount the minor member would otherwise receive only after the department refers the minor member to the appropriate state agency, counselor or community program for appropriate resolution of the attendance problem. The department shall not consider participation in cultural and religious activities an unexcused absence, as long as the student has parental consent.

History: Laws 1998, ch. 8, § 9 and Laws 1998, ch. 9, § 9.

27-2B-10. Individual development accounts.

A participant may establish an individual development account pursuant to the Individual Development Account Act [58-30-1 NMSA 1978].

History: Laws 1998, ch. 8, § 10 and Laws 1998, ch. 9, § 10; 2003, ch. 362, § 14; 2006, ch. 96, § 16; 2007, ch. 349, § 16.

27-2B-11. Ineligibility.

A. The following are ineligible to be members of a benefit group:

(1) an inmate or patient of a nonmedical institution;

(2) a person who, in the two years preceding application, assigned or transferred real property unless the person:

(a) received or receives a reasonable return;

(b) attempted to or attempts to receive a reasonable return; or

(c) attempted to or attempts to regain title to the real property;

(3) a minor unmarried parent who has not successfully completed a high school education and who has a child at least twelve weeks of age in the minor unmarried parent's care unless the minor unmarried parent:

(a) participates in educational activities directed toward the attainment of a high school diploma or its equivalent; or

(b) participates in an alternative educational or training program that has been approved by the department;

(4) a minor unmarried parent who is not residing in a place of residence maintained by a parent, legal guardian or other adult relative unless the department:

(a) refers or locates the minor unmarried parent to a second-chance home, maternity home or other appropriate adult-supervised supportive living arrangement, and takes into account the needs and concerns of the minor unmarried parent;

(b) determines that the minor unmarried parent has no parent, legal guardian or other appropriate adult relative who is living or whose whereabouts are known;

(c) determines that a minor unmarried parent is not allowed to live in the home of a living parent, legal guardian or other appropriate adult relative;

(d) determines that the minor unmarried parent is or has been subjected to serious physical or emotional harm, sexual abuse or exploitation in the home of the parent, legal guardian or other appropriate adult relative;

(e) finds that substantial evidence exists of an act or a failure to act that presents an imminent or serious harm to the minor unmarried parent and the child of the minor unmarried parent if they live in the same residence with the parent, legal guardian or other appropriate adult relative; or

(f) determines that it is in the best interest of the unmarried minor parent to waive this requirement;

(5) a minor child who has been absent or is expected to be absent from the home for forty-five days;

(6) a person who does not provide a social security number or who refuses to apply for one;

(7) a person who is not a resident of New Mexico;

(8) a person who fraudulently misrepresented residency to receive assistance in two or more states simultaneously, except that the person shall be ineligible only for ten years;

(9) a person who is a fleeing felon or a probation and parole violator; and

(10) a person concurrently receiving supplemental security income, tribal temporary assistance for needy families or bureau of Indian affairs general assistance.

B. For the purposes of this section, "second-chance home" means an entity that provides a supportive and supervised living arrangement to a minor unmarried parent where the minor unmarried parent is required to learn parenting skills, including child development, family budgeting, health and nutrition, and other skills to promote long-term economic independence and the well-being of children.

C. Pursuant to the authorization provided to the states in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 21 U.S.C. Section 862a(d)(1)(A), New Mexico elects to exempt all persons domiciled in the state from application of 21 U.S.C. Section 862a(d)(1)(A) concerning the restriction of eligibility for benefits on the basis of a conviction for distribution of a controlled substance.

History: Laws 1998, ch. 8, § 11 and Laws 1998, ch. 9, § 11; 2001, ch. 295, § 6; 2001, ch. 326, § 6; 2002, ch. 5, § 1; 2002, ch. 6, § 1; 2007, ch. 350, § 6.

27-2B-12. Services.

Subject to the availability of federal and state funds, a benefit group that is not receiving cash assistance but has an income less than one hundred percent of the federal poverty guidelines may be eligible to receive services.

History: Laws 1998, ch. 8, § 12 and Laws 1998, ch. 9, § 12; 1999, ch. 273, § 3.

27-2B-13. Fair hearing; review and appeal.

A. A participant may request a hearing if:

(1) an application is not acted on within a reasonable time after the filing of the application;

(2) an application is denied in whole or in part; or

(3) the cash assistance or services are modified, terminated or not provided.

B. The department shall notify the participant of his rights under this section.

C. The department shall by rule establish procedures for the filing of a request for a hearing and the time limits within which a request may be filed; provided, however, that the department may grant reasonable extensions of the time limits. If the request is filed in a timely manner, cash assistance and services shall be provided until the appeal is resolved. If the request is not filed within the specified time for appeal or within whatever extension the department may grant, the department action shall be final. Upon receipt of a timely request, the department shall give the participant reasonable notice of an opportunity for a fair hearing in accordance with the rules of the department.

D. The hearing shall be conducted by a hearing officer designated by the director. The powers of the hearing officer shall include administering oaths or affirmations to witnesses called to testify, taking testimony, examining witnesses, admitting or excluding evidence and reopening a hearing to receive additional evidence. The technical rules of evidence and the rules of civil procedure shall not apply. The hearing shall be conducted so that the contentions or defenses of each party to the hearing are amply and fairly presented. Either party may be represented by counsel or other representative of his designation, and he or his representative may conduct cross-examination. Oral or documentary evidence may be received but the hearing officer may exclude irrelevant, immaterial or unduly repetitious evidence.

E. The director shall review the record of the proceedings and shall make his decision on the record. The participant or his representative shall be notified in writing of the director's decision and the reasons for the decision. The written notice shall inform the participant of his right to judicial review. The department shall be responsible for ensuring that the decision is enforced.

F. Within thirty days after receiving written notice of the decision of the director, a participant may file a notice of appeal with the court of appeals together with a copy of the notice of the decision. The clerk of the court shall transmit a copy of the notice of appeal to the director.

G. The filing of a notice of appeal shall not stay the enforcement of the decision of the director, but the department may grant, or the court upon motion and good cause shown may order, a stay.

H. Within twenty days after receipt of the notice of appeal, the department shall file with the clerk of the court three copies and furnish to the appellant one copy of the written transcript of the record of the proceedings.

I. If, before the date set for argument, application is made to the court for leave to present additional evidence and the court is satisfied that the additional evidence is material and there was good reason for not presenting it in the hearing, the court may order the additional evidence taken before the department. If the application to present additional evidence is filed by the department and is approved by the court, the department's decision that is being appealed shall be stayed. The director may modify his findings and decision by reason of the additional evidence and shall file with the

court a transcript of the additional evidence together with any modified or new findings or decision.

J. The review of the court shall be made upon the decision and the record of the proceedings.

K. The court shall set aside a decision and order of the director only if found to be:

(1) arbitrary, capricious or an abuse of discretion;

(2) not supported by substantial evidence in the record as a whole; or

(3) otherwise not in accordance with law.

L. The department shall not authorize or allow expenditures for the affected programs in excess of the amounts previously appropriated by the legislature.

History: Laws 1998, ch. 8, § 13 and Laws 1998, ch. 9, § 13.

27-2B-14. Sanctions.

A. The department shall sanction a member of a benefit group for noncompliance with work requirements or child support requirements.

B. The sanction shall be applied at the following levels:

(1) twenty-five percent reduction of cash assistance for the first occurrence of noncompliance;

(2) fifty percent reduction of cash assistance for the second occurrence of noncompliance; and

(3) termination of cash assistance and ineligibility to reapply for six months for the third occurrence of noncompliance.

C. Prior to imposing the first sanction, if the department determines that a participant is not complying with the work participation requirement or child support requirements, the participant shall be required to enter into a conciliation process established by the department to address the noncompliance and to identify good cause for noncompliance or barriers to compliance. The conciliation process shall occur only once prior to the imposition of the sanction. The participant shall have ten working days from the date a conciliation notice is mailed to contact the department to initiate the conciliation process. A participant who fails to initiate the conciliation process shall have a notice of adverse action mailed to him after the tenth working day following the date on which the conciliation notice is mailed. Participants who begin but do not complete

the conciliation process shall be mailed a notice of adverse action thirty days from the date the original conciliation notice was mailed.

D. Reestablishing compliance shall allow full payment to resume.

E. Noncompliance with reporting requirements may subject a participant to other sanctions, except that an adult member of the benefit group shall not be sanctioned for the failure of a dependent child to attend school.

F. Effective October 1, 2001, the department shall not terminate the medicaid benefits of any member of a benefit group due to imposition of a sanction pursuant to the provisions of this section.

History: Laws 1998, ch. 8, § 14 and Laws 1998, ch. 9, § 14; 2001, ch. 295, § 7; 2001, ch. 326, § 7; 2003, ch. 311, § 5; 2003, ch. 432, § 5.

27-2B-15. Medicaid eligibility.

A. The following are eligible for medicaid:

(1) a participant who is in transition to self-sufficiency due to employment or child support;

(2) a pregnant woman who meets the income and resource requirements for New Mexico's aid to families with dependent children as they existed on July 16, 1996;

(3) a member of a benefit group who is eighteen years of age or younger if the benefit group's income is below one hundred eighty-five percent of the federal poverty guidelines;

(4) a pregnant woman whose income is below one hundred eighty-five percent of the federal poverty guidelines;

(5) participants receiving federal supplemental security income;

(6) an aged, blind or disabled person in an institution who meets all the supplemental security income standards except for income;

(7) a person who meets all standards for institutional care but is cared for at home and meets eligibility standards for medicaid;

(8) a qualified medicare beneficiary, qualified disabled working person or specified low-income medicare beneficiary; and

(9) a foster child in the custody of the state or of an Indian pueblo, tribe or nation who meets eligibility standards for medicare.

B. Effective October 1, 2001, for the medicaid category designated "JUL medicaid" by the department, the income eligibility criteria shall be the same as the income eligibility criteria set forth in the New Mexico Works Act [27-2B-1 to 27-2B-20 NMSA 1978].

History: Laws 1998, ch. 8, § 15 and Laws 1998, ch. 9, § 15; 2001, ch. 295, § 8; 2001, ch. 326, § 8.

27-2B-16. Immigrant eligibility.

An immigrant may be eligible to receive cash assistance and services if the immigrant is:

A. from one of the classes of immigrants defined in the federal act who entered the United States prior to August 22, 1996; or

B. a qualified immigrant as defined in the federal act who entered the United States after August 22, 1996.

History: Laws 1998, ch. 8, § 16 and Laws 1998, ch. 9, § 16.

27-2B-17. Records; confidentiality.

A. Pursuant to the federal act, the department shall establish and enforce rules governing the custody, use and preservation of the records, papers, files and communications to restrict the use or disclosure of information contained in those documents concerning participants.

B. It is unlawful for a person, body, association, firm, corporation or other agency outside the department to solicit, disclose, receive or make use of or authorize, knowingly permit, participate in or acquiesce in the use of a name or list of names of participants for commercial or political purposes.

C. A person, body, association, firm, corporation or other agency that willfully or knowingly violates a provision of this section is guilty of a misdemeanor and upon conviction shall be punished by a fine of not less than twenty-five dollars ($25.00) nor more than one thousand dollars ($1,000) or by imprisonment in the county jail for a definite term not to exceed sixty days or both.

History: Laws 1998, ch. 8, § 17 and Laws 1998, ch. 9, § 17.

27-2B-18. Certification.

The governor shall make the certifications mandated by the federal act.

History: Laws 1998, ch. 8, § 18 and Laws 1998, ch. 9, § 18.

27-2B-19. Subsidized employment.

A. The department may administer a wage subsidy program based on availability of federal and state funds.

B. The wage subsidy program shall include the following requirements:

(1) participating employers shall hire participants who receive cash assistance for subsidized job slots that are full time and that offer a reasonable possibility of unsubsidized employment after the subsidy period;

(2) participating employers shall receive a subsidy for up to twelve months;

(3) subsidized employees shall not be required to work in excess of forty hours per week;

(4) subsidized employees shall be paid a wage that is substantially like the wage paid for similar jobs with the employer with appropriate adjustments for experience and training but not less than the federal minimum hourly wage;

(5) subsidized employment does not impair an existing contract or collective bargaining agreement;

(6) subsidized employment does not displace currently employed workers or fill positions that are vacant due to a layoff;

(7) wage subsidy employers shall:

(a) maintain health, safety and working conditions at or above levels generally acceptable in the industry and not less than those of comparable jobs offered by the employer;

(b) provide on-the-job training necessary for subsidized employees to perform their duties;

(c) sign an agreement for each placement outlining the specific job offered to a subsidized employee and agree to abide by all of the requirements of the program;

(d) provide workers' compensation coverage for each subsidized employee; and

(e) provide the subsidized employee with benefits equal to those for new employees or as required by state and federal law, whichever is greater;

(8) the department shall determine whether a participant is eligible to be a subsidized employee by establishing:

(a) that the participant has sufficient work experience to obtain unsubsidized employment;

(b) that the participant has completed an employment preparation program; or

(c) that the department or participant may benefit from this employment strategy;

(9) a disregard of income earned by the subsidized employee in the subsidized job shall be applied in the eligibility determination for services;

(10) the department shall suspend regular payments of cash assistance to the benefit group for the calendar month in which an employer makes the first subsidized wage payment to a subsidized employee who is otherwise eligible for cash assistance and food stamps;

(11) the department shall pay employers each month, from cash assistance;

(12) a subsidized employee shall be eligible for supplemental payments if the net monthly full-time wage paid to the subsidized employee is less than the monthly total of the cash assistance the participant is eligible to receive. The department shall authorize issuance of a supplemental cash payment to compensate for the deficit. To determine if a deficit exists, the department shall adopt an equivalency scale that is adjustable to household size and other factors; and

(13) the department shall determine monthly and pay in advance supplemental payments to eligible subsidized employees. In calculating the payment, the department shall assume that the subsidized employee will work forty hours per week during the month unless an employer provides information that the number of hours to be worked by the subsidized employee will be reduced.

C. For the purposes of this section, "benefits" includes health care coverage, paid sick leave and holiday and vacation pay.

D. For the purposes of this section, "subsidized employee" means a participant engaged in a subsidized employment activity.

E. For the purposes of this section, "net monthly full-time wage" means a subsidized employee's wages after the required payroll deductions.

History: Laws 1998, ch. 8, § 19 and Laws 1998, ch. 9, § 19; 2007, ch. 350, § 7.

27-2B-20. Repealed.

ARTICLE 2C
Pharmaceutical Supplemental Rebate

27-2C-1. Short title.

Chapter 27, Article 2C NMSA 1978 may be cited as the "Pharmaceutical Supplemental Rebate Act".

History: Laws 2002, ch. 105, § 1; 2024, ch. 39, § 89.

27-2C-2. Definitions.

As used in the Pharmaceutical Supplemental Rebate Act:

A. "authority" or "department" means the health care authority;

B. "labeler" means a person that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and that has a labeler code from the federal food and drug administration;

C. "manufacturer" means a manufacturer of prescription drugs as defined in 42 U.S.C. 1396r-8(k)(5), including a subsidiary or affiliate of a manufacturer;

D. "medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal Social Security Act;

E. "participating retail pharmacy" means a retail pharmacy or other business licensed to dispense prescription drugs that participates in the state medicaid program;

F. "secretary" means the secretary of health care authority; and

G. "wholesaler" means a business licensed to distribute prescription drugs in the state.

History: Laws 2002, ch. 105, § 2; 2024, ch. 39, § 90.

27-2C-3. Medicaid formulary for prescription drugs.

A. The department shall develop or implement a formulary or preferred drug list, taking into consideration the clinical efficacy, safety and cost effectiveness of a product.

B. The department shall ensure that the administration or delivery of health care services and products under the medicaid program includes a formulary that will provide medically appropriate drug therapies for patients.

C. The department shall require a prior authorization before a drug not listed on the medicaid program formulary may be dispensed unless otherwise provided pursuant to Subsection C of Section 27-2C-4 NMSA 1978.

D. The department shall ensure that atypical antipsychotic medications are available in the same manner as conventional antipsychotic medications for medicaid patients for the treatment of severe mental illnesses that are listed in a current national diagnostic and statistical manual of mental disorders published by a national psychiatric association, including schizophrenia, clinical depression, bipolar disorder, anxiety-panic attack disorder and obsessive compulsive disorder.

History: Laws 2002, ch. 105, § 3; 2003, ch. 344, § 1.

27-2C-4. Negotiated drug discounts and rebates.

A. The secretary shall negotiate discount prices or rebates for prescription drugs from drug manufacturers and labelers that include supplemental rebates for the medicaid program over and above those required under 42 U.S.C. 1396r-8.

B. In negotiating rebate terms, the secretary shall consider the rebate calculated under the medicaid rebate program pursuant to 42 U.S.C. 1396r-8, the price provided to eligible entities under 42 U.S.C. 256b and other available information on prescription drug prices, discounts and rebates.

C. The secretary shall prompt a review of whether to place a manufacturer's or labeler's products on the prior authorization list for the medicaid program if:

(1) the secretary and a drug manufacturer or labeler fail to reach agreement on the terms of a supplemental medicaid rebate or discount; and

(2) the discounts or rebates offered by the manufacturer or labeler are not as favorable to the state as the prices provided to eligible entities under 42 U.S.C. 256b.

D. Any prior authorization shall meet the requirements of 42 U.S.C. 1396r-8(d)(5) and be done in accordance with the Public Assistance Act [27-2-1 NMSA 1978] or department rules.

E. The names of manufacturers and labelers that do not enter into rebate agreements are public information, and the department shall release this information to the public and actively distribute it to physicians, pharmacists and other health care professionals.

History: Laws 2002, ch. 105, § 4.

27-2C-5. Reporting.

The department shall report the savings from the pharmaceutical supplemental rebates for the preceding fiscal year to the legislative health and human services committee by November 1 of each year.

History: Laws 2002, ch. 105, § 5.

27-2C-6. Coordination with other programs.

When the secretary finds that it is beneficial to the medicaid program and another state program to combine drug pricing negotiations to maximize drug rebates, the secretary may do so.

History: Laws 2002, ch. 105, § 6.

27-2C-7. Rulemaking.

The department shall adopt rules to implement the provisions of the Pharmaceutical Supplemental Rebate Act [27-2C-1 NMSA 1978].

History: Laws 2002, ch. 105, § 7.

27-2C-8. Waivers.

The department shall seek any waivers of federal law or rule necessary to implement the provisions of the Pharmaceutical Supplemental Rebate Act [27-2C-1 NMSA 1978].

History: Laws 2002, ch. 105, § 8.

ARTICLE 2D
Education Works

27-2D-1. Short title.

Chapter 27, Article 2D NMSA 1978 may be cited as the "Education Works Act".

History: Laws 2003, ch. 317, § 1; 2009, ch. 186, § 4.

27-2D-2. Definitions.

As used in the Education Works Act:

A. "applicant" means a person applying for cash assistance on behalf of a benefit group;

B. "benefit group" means a pregnant woman or a group of people that includes a dependent child, all of that dependent child's full, half, step- or adopted siblings living with the dependent child's parent or relative within the fifth degree of consanguinity and the parent with whom the children live;

C. "cash assistance" means cash payments distributed by the authority pursuant to the Education Works Act;

D. "authority" or "department" means the health care authority;

E. "dependent child" means a natural, adopted stepchild or ward who is:

(1) seventeen years of age or younger;

(2) eighteen years of age and is enrolled in high school; or

(3) between eighteen and twenty-two years of age and is receiving special education services regulated by the public education department;

F. "director" means the director of the income support division of the authority;

G. "earned income" means cash or payment in kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services;

H. "education works program" means the cash assistance, activities and services available to a recipient pursuant to the Education Works Act;

I. "federal act" means the federal Social Security Act and rules promulgated pursuant to the Social Security Act;

J. "federal poverty guidelines" means the level of income defining poverty by family size published annually in the federal register by the United States department of health and human services;

K. "parent" means natural parent, adoptive parent or stepparent;

L. "person" means an individual;

M. "recipient" means a person who receives cash assistance or services or a member of a benefit group who has reached the age of majority;

N. "secretary" means the secretary of health care authority;

O. "services" means child-care assistance; payment for education- or employment-related transportation costs; job search assistance; employment counseling; employment, education and job training placement; an annual payment for education-related costs; case management; or other activities whose purpose is to assist transition into employment;

P. "unearned income" means old age, survivors and disability insurance; railroad retirement benefits; veterans administration compensation or pension; military retirement; pensions, annuities and retirement benefits; lodge or fraternal benefits; shared shelter payments; settlement payments; individual Indian money; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income; and

Q. "vehicle" means a conveyance for the transporting of persons to or from employment or education for the activities of daily living or for the transportation of goods; "vehicle" does not include boats, trailers or mobile homes used as a principal place of residence.

History: Laws 2003, ch. 317, § 2; 2007, ch. 350, § 8; 2009, ch. 186, § 5; 2024, ch. 39, § 91.

27-2D-3. Application; resource planning session; individual education plan; review periods.

A. Application for cash assistance or services shall be made to the department. The application shall be in writing or reduced to writing in the manner and on the form prescribed by the department. The application shall be made under oath by an applicant with whom a dependent child resides and shall contain a statement of the age of the child, residence, a complete statement of the amount of property in which the applicant has an interest, a statement of all income that the applicant and other benefit group members have at the time of the filing of the application and other information required by the department.

B. The department shall assist applicants in completing the application for cash assistance or services and shall evaluate applicants to determine all department programs for which the applicant may be eligible. The department shall process all expedited food stamp applications within two business days of submission, and the department shall deliver expedited food stamps to eligible applicants within seven days of the application.

C. At the time of application for cash assistance and services, an applicant shall identify everyone who is to be counted in the benefit group. Once an application is approved, the recipient shall advise the department if there are any changes in the membership of the benefit group.

D. No later than thirty days after an application is filed, the department shall make referrals and act on the application.

E. No later than five days after an application is approved, the department shall provide reimbursement for child care.

F. Whenever the department receives an application for assistance, a verification and record of the applicant's circumstances shall promptly be made to ascertain the facts supporting the application and to obtain other information required by the department. The verification may include a visit to the home of the applicant, as long as the department gives adequate prior notice of the visit to the applicant.

G. The department shall work with the recipient to develop an individual educational plan that:

(1) sets forth the educational goal for the recipient, identifies barriers to that goal and identifies the steps to be taken by the recipient to achieve that goal;

(2) describes the services the department may provide so that the recipient may complete the recipient's educational goal; and

(3) provides for meetings with the recipient every six months or at the end of each academic term to review the eligibility of the benefit group and to review and revise the recipient's individual education plan.

H. The recipient and the department shall sign the recipient's individual education plan. The department shall:

(1) not allow a recipient to decline to participate in developing an individual education plan;

(2) not waive the requirement that a recipient develop an individual education plan; and

(3) emphasize the importance of the individual education plan to the recipient.

History: Laws 2003, ch. 317, § 3; 2007, ch. 350, § 9.

27-2D-4. Education works program; eligibility; restrictions; requirements.

A. A person is eligible to receive education works services or cash assistance if the person demonstrates that:

(1) the person has been accepted or has been determined to be eligible to enroll in a two- or four-year post-secondary or graduate or post-graduate degree program; and

(2) the degree the person will receive will increase the person's ability to engage in full-time paid employment.

B. A recipient shall not receive cash assistance funded by the temporary assistance for needy families block grant during the period in which the recipient is receiving cash assistance pursuant to the Education Works Act.

C. A recipient shall apply for all financial aid available from the post-secondary, graduate or post-graduate educational institution that the recipient attends.

D. During the twenty-four months of participation in the education works program, a recipient shall engage in at least twenty hours per week of class time, studying, work, work-study or volunteering. The department shall assume that a recipient spends one and one-half hours studying for every hour of class time.

E. A recipient may participate in the education works program for no more than twenty-four months, except that a recipient may participate in the education works program for one additional academic term following the twenty-four-month participation limit, or for two additional academic terms following the twenty-four-month participation limit at the discretion of the director, if doing so will result in the recipient earning a degree.

F. The number of recipients enrolled in the education works program is limited to the number of recipients who can be served by the funds available.

G. For purposes of this section, "work" means work-study, training-related practicums, internships, paid employment, volunteering or any other activity approved by the department.

History: Laws 2003, ch. 317, § 4; 2005, ch. 265, § 1; 2006, ch. 84, § 1.

27-2D-5. Financial standard of need.

A. The secretary shall adopt a financial standard of need based upon the availability of state funds.

B. The following income sources are exempt from the gross income test, the net income test and the cash payment calculation:

(1) medicaid;

(2) food stamps;

(3) government-subsidized foster care payments if the child for whom the payment is received is also excluded from the benefit group;

(4) supplemental security income;

(5) government-subsidized housing or housing payments;

(6) federally excluded income;

(7) educational payments made directly to an educational institution;

(8) government-subsidized child care;

(9) earned income that belongs to a person seventeen years of age or younger who is not the head of household;

(10) child support passed through to the participant by the child support enforcement division of the department in the following amounts:

(a) fifty dollars ($50.00) per month through December 31, 2008; and

(b) no later than January 1, 2009, a minimum of one hundred dollars ($100) for one child and two hundred dollars ($200) for two or more children as based on availability of state and federal funds; and

(11) other income sources as determined by the department.

C. The total countable gross earned and unearned income of the benefit group shall not exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

D. For a benefit group to be eligible to participate:

(1) earned and unearned income that belongs to the benefit group shall not exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group; and

(2) earned and unearned income that belongs to the benefit group shall not equal or exceed the financial standard of need after applying the disregards set out in Paragraphs (1) through (4) of Subsection E of this section.

E. Subject to the availability of state funds, the department shall determine the cash payment of the benefit group by applying the following disregards to the benefit group's earned income and then subtracting that amount from the benefit group's financial standard of need:

(1) one hundred twenty-five dollars ($125) of monthly earned income and one-half of the remainder, or for a two-parent family, two hundred twenty-five dollars ($225) of monthly earned income and one-half of the remainder for each parent;

(2) monthly payments made for child care at a maximum of two hundred dollars ($200) for a child under two years of age and a maximum of one hundred seventy-five dollars ($175) for a child two years of age or older;

(3) costs of self-employment income; and

(4) business expenses.

F. In addition to the disregards specified in Subsection E of this section, and between June 28, 2007 and June 30, 2008, or until implementation of the employment retention and advancement bonus program in the New Mexico Works Act [27-2B-1 NMSA 1978], the department shall apply the following income disregards to the benefit group's earned income and then subtract that amount from the benefit group's financial standard of need:

(1) for the first two years of receiving cash assistance or services, if a participant works over the work requirement rate set by the department pursuant to the New Mexico Works Act, one hundred percent of the income earned by the participant beyond that rate; and

(2) for the first two years of receiving cash assistance or services, for a two-parent benefit group in which one parent works more than thirty-five hours per week and the other works more than twenty-four hours per week, one hundred percent of income earned by each participant beyond the work requirement rate set by the department.

G. The department may recover overpayments of cash assistance on a monthly basis not to exceed fifteen percent of the financial standard of need applicable to the benefit group.

H. Subject to the availability of state and federal funds, the department may limit the eligibility of benefit groups that are eligible because a legal guardian is not included in the benefit group.

History: Laws 2003, ch. 317, § 5; 2007, ch. 350, § 10; 2009, ch. 186, § 6.

27-2D-6. Resources.

A. Liquid and nonliquid resources owned by the benefit group shall be counted in the eligibility determination.

B. A benefit group may at a maximum own the following resources:

(1) two thousand dollars ($2,000) in nonliquid resources;

(2) one thousand five hundred dollars ($1,500) in liquid resources, excluding funds deposited in an individual development account established pursuant to the Individual Development Account Act or a qualified tuition program, as defined in Section 529 of the Internal Revenue Code of 1986;

(3) the value of the principal residence of the participant;

(4) the value of burial plots and funeral contracts for family members; and

(5) the value of work-related equipment up to one thousand dollars ($1,000).

C. Vehicles owned by the benefit group shall not be considered in the determination of resources attributed to the benefit group.

History: Laws 2003, ch. 317, § 6; 2006, ch. 96, § 17; 2007, ch. 349, § 17; 2019, ch. 225, § 2.

27-2D-7. Ineligibility.

A. The following are ineligible to be members of a benefit group:

(1) an inmate or patient of a nonmedical institution;

(2) a person who, in the two years preceding application, assigned or transferred real property unless he:

(a) received or receives a reasonable return;

(b) attempted to or attempts to receive a reasonable return; or

(c) attempted to or attempts to regain title to the real property;

(3) a minor unmarried parent who has not successfully completed a high school education and who has a child at least twelve weeks of age in his care unless the minor unmarried parent:

(a) participates in educational activities directed toward the attainment of a high school diploma or its equivalent; or

(b) participates in an alternative educational or training program that has been approved by the department;

(4) a minor unmarried parent who is not residing in a place of residence maintained by his parent, legal guardian or other adult relative unless the department:

(a) refers or locates the minor unmarried parent to a second-chance home, maternity home or other appropriate adult-supervised supportive living arrangement and takes into account the needs and concerns of the minor unmarried parent;

(b) determines that the minor unmarried parent has no parent, legal guardian or other appropriate adult relative who is living or whose whereabouts are known;

(c) determines that a minor unmarried parent is not allowed to live in the home of a living parent, legal guardian or other appropriate adult relative;

(d) determines that the minor unmarried parent is or has been subjected to serious physical or emotional harm, sexual abuse or exploitation in the home of the parent, legal guardian or other appropriate adult relative;

(e) finds that substantial evidence exists of an act or a failure to act that presents an imminent or serious harm to the minor unmarried parent and the child of the minor unmarried parent if they live in the same residence with the parent, legal guardian or other appropriate adult relative; or

(f) determines that it is in the best interest of the unmarried minor parent to waive this requirement;

(5) a minor child who has been absent or is expected to be absent from the home for forty-five days;

(6) a person who does not provide a social security number or who refuses to apply for one;

(7) a person who is not a resident of New Mexico;

(8) a person who fraudulently misrepresented residency to receive assistance in two or more states simultaneously, except that the person shall be ineligible only for ten years;

(9) a person who is a fleeing felon or a probation and parole violator;

(10) a person concurrently receiving supplemental security income, tribal temporary assistance for needy families or bureau of Indian affairs general assistance; and

(11) unless he demonstrates good cause, a parent who does not assist the department in establishing paternity or obtaining child support or who does not assign support rights to New Mexico as required pursuant to the federal act.

B. For the purposes of this section, "second-chance home" means an entity that provides a supportive and supervised living arrangement to a minor unmarried parent

where the minor unmarried parent is required to learn parenting skills, including child development, family budgeting, health and nutrition and other skills to promote long-term economic independence and the well-being of children.

C. Pursuant to the authorization provided to the states in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 21 U.S.C. Section 862a(d)(1)(A), New Mexico elects to exempt all persons domiciled in the state from application of 21 U.S.C. Section 862a(a).

History: Laws 2003, ch. 317, § 7.

27-2D-8. Fair hearing; review and appeal.

A. A recipient may request a hearing if:

(1) an application is not acted on within a reasonable time after the filing of the application;

(2) an application is denied in whole or in part; or

(3) the cash assistance or services are modified, terminated or not provided.

B. The department shall notify the recipient of his rights under this section.

C. The department shall by rule establish procedures for the filing of a request for a hearing and the time limits within which a request may be filed; provided, however, that the department may grant reasonable extensions of the time limits. If the request is filed in a timely manner, cash assistance and services shall be provided until the appeal is resolved. If the request is not filed within the specified time for appeal or within whatever extension the department may grant, the department action shall be final. Upon receipt of a timely request, the department shall give the recipient reasonable notice of an opportunity for a fair hearing in accordance with the rules of the department.

D. The hearing shall be conducted by a hearing officer designated by the director. The powers of the hearing officer shall include administering oaths or affirmations to witnesses called to testify, taking testimony, examining witnesses, admitting or excluding evidence and reopening a hearing to receive additional evidence. The technical rules of evidence and the rules of civil procedure shall not apply. The hearing shall be conducted so that the contentions or defenses of each party to the hearing are amply and fairly presented. Each party may be represented by counsel or other representative and may conduct cross-examination. Oral or documentary evidence may be received, but the hearing officer may exclude irrelevant, immaterial or unduly repetitious evidence.

E. The director shall review the record of the proceedings and shall make his decision on the record. The recipient or his representative shall be notified in writing of

the director's decision and the reasons for the decision. The written notice shall inform the recipient of his right to judicial review. The department shall be responsible for ensuring that the decision is enforced.

F. Within thirty days after receiving written notice of the decision of the director, a recipient may file a notice of appeal with the court of appeals together with a copy of the notice of the decision. The clerk of the court shall transmit a copy of the notice of appeal to the director.

G. The filing of a notice of appeal shall not stay the enforcement of the decision of the director, but the department may grant, or the court upon motion and good cause shown may order, a stay.

H. Within twenty days after receipt of the notice of appeal, the department shall file with the clerk of the court three copies and furnish to the appellant one copy of the written transcript of the record of the proceedings.

I. If, before the date set for argument, application is made to the court for leave to present additional evidence and the court is satisfied that the additional evidence is material and there was good reason for not presenting it in the hearing, the court may order the additional evidence taken before the department. If the application to present additional evidence is filed by the department and is approved by the court, the department's decision that is being appealed shall be stayed. The director may modify his findings and decision by reason of the additional evidence and shall file with the court a transcript of the additional evidence together with any modified or new findings or decision.

J. The review of the court shall be made upon the decision and the record of the proceedings.

K. The court shall set aside a decision and order of the director only if the decision is found to be:

(1) arbitrary, capricious or an abuse of discretion;

(2) not supported by substantial evidence in the record as a whole; or

(3) otherwise not in accordance with law.

L. The department shall not authorize or allow expenditures in excess of the amounts previously appropriated by the legislature.

History: Laws 2003, ch. 317, § 8.

27-2D-9. Satisfactory participation.

A. To maintain satisfactory participation in the education works program, a recipient shall be a full-time student as defined by the school that the recipient attends.

B. A recipient may demonstrate good cause for failure to maintain satisfactory participation in the education works program, and must work with the department to address the barrier, in any month of participation for the following reasons:

(1) extended illness or injury of the recipient;

(2) the recipient is the primary caretaker for a special needs child or an ill or aging parent; or

(3) the recipient has been assessed to have a learning disability or a mental or physical health problem.

C. If a recipient falls below the academic standard of the school in one academic term, he shall be placed on probationary status for one academic term to improve his grades. If a recipient's overall grade point average falls below 2.0 based on a four-point system, the department shall place him on probation for a maximum of two academic terms to allow him to bring up his overall grade point average.

D. A recipient shall:

(1) attend classes as scheduled and participate as required by the standard of the school;

(2) report to the department a change that may affect the benefit group's eligibility for or anything that may affect the recipients ability to participate in the education works program;

(3) provide the department with copies of any financial aid award letters; and

(4) provide the department with copies of his grades as they become available.

E. If a recipient does not comply with Subsection C of this section or with the provisions of the Education Works Act, the department may require the recipient to apply for public assistance pursuant to the New Mexico Works Act [27-2B-1 NMSA 1978]. This decision shall be made in writing and the recipient shall have the opportunity to appeal the decision.

History: Laws 2003, ch. 317, § 9.

ARTICLE 2E
Prescription Drug Pricing

27-2E-1. Average manufacturer price; filing; reporting.

A. A person who manufactures a prescription drug, including a generic prescription drug, that is sold in New Mexico shall file with the health care authority:

(1) the average manufacturer price for the drug;

(2) the price that each wholesaler or pharmacy benefit manager doing business in this state pays the manufacturer to purchase the drug; and

(3) the price paid to the manufacturer by any entity in an arrangement or contract that sells or provides prescription drugs in New Mexico without the services of a wholesaler.

B. The information required under Subsection A of this section shall be filed annually or more frequently, as determined by the health care authority. The information required under Subsection A of this section is confidential and shall not be disclosed pursuant to Section 27-2E-3 NMSA 1978 and shall not be subject to public inspection pursuant to the provisions of Section 14-2-1 NMSA 1978.

C. A person who engages in the wholesale distribution of prescription drugs in New Mexico shall file with the health care authority information showing the actual price at which the wholesaler or distributor sells a particular drug to a pharmacy.

D. As used in this section, "average manufacturer price" means the average price paid to the manufacturer for the drug in New Mexico, including rebates, discounts and market incentives, after deducting customary prompt-pay discounts.

History: Laws 2003, ch. 381, § 1; 2024, ch. 39, § 92.

27-2E-2. Unlawful disclosure; penalties.

A. It is unlawful for an employee, former employee, contractor or former contractor of the health care authority to reveal to another person, except to another employee or contractor of the authority as required by the employee's or contractor's duties or responsibilities or by state or federal court order, information acquired pursuant to Section 27-2E-1 NMSA 1978 or any other information about a prescription drug manufacturer acquired as a result of employment or contract by the authority and not available from public sources.

B. An employee, former employee, contractor or former contractor of the health care authority who reveals to another person information that the person is prohibited from lawfully revealing is guilty of a misdemeanor and shall, upon conviction thereof, be fined not more than one thousand dollars ($1,000) or imprisoned not more than one year, or both, together with costs of prosecution, and shall not be employed by the state for a period of five years after the date of the conviction.

History: Laws 2003, ch. 381, § 2; 2024, ch. 39, § 93.

27-2E-3. Enforcement.

The office of the attorney general may take action to investigate and enforce the requirements of Sections 27-2E-1 and 27-2E-2 NMSA 1978.

History: Laws 2003, ch. 381, § 3; 2024, ch. 39, § 94.

ARTICLE 3
Public Assistance Appeals

27-3-1. Short title.

Chapter 27, Article 3 NMSA 1978 may be cited as the "Public Assistance Appeals Act".

History: 1953 Comp., § 13-18-1, enacted by Laws 1973, ch. 256, § 1; 2024, ch. 39, § 95.

27-3-2. Definitions.

As used in the Public Assistance Appeals Act:

A. "authority" or "department" means the income support division or the medical assistance division of the health care authority;

B. "board" means the income support division or the medical assistance division of the authority; and

C. "director" means the director of the income support division or the medical assistance division of the authority.

History: 1953 Comp., § 13-18-2, enacted by Laws 1973, ch. 256, § 2; 1977, ch. 252, § 22; 1991, ch. 155, § 2; 2024, ch. 39, § 96.

27-3-3. Fair hearing.

A. An applicant for or recipient of assistance or services under any provisions of the Public Assistance Act [27-2-1 NMSA 1978], Social Security Act or Special Medical Needs Act [Chapter 27, Article 4 NMSA 1978] or regulations of the board adopted pursuant to those acts may request a hearing in accordance with regulations of the board if:

(1) an application is not acted upon within a reasonable time after the filing of the application;

(2) an application is denied in whole or in part; or

(3) the assistance or services are modified, terminated or not provided.

The department shall notify the recipient or applicant of his rights under this section.

B. The board shall by regulation establish procedures for the filing of a request for a hearing and the time limits within which a request may be filed; provided, however, that the department may grant reasonable extensions of the time limits. If the request is not filed within the specified time for appeal or within whatever extension the department may grant, the department action shall be final. Upon receipt of a timely request, the department shall give the applicant or recipient reasonable notice of an opportunity for a fair hearing in accordance with the regulations of the board.

C. The hearing shall be conducted by a hearing officer designated by the director. The powers of the hearing officer shall include administering oaths or affirmations to witnesses called to testify, taking testimony, examining witnesses, admitting or excluding evidence and reopening any hearing to receive additional evidence. The technical rules of evidence and the rules of civil procedure shall not apply. The hearing shall be conducted so that the contentions or defenses of each party to the hearing are amply and fairly presented. Either party may be represented by counsel or other representative of his designation, and he or his representative may conduct cross-examination. Any oral or documentary evidence may be received, but the hearing officer may exclude irrelevant, immaterial or unduly repetitious evidence.

D. The director shall review the record of the proceedings and shall make a decision thereon. The applicant or recipient or his representative shall be notified in writing of the director's decision and the reasons for the decision. The written notice shall inform the applicant or recipient of his right to judicial review. The department shall be responsible for assuring that the decision is enforced.

History: 1953 Comp., § 13-18-3, enacted by Laws 1973, ch. 256, § 3; 1991, ch. 155, § 3.

27-3-4. Appeal.

Within thirty days after receiving written notice of the decision of the director pursuant to Section 27-3-3 NMSA 1978, an applicant or recipient may file a notice of appeal with the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: 1953 Comp., § 13-18-4, enacted by Laws 1973, ch. 256, § 4; 1998, ch. 55, § 37; 1999, ch. 265, § 39.

27-3-5. [Expenditures for programs.]

Nothing in the Public Assistance Act [27-2-1 NMSA 1978] or the Fair Hearing Act shall be construed as authorizing or allowing expenditures for the affected programs in excess of the amounts previously appropriated by the legislature for such programs.

History: Laws 1991, ch. 155, § 4.

ARTICLE 4
Special Medical Needs

27-4-1. Short title.

Chapter 27, Article 4 NMSA 1978 may be cited as the "Special Medical Needs Act".

History: 1953 Comp., § 13-15-1, enacted by Laws 1973, ch. 311, § 1; 2024, ch. 39, § 97.

27-4-2. Definitions.

As used in the Special Medical Needs Act:

A. "department" or "division" means the income support division of the health care authority;

B. "board" means the division;

C. "aged person" means a person who has attained the age of sixty-five years and does not have a spouse financially able, according to rules of the division, to furnish support;

D. "person with a disability" means a person who has attained the age of eighteen years and is determined to have a permanent and total disability, according to rules of the division; and

E. "blind person" means a person who is determined to be blind according to rules of the division.

History: 1953 Comp., § 13-15-2, enacted by Laws 1973, ch. 311, § 2; 1977, ch. 252, § 20; 2007, ch. 46, § 20; 2024, ch. 39, § 98.

27-4-3. Persons with special needs.

A. The division shall by regulation establish a program to provide essential medical care for persons who are elderly or blind or who have a disability and who are not eligible for public assistance under the Public Assistance Act [27-2-1 NMSA 1978] and who have a serious medical condition that will as a reasonable medical probability lead to death in the near future.

B. Such medical condition shall be certified by an individual licensed under state law to practice medicine or osteopathy. The medical care shall be reviewed and approved according to regulations of the division.

History: 1953 Comp., § 13-15-3, enacted by Laws 1973, ch. 311, § 3; 2007, ch. 46, § 21.

27-4-4. Standard of need; income determination.

A. Standard of need for purposes of the Special Medical Needs Act [27-4-1 NMSA 1978] shall be determined in accordance with regulations adopted by the board.

B. The board shall define by regulation exempt and nonexempt income and resources. Medical expenses shall not be deducted from either income or resources in determining eligibility.

History: 1953 Comp., § 13-15-4, enacted by Laws 1973, ch. 311, § 4; 1975, ch. 187, § 1.

27-4-5. Eligibility requirements.

A person is eligible for medical care under the Special Medical Needs Act [27-4-1 NMSA 1978] if:

A. pursuant to Section 27-4-4 NMSA 1978, the total amount of his nonexempt income is less than the applicable standard of need; and

B. nonexempt specific and total resources are less than the level of maximum permissible resources established by the board; and

C. he meets all qualifications for persons with special needs, pursuant to Section 27-4-3 NMSA 1978; and

D. within two years immediately prior to the filing of an application for assistance, he has not made an assignment or transfer of real property unless he has received a reasonable return for the real property; or, if he has not received such reasonable return, he is willing to attempt to obtain such return and, if such attempt proves futile, he is willing to attempt to regain title to the property; and

E. he is not an inmate of any public nonmedical institution at the time of receiving assistance; and

F. he is a resident of New Mexico.

History: 1953 Comp., § 13-15-5, enacted by Laws 1973, ch. 311, § 5; 1975, ch. 187, § 2.

ARTICLE 5
Indigent Hospital and County Health Care

27-5-1. Short title.

Chapter 27, Article 5 NMSA 1978 may be cited as the "Indigent Hospital and County Health Care Act".

History: 1953 Comp., § 13-2-12, enacted by Laws 1965, ch. 234, § 1; 1993, ch. 321, § 1.

27-5-2. Purpose of Indigent Hospital and County Health Care Act.

The purpose of the Indigent Hospital and County Health Care Act is:

A. to recognize that each individual county of this state is the responsible agency for ambulance transportation, hospital care or the provision of health care to indigent patients domiciled in that county, as determined by resolution of the board of county commissioners, in addition to providing support for the state's medicaid program;

B. to recognize that the counties of the state are responsible for supporting indigent patients by providing local revenues to match federal funds for the state medicaid program pursuant to Section 7-20E-9 NMSA 1978 and the transfer of funds to the county-supported medicaid fund pursuant to the Statewide Health Care Act [Chapter 27, Article 10 NMSA 1978]; and

C. to recognize that the counties of the state can improve the provision of health care to indigent patients by providing local revenues for countywide or multicounty health planning.

History: 1953 Comp., § 13-2-13, enacted by Laws 1965, ch. 234, § 2; 1971, ch. 72, § 1; 1983, ch. 234, § 1; 1987, ch. 88, § 1; 1993, ch. 321, § 2; 1997, ch. 51, § 1; 2014, ch. 79, § 4.

27-5-3. Public assistance provisions.

A. A hospital shall not be paid from the fund under the Indigent Hospital and County Health Care Act for costs of an indigent patient for services that have been determined by the department to be eligible for medicaid reimbursement.

B. No action for collection of claims under the Indigent Hospital and County Health Care Act shall be allowed against an indigent patient who is medicaid eligible for medicaid covered services, nor shall action be allowed against the person who is legally responsible for the care of the indigent patient during the time that person is medicaid eligible.

History: 1953 Comp., § 13-2-14, enacted by Laws 1965, ch. 234, § 3; 1984, ch. 101, § 1; 1993, ch. 321, § 3; 2003, ch. 413, § 1; 2014, ch. 79, § 5.

27-5-4. Definitions.

As used in the Indigent Hospital and County Health Care Act:

A. "ambulance provider" or "ambulance service" means a specialized carrier based within the state authorized under provisions and subject to limitations as provided in individual carrier certificates issued by the department of transportation to transport persons alive, dead or dying en route by means of ambulance service. The rates and charges established by department of transportation tariff shall govern as to allowable cost. Also included are air ambulance services approved by the county. The air ambulance service charges shall be filed and approved pursuant to Subsection D of Section 27-5-6 NMSA 1978 and Section 27-5-11 NMSA 1978;

B. "cost" means all allowable costs of providing health care services, to the extent determined by resolution of a county, for an indigent patient. Allowable costs shall be based on medicaid fee-for-service reimbursement rates for hospitals, licensed medical doctors and osteopathic physicians;

C. "county" means a county except a class A county with a county hospital operated and maintained pursuant to a lease or operating agreement with a state educational institution named in Article 12, Section 11 of the constitution of New Mexico;

D. "department" or "authority" means the health care authority;

E. "fund" means a county health care assistance fund;

F. "health care services" means treatment and services designed to promote improved health in the county indigent population, including primary care, prenatal care, dental care, behavioral health care, alcohol or drug detoxification and rehabilitation, hospital care, provision of prescription drugs, preventive care or health outreach services, to the extent determined by resolution of the county;

G. "indigent patient" means a person to whom an ambulance service, a hospital or a health care provider has provided medical care, ambulance transportation or health care services and who can normally support the person's self and the person's dependents on present income and liquid assets available to the person but, taking into consideration the person's income, assets and requirements for other necessities of life for the person and the person's dependents, is unable to pay the cost of the ambulance transportation or medical care administered or both; provided that if a definition of "indigent patient" is adopted by a county in a resolution, the definition shall not include any person whose annual income together with that person's spouse's annual income totals an amount that is fifty percent greater than the per capita personal income for New Mexico as shown for the most recent year available in the survey of current business published by the United States department of commerce. "Indigent patient" includes a minor who has received ambulance transportation or medical care or both and whose parent or the person having custody of that minor would qualify as an indigent patient if transported by ambulance, admitted to a hospital for care or treated by a health care provider;

H. "medicaid eligible" means a person who is eligible for medical assistance from the department;

I. "planning" means the development of a countywide or multicounty health plan to improve and fund health services in the county based on the county's needs assessment and inventory of existing services and resources and that demonstrates coordination between the county and state and local health planning efforts;

J. "public entity" means a state, local or tribal government or other political subdivision or agency of that government; and

K. "qualifying hospital" means an acute care general hospital licensed by the authority that is qualified to receive payments from the safety net care pool pursuant to an agreement with the federal centers for medicare and medicaid services.

History: 1953 Comp., § 13-2-15, enacted by Laws 1965, ch. 234, § 4; 1975, ch. 44, § 1; 1977, ch. 253, § 43; 1978, ch. 123, § 1; 1979, ch. 146, § 1; 1983, ch. 234, § 2; 1987, ch. 50, § 1; 1987, ch. 88, § 2; 1990, ch. 37, § 1; 1991, ch. 171, § 1; 1991, ch. 212, § 19; 1993, ch. 321, § 4; 1997, ch. 51, § 2; 1999, ch. 37, § 1; 1999, ch. 270, § 4; 2001, ch. 30, § 1; 2001, ch. 272, § 1; 2001, ch. 280, § 1; 2003, ch. 413, § 2; 2004, ch. 94, § 1; 2012, ch. 18, § 1; 2014, ch. 79, § 6; 2023, ch. 100, § 15; 2024, ch. 39, § 99.

27-5-4.1. Repealed.

History: 1953 Comp., § 13-2-15.1, enacted by Laws 1978, ch. 123, § 2; repealed by Laws 2012, ch. 18, § 4.

27-5-5. Repealed.

History: 1953 Comp., § 13-2-16, enacted by Laws 1965, ch. 234, § 5; 1993, ch. 321, § 5; repealed by Laws 2014, ch. 79, § 22.

27-5-5.1. Indigent health care report; required.

Every county in New Mexico shall file an annual report on all indigent health care funding by the county with the commission. The report shall contain the county's eligibility criteria for indigent patients, services provided to indigent patients, restrictions on services provided to indigent patients, conditions for reimbursement to providers of health care, revenue sources used to pay for indigent health care and other related information as determined by the commission. The report shall be submitted by October 1 of each year on a form provided by the commission. The commission shall make the report available to interested parties.

History: Laws 1993, ch. 321, § 17; 1999, ch. 37, § 2.

27-5-5.2. Nondiscrimination; indigent patients.

Qualifying hospitals and hospitals with which a county contracts to provide for the services of indigent patients shall provide those services for indigent patients, including financial assistance, to all non-citizens, regardless of immigration status, if they meet all other qualifying criteria for such services.

History: Laws 2021, ch. 127, § 4.

27-5-6. Powers and duties of counties relating to indigent care.

A county:

A. may budget for expenditure on ambulance services, burial expenses, hospital or medical expenses for indigent residents of that county and for costs of development of a countywide or multicounty health plan. The combined costs of administration and planning shall not exceed the following percentages of revenues based on the previous fiscal year revenues for a fund that has existed for at least one fiscal year or based on projected revenues for the year being budgeted for a fund that has existed for less than one fiscal year. The percentage of the revenues in the fund that may be used for such combined administrative and planning costs is equal to the sum of the following:

(1) ten percent of the amount of the revenues in the fund not over five hundred thousand dollars ($500,000);

(2) eight percent of the amount of the revenues in the fund over five hundred thousand dollars ($500,000) but not over one million dollars ($1,000,000); and

(3) four and one-half percent of the amount of the revenues in the fund over one million dollars ($1,000,000);

B. may accept contributions of public funds for county health care services, which shall be deposited in the fund;

C. may hire personnel to carry out the provisions of the Indigent Hospital and County Health Care Act;

D. shall transfer to the state by the last day of March, June, September and December of each year an amount equal to one-fourth of the county's payment pursuant to Section 27-5-6.2 NMSA 1978. This money shall be deposited in the safety net care pool fund;

E. shall, in carrying out the provisions of the Indigent Hospital and County Health Care Act, comply with the standards of the federal Health Insurance Portability and Accountability Act of 1996;

F. may provide for the transfer of money from the fund to the county-supported medicaid fund to meet the requirements of the Statewide Health Care Act [Chapter 27, Article 10 NMSA 1978]; and

G. may contract with ambulance providers, hospitals or health care providers for the provision of services for indigent patients domiciled within the county; such services shall be provided to all non-citizens, regardless of immigration status, if they meet all other qualifying criteria for such services.

History: 1953 Comp., § 13-2-17, enacted by Laws 1965, ch. 234, § 6; 1979, ch. 146, § 2; 1983, ch. 234, § 3; 1987, ch. 88, § 3; 1991, ch. 212, § 20; 1993, ch. 321, § 6; 1997, ch. 51, § 3; 1999, ch. 37, § 3; 2003, ch. 413, § 3; 2014, ch. 79, § 7; 2021, ch. 127, § 3.

27-5-6.1. Safety net care pool fund created.

A. The "safety net care pool fund" is created as a nonreverting fund in the state treasury. The safety net care pool fund, which shall be administered by the authority, shall consist of public money provided through intergovernmental transfers from counties or other public entities and transferred from counties pursuant to Section 27-5-6.2 NMSA 1978. Money in the fund shall be invested by the state treasurer as other state funds are invested.

B. Money in the safety net care pool fund is appropriated to the authority to make payments to qualifying hospitals. No safety net care pool fund payments or money in the safety net care pool fund shall be used to supplant any general fund support for the state medicaid program.

History: Laws 1993, ch. 321, § 18; 2012, ch. 18, § 2; 2014, ch. 79, § 8; 2024, ch. 39, § 100.

27-5-6.2. Transfer to safety net care pool fund.

A. A county shall, by ordinance to be effective July 1, 2014, dedicate to the safety net care pool fund an amount equal to a gross receipts tax rate of one-twelfth percent applied to the taxable gross receipts reported during the prior fiscal year by persons engaging in business in the county. For purposes of this subsection, a county may use public funds from any existing authorized revenue source of the county.

B. A county enacting an ordinance pursuant to Subsection A of this section shall transfer to the safety net care pool fund by the last day of March, June, September and December of each year an amount equal to one-fourth of the county's payment to the safety net care pool fund.

History: Laws 2014, ch. 79, § 16.

27-5-7. Health care assistance fund.

A. There is created in the county treasury of each county a "health care assistance fund".

B. Collections under the levy made pursuant to the Indigent Hospital and County Health Care Act and all payments shall be placed into the fund, and the amount placed in the fund shall be budgeted and expended only for the purposes specified in the Indigent Hospital and County Health Care Act, by warrant upon vouchers approved by the county. Payments for indigent hospitalizations shall not be made from any other county fund.

C. The fund shall be audited in the manner that other state and county funds are audited, and all records of payments and verified statements of qualification upon which payments were made from the fund shall be open to the public.

D. Any balance remaining in the fund at the end of the fiscal year shall carry over into the ensuing year, and that balance shall be taken into consideration in the determination of the ensuing year's budget and certification of need for purposes of making a tax levy.

E. Money may be transferred to the fund from other sources, but no transfers may be made from the fund for any purpose other than those specified in the Indigent Hospital and County Health Care Act.

History: 1953 Comp., § 13-2-18, enacted by Laws 1965, ch. 234, § 7; 1991, ch. 212, § 21; 1992, ch. 31, § 1; 1993, ch. 321, § 7; 1996, ch. 29, § 4; 1998, ch. 71, § 1; 1999, ch. 188, § 1; 2014, ch. 79, § 9.

27-5-7.1. County health care assistance fund; authorized uses of the fund.

A. The fund may be used to pay for:

(1) expenses of burial or cremation of an indigent person;

(2) ambulance transportation, hospital care and health care services for indigent patients; or

(5) [(3)] county administrative expenses associated with fund expenditures authorized in Paragraphs of this subsection.

B. The fund may be used to meet a county's obligation under Section 27-10-4 NMSA 1978.

History: Laws 1993, ch. 321, § 16; 2001, ch. 307, § 2; 2014, ch. 79, § 10.

27-5-8. Repealed.

History: 1953 Comp., § 13-2-19, enacted by Laws 1965, ch. 234, § 8; 1993, ch. 321, § 8; repealed by Laws 2014, ch. 79, § 22.

27-5-9. Tax levies authorized.

A. Subject to the provisions of Subsection B of this section, the board of county commissioners, upon the certification of the county as to the amount needed to provide health care to indigent residents of the county or to support the state's medicaid program, shall impose a levy against the net taxable value, as that term is defined in the Property Tax Code [Articles 35 to 38 of Chapter 7 NMSA 1978], of the property in the county sufficient to raise the amount certified by the county.

B. The question of imposing an indigent and medicaid health care levy for the purpose of the Indigent Hospital and County Health Care Act shall be submitted to the electors and voted upon as a separate question at the next subsequent general election or any special election called prior thereto for such purpose.

C. Upon finding by the board of county commissioners that an election will be necessary, the board of county commissioners shall meet and order an election to be held at a designated time in the county upon the question of imposing an indigent and medicaid health care levy for the purpose of the Indigent Hospital and County Health Care Act in the county. If the question is to be voted upon at a special election, the election shall be held not less than thirty nor more than fifty days after the finding, but in no event shall the election be held within fifty days preceding or succeeding any general election held in the county. The order for the election shall be made a part of the official minutes of the board of county commissioners. A copy of the order shall be published in a newspaper of general circulation in the county at least fifteen days before the date set for the election, and an affidavit of publication shall be obtained. At least five days prior to the date for holding the election, the board of county commissioners shall publish in a newspaper of general circulation in the county and post in five conspicuous places in the county a notice of election, which shall be in substantially the following form:

"NOTICE OF ELECTION ON SPECIAL INDIGENT

AND MEDICAID HEALTH CARE LEVY

Notice is given on the _____ day of _____, 20_____, there will be held in _____ county of New Mexico an election on the question of imposing an indigent and medicaid health care levy to provide health care to indigent residents of the county or to support the state's medicaid program, such levy to be made annually against the taxable value of the property in the county and limited to an amount sufficient to provide funds necessary to support the state's medicaid program or to provide health care to indigent residents of the county who do not qualify for medicaid.

_____
Official Title of the Authority".

The election shall be held on the date specified in the notice and shall be, if a special election, conducted and canvassed in substantially the same manner as general elections are conducted and canvassed in the county; provided that the ballot used in any election shall be a special and separate ballot and shall be in substantially the following form:

"BALLOT

On the question of imposing an indigent and medicaid health care levy for the purposes of the Indigent Hospital and County Health Care Act, such levy to be made annually against the taxable value of the property in _____ county of New Mexico, and limited to an amount sufficient to provide funds budgeted and certified as necessary for health care for indigent residents of the county in addition to those services provided by the state or to support the state's medicaid program:

FOR THE LEVY....._____

AGAINST THE LEVY....._____".

D. If the electors vote in favor of an indigent and medicaid health care levy, the levy shall become effective in the same manner prescribed by law for all levies upon property within that county, and a levy for those purposes in such an amount as will provide sufficient money for the fund shall be made for each year thereafter.

E. Any board of county commissioners that has, prior to the effective date of this section, made a valid imposition of a property tax for the purpose of the Indigent Hospital and County Health Care Act shall not be required to hold an election on the existing tax, and that tax may be imposed and continue to be imposed in accordance with the provisions of law existing at the time of its imposition. However, if any such tax is not imposed in a given property tax year or if the authorization for its imposition

terminates or expires, the election requirements of Subsections B and C of this section shall apply to any subsequent proposed imposition of a property tax for indigent health care for county residents or to support the state's medicaid program.

History: 1953 Comp., § 13-2-20, enacted by Laws 1965, ch. 234, § 9; 1981, ch. 37, § 85; 1993, ch. 321, § 9; 2014, ch. 79, § 11; 2015, ch. 145, § 99.

27-5-10. Repealed.

History: 1953 Comp., § 13-2-22, enacted by Laws 1965, ch. 234, § 11; repealed by Laws 2014, ch. 79, § 22.

27-5-11. Qualifying hospital duties and reporting.

A. A qualifying hospital shall accept every indigent patient who seeks health care services from the qualifying hospital.

B. Qualifying hospitals shall:

have written financial assistance policies that are publicized.

D. [C.] Within thirty days of receiving a payment from the safety net care pool, a qualifying hospital shall report the amount of such payment to the county within which it is located.

E. [D.] In addition to the report required in Subsection D of this section, a qualifying hospital shall annually report to the county within which it is located the total costs of health care services provided in the previous calendar year.

History: 1953 Comp., § 13-2-23, enacted by Laws 1965, ch. 234, § 12; 1983, ch. 234, § 4; 1993, ch. 321, § 10; 2003, ch. 413, § 4; 2014, ch. 79, § 12.

27-5-12. Payment of claims.

A. A hospital, ambulance service or health care provider filing a claim with the county shall:

(1) file the claim with the county in which the indigent patient is domiciled;

(2) file the claim for each patient separately, with an itemized detail of the total cost; and

(3) file with the claim a verified statement of qualification for ambulance service, indigent hospital care or care from a health care provider signed by the patient or by the parent or person having custody of the patient to the effect that the patient qualifies under the provisions of the Indigent Hospital and County Health Care Act as an

indigent patient and is unable to pay the cost for the care administered and listing all assets owned by the patient or any person legally responsible for the patient's care. The statement shall constitute an oath of the person signing it, and any false statements in the statement made knowingly constitute a felony.

B. A hospital, ambulance service or health care provider that has contracted with a county for provision of health care services shall provide evidence of health care services rendered for payment for services in accordance with the procedures specified in the contract.

History: 1953 Comp., § 13-2-24, enacted by Laws 1965, ch. 234, § 13; 1983, ch. 234, § 5; 1984, ch. 101, § 2; 1993, ch. 321, § 11; 1997, ch. 51, § 4; 2014, ch. 79, §13.

27-5-12.1. Appeal.

Any hospital or ambulance service aggrieved by any decision of the county may appeal to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: 1978 Comp., § 27-5-12.1, enacted by Laws 1979, ch. 146, § 3; 1983, ch. 234, § 6; 1998, ch. 55, § 38; 1999, ch. 265, § 40; 2014, ch. 79, § 14.

27-5-12.2. Repealed.

History: Laws 1993, ch. 321, § 15; 2003, ch. 413, § 5; 2012, ch. 18, § 3; repealed by Laws 2014, ch. 79, § 22.

27-5-13. Repealed.

History: 1953 Comp., § 13-2-25, enacted by Laws 1965, ch. 234, § 14; 1978, ch. 123, § 3; 1983, ch. 234, § 7; repealed by Laws 2014, ch. 79, § 22.

27-5-14. Repealed.

History: 1953 Comp., § 13-2-26, enacted by Laws 1965, ch. 234, § 15; 1975, ch. 178, § 1; 1987, ch. 88, § 4; 1993, ch. 321, § 12; repealed by Laws 2014, ch. 79, § 22.

27-5-15. Repealed.

History: 1953 Comp., § 13-2-26.1, enacted by Laws 1971, ch. 72, § 2; 1975, ch. 178, § 2; repealed by Laws 2014, ch. 79, § 22.

27-5-16. Authority; payments; cooperation; reporting.

A. The authority shall not decrease the amount of any assistance payments made to the hospitals or health care providers of this state pursuant to law because of any

financial reimbursement made to ambulance services, hospitals or health care providers for indigent or medicaid eligible patients as provided in the Indigent Hospital and County Health Care Act.

B. The authority shall cooperate with each county in furnishing information or assisting in the investigation of any person to determine whether the person meets the qualifications of an indigent patient as defined in the Indigent Hospital and County Health Care Act.

C. The authority shall provide an annual report to each county and each qualifying hospital on the previous calendar year's payments from the safety net care pool for uncompensated care to qualifying hospitals and estimated payments of enhanced medicaid base rates. The annual report for the previous year shall be provided by July 1 of the succeeding year.

History: 1953 Comp., § 13-2-27, enacted by Laws 1965, ch. 234, § 16; 1987, ch. 88, § 5; 1993, ch. 321, § 13; 2013, ch. 151, § 1; 2014, ch. 79, § 15; 2024, ch. 39, § 101.

27-5-17. Repealed.

27-5-18. Repealed.

History: 1953 Comp., § 13-2-29, enacted by Laws 1965, ch. 234, § 20; 1993, ch. 321, § 14; repealed by Laws 2014, ch. 79, § 22.

ARTICLE 6
Utility Supplements and Assistance

27-6-1 to 27-6-10. Deleted.

27-6-11. Short title.

Chapter 27, Article 6 NMSA 1978 may be cited as the "Low Income Utility Assistance Act".

History: Laws 1979, ch. 290, § 1; 2009, ch. 232, § 1.

27-6-12. Legislative intent and purpose.

It is the intent of the legislature and the purpose of the Low Income Utility Assistance Act to assist indigent residents to meet the increased costs for gas and electrical utilities, liquefied petroleum fuel, wood and coal to the maximum extent possible, particularly the cost of fuel adjustments and the cost of service indexing.

History: Laws 1979, ch. 290, § 2; 1980, ch. 118, § 1.

27-6-13. Administration of Low Income Utility Assistance Act.

A. As used in the Low Income Utility Assistance Act:

(1) "authority" or "department" means the health care authority; and

(2) "utility" means a publicly, privately or municipally owned utility or a distribution cooperative utility for the rendition of electric power or gas.

B. The authority shall determine eligibility, establish payment amounts, make utility assistance payments to or on behalf of eligible recipients and otherwise administer the Low Income Utility Assistance Act.

C. The authority shall use funds appropriated under the Low Income Utility Assistance Act to the maximum extent to generate available federal and local government funds and to mobilize other resources that may be applied to the concepts of the Low Income Utility Assistance Act.

History: Laws 1979, ch. 290, § 3; 1980, ch. 118, § 2; 2009, ch. 232, § 2; 2024, ch. 39, § 102.

27-6-14. Persons eligible for utility assistance.

A. Utility assistance supplements shall be paid to or on behalf of those persons who are determined to be eligible by rule of the authority.

B. The authority shall determine the amount of payment to be made; provided that no payment shall be made if a payment for the same services or incurred bills has been made to the household under a federal program for a similar purpose.

History: Laws 1979, ch. 290, § 4; 1980, ch. 118, § 3; 1984, ch. 94, § 1; 2024, ch. 39, § 103.

27-6-15. Utility assistance supplement program established; distribution to eligible recipients.

A. The authority is authorized to establish a utility assistance supplement program for purposes of the Low Income Utility Assistance Act.

B. Beginning on July 1, 1980 and each year thereafter, the authority shall pay utility assistance supplement payments, subject to the availability of funds from the low income utility assistance fund created under the provisions of Section 27-6-16 NMSA 1978.

History: Laws 1979, ch. 290, § 5; 1980, ch. 118, § 4; 2024, ch. 39, § 104.

27-6-16. Fund created.

The "low income utility assistance fund" is created in the state treasury. Payments shall be made from the low income utility assistance fund upon warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of health care authority. Such payments shall be made for the costs and administration of the Low Income Utility Assistance Act.

History: Laws 1979, ch. 290, § 6; 1980, ch. 118, § 5; 2024, ch. 39, § 105.

27-6-17. Utility service; procedures to follow prior to service being discontinued.

A. Unless requested by the customer, no gas or electric utility shall discontinue service to any residential customer for nonpayment during the period from November 15 through March 15 unless the following procedures are followed:

(1) at least fifteen days prior to the date scheduled for utility service to be discontinued, unless the public regulation commission provides for a shorter period, the utility shall mail or hand-deliver to the customer a notice printed in both English and Spanish and in simple language, which notice clearly explains that:

(a) utility service shall stop on a specific date;

(b) the customer may be eligible for financial assistance to pay for the utility service; and

(c) for assistance, the customer should contact the utility or the authority;

(2) any utility subject to this section shall attempt to advise customers who contact the utility seeking financial assistance of the program administered under the Low Income Utility Assistance Act and of assistance programs the utility may administer on its own or in conjunction with others;

(3) the utilities subject to this section and the authority shall provide application forms for utility service payment assistance at billing and agency offices; and

(4) before the service is actually discontinued, the utility shall attempt to make contact in person or by telephone to remind the customer of the pending date of discontinuance of service and that financial assistance for utility payments may be available.

B. Unless requested by the customer, no gas or electric utility shall discontinue service to any residential customer for nonpayment during the period from November 15

through March 15 until at least fifteen days after the date scheduled for discontinuance of service if the authority has certified to the utility that a customer is eligible for utility payment assistance under the Low Income Utility Assistance Act and that payment for the utility service provided to the customer will be made within the fifteen-day period.

C. The authority and the public regulation commission shall coordinate and adopt, as they deem appropriate, either separate or joint rules necessary to implement the provisions of this section; provided that nothing in this section authorizes the authority to revise tariffs or rate filings subject to the jurisdiction of the public regulation commission.

History: Laws 1991, ch. 81, § 1; 1993, ch. 282, § 17; 2024, ch. 39, § 106.

27-6-18. Repealed.

History: Laws 2005 (1st S.S.) ch. 2, § 2; repealed by Laws 2007, ch. 231, § 2.

27-6-18.1. Prohibition on discontinuance or disconnection of utility service during the winter heating season; minimum payments; payment plans; exceptions.

A. Except as provided in Subsection C of this section, unless requested by the customer, no utility shall discontinue or disconnect service to a residential customer during the heating season for nonpayment of the customer's utility bill if the customer meets the qualifications to receive assistance pursuant to the low-income home energy assistance program from the administering authority during the program's current heating season.

B. The utility shall make payment plan options available to the customer pursuant to rules adopted by the public regulation commission.

C. If the customer does not pay the past due charges from the customer's utility bill before the beginning of the next heating season, the customer shall not be eligible for protection from discontinued or disconnected utility service pursuant to this section during that next heating season until the past due charges are paid in full.

D. A customer who has defaulted on the customer's chosen payment plan and whose utility service has been discontinued or disconnected during the nonheating season can be reconnected and maintain the protection afforded by this section by paying reconnection charges, if any, and by paying the amount due pursuant to the payment plan by the date on which service is reconnected.

E. If a customer notifies the utility that the customer needs payment assistance and if the customer requests, the utility shall promptly report the customer's request for assistance to the administering authority. The administering authority shall take prompt

action to evaluate the customer's eligibility for the low-income home energy assistance program.

F. Utilities subject to this section shall make the following information available to the public regarding:

(1) the low-income home energy assistance program's:

(a) application forms;

(b) requirements for qualifying for the program;

(c) procedures for making an application; and

(d) location to which an application may be submitted; and

(2) the protection against discontinued and disconnected service set forth in this section for customers seeking assistance paying utility bills during a heating season, including:

(a) payment options; and

(b) circumstances under which disconnection or discontinuance of service may occur.

G. As used in this section:

(1) "administering authority" means the health care authority or a tribal entity that administers its own low-income home energy assistance program;

(2) "current season" means the period beginning in September and continuing through August of the subsequent year;

(3) "heating season" means the period beginning November 15 and continuing through March 15 of the subsequent year;

(4) "nonheating season" means the period beginning on March 16 and continuing through November 14 of the same year; and

(5) "tribal entity" means the governing body or an agency of a federally recognized Indian nation, tribe or pueblo located in whole or in part in New Mexico.

History: Laws 2007, ch. 231, § 1; 2024, ch. 39, § 107.

ARTICLE 6A
Low Income Water, Sewer and Solid Waste Service Assistance

27-6A-1. Short title.

Chapter 27, Article 6A NMSA 1978 may be cited as the "Low Income Water, Sewer and Solid Waste Service Assistance Act".

History: Laws 1993, ch. 206, § 1; 2024, ch. 39, § 108.

27-6A-2. Purpose.

It is the purpose of the Low Income Water, Sewer and Solid Waste Service Assistance Act:

A. to assure that water, sewer or solid waste user rate increases do not force many low-income individuals to discontinue necessary water, sewer or solid waste service; and

B. to increase the availability or affordability of basic water, sewer and solid waste service to low-income individuals by providing assistance to meet the cost of basic water, sewer and solid waste service.

History: Laws 1993, ch. 206, § 2.

27-6A-3. Definitions.

As used in the Low Income Water, Sewer and Solid Waste Service Assistance Act:

A. "authority" or "department" means the health care authority; and

B. "utility" means any individual, firm, partnership, company, district, including solid waste district, water and sanitation district and special district, cooperative, association, public or private corporation, lessee, trustee or receiver appointed by any court, municipality and municipal utility as defined in the Municipal Code [3-1-1 NMSA 1978], incorporated county or county that may or does own, operate, lease or control any plant, property or facility for:

(1) the supply, storage, distribution or furnishing of water to or for the public;

(2) the supply and furnishing of sanitary sewer service to or for the public; or

(3) the supply and furnishing of collection, transportation, treatment or disposal of solid waste to or for the public. "Utility" does not include a public utility subject to the jurisdiction of the public regulation commission.

History: Laws 1993, ch. 206, § 3; 2024, ch. 39, § 109.

27-6A-4. Low income assistance rates.

A utility may provide assistance in the form of reduced or subsidized rates to or on behalf of those individuals who meet the eligibility criteria of one or more need-based assistance programs administered by the department and who are not living in nursing homes or intermediate care facilities or not living in circumstances that do not require them to pay, directly or indirectly, for water, sewer or solid waste service.

History: Laws 1993, ch. 206, § 4.

27-6A-5. Authority cooperation.

Subject to state and federal statutes and rules governing the sharing of confidential information, the authority shall cooperate with a participating utility in identifying those persons eligible for assistance in accordance with the Low Income Water, Sewer and Solid Waste Service Assistance Act.

History: Laws 1993, ch. 206, § 5; 2024, ch. 39, § 110.

ARTICLE 7
Adult Protective Services

27-7-1 to 27-7-13. Repealed.

27-7-14. Short title.

Sections 27-7-14 through 27-7-31 NMSA 1978 may be cited as the "Adult Protective Services Act".

History: Laws 1989, ch. 389, § 1; 1990, ch. 79, § 1.

27-7-15. Legislative findings; purpose.

A. The legislature recognizes that many adults in the state are unable to manage their own affairs or protect themselves from abuse, neglect or exploitation. The legislature further recognizes that the state should protect adults by providing for the detection, correction and elimination of abuse, neglect or exploitation through a program of short-term services for adults in need of protective services or protective placement.

B. It is the purpose of the Adult Protective Services Act to establish a system of protective services and protective placement and to ensure the availability of those services or placement to all adults in need of them. It is also the purpose of the Adult Protective Services Act to authorize only the least possible restriction on the exercise of personal and civil rights and religious beliefs consistent with the adult's need for protective services or protective placement and to require that due process be followed in imposing those restrictions.

C. Nothing in the Adult Protective Services Act shall be construed to mean an adult, including an incapacitated adult or a protected adult, is abused, neglected, or exploited if the adult relies upon or is being furnished with spiritual treatment through prayer alone in accordance with the express or implied intent of the adult; nor shall anything in that act be construed to authorize or require any medical care or treatment in contravention of the express or implied wish of that adult.

History: Laws 1989, ch. 389, § 2; 1997, ch. 132, § 1; 2007, ch. 91, § 1.

27-7-16. Definitions.

As used in the Adult Protective Services Act:

A. "ability to consent" means an adult's ability to understand and appreciate the nature and consequences of proposed protective services or protective placement, including benefits, risks and alternatives to the proposed services or placement and to make or communicate an informed decision;

B. "abuse" means:

(1) knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish;

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of an adult; or

(3) sexual abuse, including criminal sexual contact, incest and criminal sexual penetration;

C. "adult" means a person eighteen years of age or older;

D. "caretaker" means a facility, provider or individual that has assumed the responsibility for the care of an adult;

E. "conservator" means a person who is appointed by a court to manage the property or financial affairs, or both, of an incapacitated adult;

F. "court" means the district court having jurisdiction;

G. "department" means the aging and long-term services department;

H. "emergency" means that an adult is living in conditions that present a substantial risk of death or immediate and serious physical harm to the adult or others;

I. "exploitation" means an unjust or improper use of an adult's money or property for another person's profit or advantage, pecuniary or otherwise;

J. "facility" means a hospital, nursing home, residential care facility, group home, foster care home, assisted living facility or other facility licensed by the state, but does not include a jail, prison or detention facility;

K. "guardian" means a person who has qualified to provide for the care, custody or control of an incapacitated adult pursuant to testamentary or court appointment, but excludes one who is a guardian ad litem;

L. "incapacitated adult" means any adult with a mental, physical or developmental condition that substantially impairs the adult's ability to provide adequately for the adult's own care or protection;

M. "multidisciplinary team" means a team composed of diverse professionals who meet periodically to consult on or enhance appropriate community responses to abuse, neglect or exploitation of adults;

N. "neglect" means the failure of the caretaker of an adult to provide for the basic needs of the adult, such as clothing, food, shelter, supervision and care for the physical and mental health of that adult; "neglect" includes self-neglect;

O. "protected adult" means an adult for whom a guardian or conservator has been appointed or other protective order has been made or an abused, neglected or exploited adult who has consented to protective services or protective placement;

P. "protective placement" means the placement of an adult with a provider or in a facility or the transfer of an adult from one provider or facility to another;

Q. "protective services" means the services furnished by the department or its delegate, as described in Section 27-7-21 NMSA 1978;

R. "provider" means a private-residence or health care worker or an unlicensed residential or nonresidential entity that provides personal, custodial or health care;

S. "self-neglect" means an act or omission by an incapacitated adult that results in the deprivation of essential services or supports necessary to maintain the incapacitated adult's minimal mental, emotional or physical health and safety;

T. "substantiated" means a determination, based on a preponderance of collected and assessed credible information, that abuse, neglect or exploitation of an incapacitated or protected adult has occurred; and

U. "surrogate" means a person legally authorized to act on an adult's behalf.

History: Laws 1989, ch. 389, § 3; 1990, ch. 79, § 2; 1997, ch. 132, § 2; 2007, ch. 91, § 2.

27-7-17. Adult protective services system.

A. Subject to the availability of funds, the department shall develop a coordinated system of protective services or protective placement for incapacitated or protected adults who have been abused, neglected or exploited. In planning this system, the department shall obtain the advice of agencies, corporations, boards and associations involved in the provision of social, health, legal, nutritional and other services to adults, as well as of organizations of adults.

B. The department shall ensure that the adult protective services system for incapacitated or protected adults who have been abused, neglected or exploited includes:

(1) a process for the collection and analysis of data relating to adult protective services or protective placement and for the provision of an annual findings and recommendations report to the governor and the appropriate interim committee;

(2) the establishment and use of multidisciplinary teams to develop treatment strategies, ensure maximum coordination with existing community resources and provide comprehensive assessment and case consultation on difficult or complex cases, provided that the adults' privacy and confidentiality rights in such cases are protected;

(3) coordination among the various state or local agencies that serve incapacitated or protected adults; and

(4) an emphasis on the need for prevention of abuse, neglect or exploitation of adults.

C. Upon establishment of the adult protective services system, the department shall be responsible for continuing coordination and supervision of the system. In carrying out these duties, the department shall:

(1) adopt rules necessary to implement and operate the system;

(2) monitor and evaluate the effectiveness of the system; and

(3) use to the extent available grants from federal, state and other public and private sources to support the system.

D. The department shall administer a public information program regarding the problem of abuse, neglect and exploitation of adults; reporting and prevention of adult abuse, neglect or exploitation; and the availability of treatment and protective services or protective placement for those adults.

History: Laws 1989, ch. 389, § 4; 1997, ch. 132, § 3; 2007, ch. 91, § 3.

27-7-18. Repealed.

History: Laws 1989, ch. 389, § 5; 1997, ch. 132, § 4; repealed Laws 2005, ch. 321, § 14.

27-7-19. Department; duties; penalty.

A. The department shall:

(1) develop, maintain and update as needed a process to receive a report or referral of suspected abuse, neglect or exploitation of an adult;

(2) assess an adult and the adult's situation to determine what immediate protective services or protective placement may be required;

(3) conduct an investigation to determine if the report or referral of abuse, neglect or exploitation is substantiated;

(4) document evidence, observations and other information obtained in the course of an investigation;

(5) develop a plan to provide an adult with or refer an adult for protective services, protective placement or other intervention services, unless the department determines that the adult is knowingly and voluntarily refusing services; and

(6) ensure that the protective services or protective placement provided by or through the department is short term and has a termination date; provided that appropriate arrangements have been made for follow-up care if needed, including any long-term services for which the adult may qualify.

B. Upon request, the department, in accordance with federal or state laws that protect an adult's right to privacy and confidentiality, shall have immediate access to and may reproduce any record, including medical, personal, psychological and financial records, of the adult that the department determines is necessary to pursue an investigation mandated by this section or by the Resident Abuse and Neglect Act [30-47-1 NMSA 1978] if:

(1) the adult has the ability to consent and has given written consent;

(2) the adult is unable to consent in writing, and gives oral consent in the presence of a third party as a witness;

(3) the adult has a guardian, conservator or surrogate with the authority to approve review of the records and the department obtains the permission of the guardian, conservator or surrogate for review of the record;

(4) the adult is unable to give consent and:

(a) has no guardian, conservator or surrogate;

(b) the department is unaware of and has no reasonable grounds for believing that there is a guardian, conservator or surrogate; or

(c) the department is unable to contact the guardian, conservator or surrogate within three working days of the initiation of the investigation; or

(5) the department obtains from the district court an order granting access upon a showing that:

(a) consent is being withheld due to coercion, extortion or justifiable fear of future abuse, neglect, exploitation or abandonment of the adult; or

(b) there is reasonable cause to believe that the adult has been or is being abused, neglected or exploited and that after notice by the department of the alleged abuse, neglect or exploitation, the guardian, conservator or surrogate has refused to give consent.

C. Upon request by the department, the provider or a facility in which an adult is or has been residing shall provide to the department the name, address and telephone number of the guardian, conservator, surrogate, attorney-in-fact, legal representative or next of kin of the adult.

D. The department shall have immediate access to an adult, whether in a facility or provider setting, who is alleged to be abused, neglected or exploited to determine the accuracy of the report and the necessity of protective services or protective placement, to evaluate the adult's needs and develop a service plan to meet those needs and to provide for the services or placement by or through the department. If the department is denied access to the adult alleged to be abused, neglected or exploited, the department may gain access upon petition to the court for an order requiring appropriate access if the department can demonstrate that a facility, provider or individual has interfered with the department's attempts to access the adult under investigation.

E. Anyone willfully interfering with an investigation of adult abuse, neglect or exploitation, pursuant to this section, is guilty of a misdemeanor. Interference under this section shall not include efforts by a facility, provider or individual to establish whether there is reasonable cause to believe that there is adult abuse, neglect or exploitation, provided that the department is notified as soon as reasonable cause is established, whether or not the internal investigation has been concluded.

F. The department may assess a civil penalty not to exceed ten thousand dollars ($10,000) per violation against a facility, provider or individual who violates the provisions of Subsection B, C or D of this section. The department may assess and collect the penalty, after notice and an opportunity for hearing before a hearing officer designated by the department to hear the matter, upon a determination that a facility, provider or individual willfully interfered with the department or discriminated, disciplined or retaliated against a person who communicated or disclosed information to the department in good faith pursuant to this section. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum. Additionally, if the violation is against a person covered by the Personnel Act [10-9-1 NMSA 1978], the department shall refer the matter to the agency employing the person for disciplinary action. Any party may appeal a final decision by the department to the court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1989, ch. 389, § 6; 1997, ch. 132, § 5; 2007, ch. 91, § 4.

27-7-20. Repealed.

History: Laws 1989, ch. 389, § 7; 1990, ch. 79, § 3; 1997, ch. 132, § 6; 2007, ch. 91, § 14.

27-7-21. Nature of protective services; costs.

A. Protective services are short-term services furnished by the department or under arrangement through the department to an incapacitated or protected adult who has been abused, neglected or exploited and with the adult's consent or appropriate legal authority.

B. The protective services furnished in a protective services system may include social, psychiatric, health, legal and other services provided on a short-term basis that, if appropriate, transition to other ongoing or long-term services outside the protective services system and that detect, correct or eliminate abuse, neglect or exploitation consistent with the Adult Protective Services Act. The adult protective services system established by the department may include outreach, public information and education, prevention programs, referral for health or legal services and other activities consistent with the Adult Protective Services Act.

C. The costs of providing protective services shall be borne by the department or other appropriate agency, unless the adult agrees to pay for them or a court authorizes

the provider or the department or other agency to receive reasonable reimbursement from the adult's assets after a finding that the adult is financially able to make payment. As appropriate and as permitted by law, the department may bill the adult or a third party to receive reasonable reimbursement for protective services rendered.

History: Laws 1989, ch. 389, § 8; 1990, ch. 79, § 4; 1997, ch. 132, § 7; 2007, ch. 91, § 5.

27-7-22. Repealed.

History: Laws 1989, ch. 389, § 9; 1990, ch. 79, § 5; 2007, ch. 91, § 14.

27-7-23. Voluntary protective services; protective placement; penalty.

A. Any adult who has been abused, neglected or exploited and is in need of protective services or protective placement as determined by the department and who consents to those services or placement shall receive them. If the adult withdraws or refuses consent, voluntary protective services or protective placement shall not be provided. No legal rights are relinquished as a result of acceptance of voluntary protective services or protective placement.

B. A person who interferes with the provision of protective services or protective placement to an adult who consents to receive those services or placement is guilty of a misdemeanor. In the event that interference occurs, the department may petition the court to enjoin that interference, may impose a civil penalty or, at the department's discretion, may request criminal prosecution.

C. The department may assess a civil penalty not to exceed ten thousand dollars ($10,000) per violation against a person that violates the provisions of Subsection B of this section. The department may assess and collect the penalty after notice and an opportunity for hearing, before a hearing officer designated by the department to hear the matter, upon a determination that a person willfully interfered with the department pursuant to this subsection. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum. Additionally, if the violation is against a person covered by the Personnel Act [10-9-1 NMSA 1978], the department shall refer the matter to the agency employing the person for disciplinary action. Any party may appeal a final decision by the department to the court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1989, ch. 389, § 10; 1997, ch. 132, § 8; 2007, ch. 91, § 6.

27-7-24. Involuntary protective services and protective placement; penalty.

A. If an adult lacks the ability to consent to receive protective services or protective placement, those services or placement may be ordered by a court on an involuntary basis through an emergency order pursuant to the Adult Protective Services Act or through appointment of a guardian or conservator.

B. In ordering involuntary protective services or protective placement, the court shall authorize only that intervention that it finds to be least restrictive of the adult's liberty and rights consistent with the adult's welfare and safety. The basis for such a finding shall be stated in the record by the court.

C. The incapacitated or protected adult shall not be required to pay for involuntary protective services or protective placement unless that payment is authorized by the court upon a showing that the adult is financially able to pay. In this event, the court shall provide for reimbursement of the reasonable costs of the services or placement.

D. A person who interferes with the provision of involuntary protective services or protective placement to an adult is guilty of a misdemeanor. In the event that interference occurs, the department may petition the court to enjoin interference, may impose a civil penalty or, at the department's discretion, may request criminal prosecution.

E. The Adult Protective Services Act does not affect other state statutes governing treatment of an adult admitted to a mental health care institution for mental illness or involuntary commitment of an adult to a mental health care institution for mental illness or any other involuntary mental health treatment.

F. The department may petition the court for the appointment of a guardian or conservator if the department determines that a no less restrictive course of care or treatment is available that is consistent with the incapacitated adult's welfare and safety.

G. The department and its employees are prohibited from:

(1) taking custody of an adult;

(2) acting as guardian, conservator or surrogate for any adult in need of protective services or protective placement, except that an employee may serve in that role when related by affinity or consanguinity to an adult;

(3) acting as treatment guardian under the Mental Health and Developmental Disabilities Code [43-1-2 NMSA 1978], except that an employee may serve in that role when related by affinity or consanguinity to an adult;

(4) acting as qualified health care professionals pursuant to the Uniform Probate Code [45-1-101 NMSA 1978]; and

(5) acting as visitors under the Uniform Probate Code for any adult in need of protective services or protective placement.

H. The department may assess a civil penalty not to exceed ten thousand dollars ($10,000) per violation against a person that violates the provisions of Subsection D of this section. The department may assess and collect the penalty after notice and an opportunity for hearing, before a hearing officer designated by the department to hear the matter, upon a determination that a person willfully interfered with the department pursuant to this section. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum. Additionally, if the violation is against a person covered by the Personnel Act [10-9-1 NMSA 1978], the department shall refer the matter to the agency employing the person for disciplinary action. Any party may appeal a final decision by the department to the court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1989, ch. 389, § 11; 1997, ch. 132, § 9; 2007, ch. 91, § 7.

27-7-25. Ex-parte orders for emergency protective services or emergency protective placement; notice; petition.

A. Upon petition by the department, the court may issue an order authorizing the provision of involuntary protective services or protective placement on an emergency basis to an adult under the criteria set forth in Subsection B of this section.

B. At the time a petition is filed or any time thereafter, the court may issue an ex-parte order authorizing the provision of involuntary protective services or involuntary protective placement upon a sworn written statement of facts showing probable cause exists to believe that:

(1) the adult is incapacitated;

(2) an emergency exists;

(3) the adult lacks the ability to consent to receive protective services or protective placement; and

(4) no person authorized by law or court order to give consent for the adult is available or willing to consent to the provision of protective services or protective placement on an emergency basis.

C. The petition for an emergency ex-parte order shall set forth:

(1) the name, address and interest of the petitioner;

(2) the name, age and address of the adult in need of protective services;

(3) the facts describing the nature of the emergency;

(4) the facts describing the nature of the adult's incapacity;

(5) the proposed protective services or protective placement;

(6) the petitioner's reasonable belief, together with supporting facts, about the need for emergency intervention; and

(7) the facts showing the petitioner's attempts to obtain the adult's consent to the proposed protective services or protective placement and the outcome of those attempts.

D. An affidavit for an ex-parte order for emergency protective services or emergency protective placement may be signed by any person who has knowledge of the facts alleged or is informed of them and believes that they are true.

E. The Rules of Evidence do not apply to the issuance of an emergency ex-parte protective services or protective placement order.

F. In issuing an emergency ex-parte order, the court shall adhere to the following limitations:

(1) only the protective services or protective placement necessary to remove the conditions creating the emergency shall be ordered, and the order shall specifically designate the proposed protective services or protective placement;

(2) protective services or protective placement authorized by an emergency ex-parte order shall not include hospitalization or a change of residence, unless the order gives specific approval for the action;

(3) protective services or protective placement may be provided by emergency ex-parte order only for ten days; provided that the original order may be renewed once for a period of twenty additional days upon application to the court showing that continuation of the original order is necessary to remove the conditions creating the emergency. An application for renewal of the original order shall be supported by a written report of the results of the evaluation required by Subsection C of Section 27-7-27 NMSA 1978 and copies of the actual evaluations;

(4) the issuance of an emergency ex-parte order shall not deprive the adult of any rights except those provided for in the order;

(5) to implement an emergency ex-parte order, the court may authorize forcible entry of premises for the purposes of rendering protective services or protective placement or transporting the adult to another location for the provision of services or placement only if facts contained in the affidavit supporting the petition for ex-parte

order show that attempts to gain voluntary access to the premises have failed and forcible entry is necessary; provided that persons making an authorized forcible entry shall be accompanied by a law enforcement officer; and

(6) service of an ex-parte order authorizing forcible entry shall be according to the following procedure. The order shall be served on the alleged incapacitated adult by a person authorized to serve arrest warrants and shall direct the officer to advise the adult of the nature of the protective services or protective placement that have been ordered by the court. If the order authorizes emergency protective placement, the order shall direct the officer to assist in transfer of the adult to a place designated by the court.

G. Notice of the filing of the petition and the issuance of the emergency ex-parte order, including a copy of the petition, the ex-parte order and the affidavit for ex-parte order, shall be given to the adult and the adult's spouse or, if none, the adult children or next of kin, surrogate or guardian, if any. The notice shall be given, in language reasonably understandable by its intended recipients, within twenty-four hours, excluding Saturdays, Sundays and legal holidays, from the time that the ex-parte order authorizing protective services or protective placement is issued by the court or, if the ex-parte order authorizes forcible entry, from the time the ex-parte order is served upon the incapacitated adult. The notice shall inform the recipients that a hearing will be held no later than ten days after the date the petition is filed to determine whether the conditions creating the emergency have been removed and whether the adult should be released from the court's order for protective services or protective placement.

H. Within ten days from the filing of a petition for an emergency order for protective services or protective placement, the court shall hold a hearing upon any application for renewal of the emergency order. The hearing upon an application for renewal shall be held pursuant to the provisions of Section 27-7-27 NMSA 1978.

I. The protected adult or any interested person may petition the court to have the emergency order set aside or modified at any time, notwithstanding any prior findings by the court that the adult is incapacitated.

J. If the adult continues to need protective services or protective placement after the renewal order provided in Paragraph (3) of Subsection F of this section has expired, the department or original petitioner shall immediately petition the court to appoint a conservator or guardian or to order nonemergency protective services or protective placement pursuant to Section 27-7-26 NMSA 1978.

K. The petitioner shall not be liable for filing the petition if the petitioner acted in good faith.

History: 1978 Comp., § 27-7-25, enacted by Laws 1990, ch. 79, § 6; 1997, ch. 132, § 10; 2007, ch. 91, § 8.

27-7-25.1. Emergency protective placement by a law enforcement officer without a court order.

A. When, from personal observation of a law enforcement officer, it appears probable that an incapacitated adult will suffer immediate and irreparable physical injury or death if not immediately placed in a facility, that the adult is unable to give consent and that it is not possible due to the emergency nature of the circumstances to follow the procedures of Section 27-7-25 NMSA 1978, the law enforcement officer making that observation may transport the adult to a facility. No court order is required to authorize the law enforcement officer to act upon the officer's observation pursuant to this section.

B. A law enforcement officer who transports an incapacitated adult to a facility pursuant to the provisions of this section shall immediately notify the department of the placement.

C. The department shall file a petition pursuant to Subsection A of Section 27-7-25 NMSA 1978 within two working days after the placement of the adult by the law enforcement officer has occurred unless the department determines that the criteria for emergency removal and placement have not been met or that there is no further need for involuntary protective services or protective placement.

D. Upon receipt of notice from a law enforcement officer that an adult has been placed in a facility pursuant to the authority of this section, the department shall give notice pursuant to Subsection G of Section 27-7-25 NMSA 1978 within two working days after the placement of the adult has taken place.

E. The court shall hold a hearing on the petition filed by the department as a result of the law enforcement officer's emergency placement within ten days of the filing of the petition, pursuant to the provisions of Section 27-7-27 NMSA 1978, to determine whether the conditions creating the need for the emergency placement have been removed and whether the adult should be released from the protective placement.

History: 1978 Comp., § 27-7-25.1, enacted by Laws 1990, ch. 79, § 7; 1997, ch. 132, § 11; 2007, ch. 91, § 9.

27-7-26. Nonemergency protective services or protective placement; findings; petition; order.

A. Involuntary nonemergency protective services or protective placement shall not take place unless ordered by a court after a finding on the record based on clear and convincing evidence that:

(1) the adult is incapacitated and lacks the ability to consent;

(2) the adult is incapable of providing for the adult's own care or custody and the adult is at significant risk of abuse, neglect or exploitation that creates a substantial risk of serious physical harm to the adult or others;

(3) the adult needs care or treatment;

(4) the proposed order is substantially supported by the evaluation provided for in Subsection E of this section or, if not so supported, there are compelling reasons for ordering those protective services or that protective placement; and

(5) no less restrictive alternative course of care or treatment is available that is consistent with the incapacitated adult's welfare and safety.

B. The petition for nonemergency protective services or protective placement shall state with particularity the factual basis for the allegations specified in Subsection A of this section and shall be based on the most reliable information available to the petitioner.

C. Written notice of a petition for nonemergency protective services or protective placement shall be served upon the adult by personal service at least fourteen days prior to the time set for a hearing. Notice shall also be given to the adult's legal counsel, caretaker, guardian, conservator, surrogate, spouse and adult children or next of kin, whose names and addresses are known to the petitioner or can with reasonable diligence be ascertained. The person serving the notice shall certify to the court that the petition has been delivered and how the required notice was given. The notice shall be in language reasonably understandable by the adult who is the subject of the petition and also shall be given orally if necessary. The notice shall include:

(1) the names of all petitioners;

(2) the factual basis of the belief that protective services or protective placement is needed;

(3) the rights of the adult in the court proceedings; and

(4) the name and address of the proposed protective services or protective placement.

D. Upon the filing of a petition for nonemergency protective services or protective placement, the court shall hold a hearing pursuant to the provisions of Section 27-7-27 NMSA 1978.

E. In order to make the findings required in Paragraphs (2) through (5) of Subsection A of this section, the court shall direct that a comprehensive evaluation of the adult alleged to be in need of protective services or protective placement be conducted as provided in Subsection C of Section 27-7-27 NMSA 1978.

F. In ordering nonemergency protective placement, the court shall give consideration to the choice of residence of the adult. The court may order protective placement in a facility or with a provider.

G. The court may authorize nonemergency protective services or protective placement for an adult for a period not to exceed six months.

H. At the time of expiration of an order for nonemergency protective services or protective placement, the original petitioner may petition the court to extend its order for protective services or protective placement for an additional period not to exceed six months. The contents of the petition shall conform to the provisions of Subsections A and B of this section. Notice of the petition for the extension of protective services or protective placement shall be made in conformity with Subsection C of this section. The court shall hold a hearing to determine whether to renew the order. Any person entitled to a notice under Subsection C of this section may appear at the hearing and challenge the petition. The court shall conduct the hearing pursuant to the provisions of Section 27-7-27 NMSA 1978.

I. The services provided to or the residence of an adult that had been established pursuant to an order for nonemergency protective services or protective placement shall not be changed unless the court authorizes the change of services or transfer of residence. The adult or the adult's legal representative may petition the court to order such a change of services or transfer of residence.

J. Prior to the expiration of the nonemergency protective services or protective placement, the department shall review the need for continued services or placement, including the necessity for appointment of a conservator or guardian, and shall make such recommendation to the court.

History: Laws 1989, ch. 389, § 13; 1990, ch. 79, § 8; 1997, ch. 132, § 12; 2007, ch. 91, § 10.

27-7-27. Hearing on petition.

A. The hearing on a petition for renewal of an emergency ex-parte order for protective services or protective placement or for an order for nonemergency protective services or protective placement shall be held under the following conditions:

(1) the adult shall be present unless the court determines it is impossible for the adult to be present or it is not in the adult's best interest because of a threat to that adult's health and safety;

(2) the adult has the right to counsel whether or not the adult is present at the hearing. If the adult is indigent, the court shall appoint counsel no later than the time of the filing of the petition;

(3) counsel appointed by the court pursuant to Paragraph (2) of this subsection shall interview the allegedly incapacitated adult prior to any hearing on the petition or any application for renewal of the original emergency order;

(4) the adult shall have the right to trial by jury upon request by the adult or the adult's counsel only in hearings held on petitions for nonemergency protective services or protective placement; and

(5) the adult has the right at the adult's own expense or, if indigent, at the expense of the state to secure an independent medical, psychological or psychiatric examination relevant to the issue involved in any hearing under this section and to present a report of this independent evaluation or the evaluator's personal testimony as evidence at the hearing.

B. The duty of counsel representing an adult for whom a petition for an order for emergency protective services or for nonemergency protective services or protective placement has been filed shall be to represent the adult by protecting the adult's legal rights and presenting the adult's declared position to the court.

C. The department shall establish an evaluation or assessment process for the conduct of a comprehensive physical, mental and social evaluation of an adult for whom a petition has been filed in a court for an order for nonemergency protective services or protective placement or for whom an application for renewal of an original emergency order has been made. The court shall consider the department's evaluation or assessment in determining whether to issue an order or renewal of an order for nonemergency protective services or protective placement.

D. The court shall issue for the record a statement of its findings in support of any order for renewal of emergency protective services or for nonemergency protective services or protective placement.

History: Laws 1989, ch. 389, § 14; 1990, ch. 79, § 9; 1997, ch. 132, § 13; 2007, ch. 91, § 11.

27-7-28. Legal proceedings; filing.

For all legal proceedings called for in the Adult Protective Services Act, attorneys for the department or the district attorney's office shall file all proceedings on behalf of the petitioner.

History: Laws 1989, ch. 389, § 15.

27-7-29. Confidentiality of records; penalty.

A. All records of the department, the department's designee, including a multidisciplinary team, the court and state and local agencies that are created or

maintained pursuant to investigations under the Adult Protective Services Act or for whom application has ever been made for protection shall be confidential and shall not be disclosed directly or indirectly to the public.

B. The records described in Subsection A of this section shall be open to inspection only by persons with a legitimate interest in the records as follows:

(1) the alleged abused, neglected or exploited adult, or the adult's surrogate, except as to the identity of the referral source and second source information, such as medical or psychological evaluations;

(2) court personnel;

(3) law enforcement officials;

(4) department personnel;

(5) any state government social services agency in any other state;

(6) health care or mental health professionals involved in the evaluation, treatment, residential care or protection of the adult;

(7) parties and their counsel in all legal proceedings pursuant to the Adult Protective Services Act or legal actions pursuant to the Uniform Probate Code [45-1-101 NMSA 1978];

(8) persons who have been, or will be in the immediate future, providing care or services to the adult, except the alleged perpetrator of the abuse, neglect or exploitation;

(9) persons appointed by the court pursuant to the Uniform Probate Code to be the adult's guardian ad litem, guardian, conservator, visitor or qualified health care professional;

(10) any of the persons whom the department petitions the court appoint pursuant to the Uniform Probate Code;

(11) any other person or entity, by order of the court, having a legitimate interest in the case or the work of the court; and

(12) protection and advocacy representatives pursuant to the federal Developmental Disabilities Assistance and Bill of Rights Act, Protection and Advocacy for Individuals with Mental Illness Act or the protection and advocacy of individual rights provisions of the Rehabilitation Act.

C. Records of cases involving substantiated abuse, neglect or exploitation shall be provided as appropriate to the department of health, the district attorney's office, the medicaid fraud control unit in New Mexico, the office of the attorney general and the office of the long-term care ombudsman for appropriate additional action.

D. Any person who intentionally, unlawfully releases any information or records closed to the public pursuant to this section or releases or makes other unlawful use of records in violation of this section is guilty of a misdemeanor.

E. The department may assess a civil penalty not to exceed ten thousand dollars ($10,000) per violation against any person that intentionally, unlawfully releases any information or records closed to the public pursuant to this section or releases or makes other unlawful use of records. The department may assess and collect the penalty, after notice and an opportunity for hearing before a hearing officer designated by the department to hear the matter, upon a determination that a person violated the provisions of this subsection. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum. Additionally, if the violation is against a person covered by the Personnel Act [10-9-1 NMSA 1978], the department shall refer the matter to the agency employing the person for disciplinary action. Any party may appeal a final decision by the department to the court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1989, ch. 389, § 16; 1997, ch. 132, § 14; 2007, ch. 91, § 12.

27-7-30. Duty to report; penalty.

A. Any person, including financial institutions, having reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited shall immediately report that information to the department.

B. The report required in Subsection A of this section may be made orally or in writing. The report shall include the name, age and address of the adult, the name and address of any other person responsible for the adult's care, the nature and extent of the adult's condition, the basis of the reporter's knowledge and other relevant information.

C. Any person failing or refusing to report, or obstructing or impeding any investigation, as required by Subsection A of this section is guilty of a misdemeanor.

D. The department may assess a civil penalty not to exceed ten thousand dollars ($10,000) per violation against a person that violates the provisions of Subsection A of this section or obstructs or impedes any investigation as required pursuant to Subsection A of this section. The department may assess and collect the penalty, after notice and an opportunity for hearing before a hearing officer designated by the department to hear the matter, upon a determination that a person violated the provisions of Subsection A of this section or obstructed or impeded any investigation as

required pursuant to this section. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum. Additionally, if the violation is against a person covered by the Personnel Act [10-9-1 NMSA 1978], the department shall refer the matter to the agency employing the person for disciplinary action. Any party may appeal a final decision by the department to the court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 1989, ch. 389, § 17; 1990, ch. 79, § 10; 1997, ch. 132, § 15; 2007, ch. 91, § 13.

27-7-31. Immunity.

Any person making a report pursuant to Section 27-7-30 NMSA 1978, testifying in any judicial proceeding arising from the report or participating in a required evaluation pursuant to the Adult Protective Services Act or any law enforcement officer carrying out his responsibilities under that act or any person providing records or information as required under that act shall be immune from civil or criminal liability on account of that report, testimony or participation, unless the person acted in bad faith or with a malicious purpose.

History: Laws 1989, ch. 389, § 18; 1997, ch. 132, § 16.

ARTICLE 7A
Employee Abuse Registry Act

27-7A-1. Short title.

This act [27-7A-1 to 27-7A-8 NMSA 1978] may be cited as the "Employee Abuse Registry Act".

History: Laws 2005, ch. 256, § 1.

27-7A-2. Definitions.

As used in the Employee Abuse Registry Act:

A. "abuse" means:

(1) knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish; or

(2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person;

B. "department" means the department of health;

C. "direct care" means face-to-face services provided or routine and unsupervised physical or financial access to a recipient of services;

D. "employee" means a person employed by or on contract with a provider, either directly or through a third party arrangement to provide direct care. "Employee" does not include a New Mexico licensed health care professional practicing within the scope of the profession's license or a certified nurse aide;

E. "exploitation" means an unjust or improper use of a person's money or property for another person's profit or advantage, pecuniary or otherwise;

F. "neglect" means, subject to a person's right to refuse treatment and subject to a provider's right to exercise sound medical discretion, the failure of an employee to provide basic needs such as clothing, food, shelter, supervision and care for the physical and mental health of a person or failure by a person that may cause physical or psychological harm;

G. "provider" means an intermediate care facility for individuals with developmental or intellectual disabilities; a rehabilitation facility; a home health agency; a homemaker agency; a home for the aged or disabled; a group home; an adult foster care home; a case management entity that provides services to elderly people or people with developmental disabilities; a corporate guardian; a private residence that provides personal care, adult residential care or natural and surrogate family services provided to persons with developmental disabilities; an adult daycare center; a boarding home; an adult residential care home; a residential service or habilitation service authorized to be reimbursed by medicaid; any licensed or medicaid-certified entity or any program funded by the aging and long-term services department that provides respite, companion or personal care services; programs funded by the children, youth and families department that provide homemaker or adult daycare services; and any other individual, agency or organization that provides respite care or delivers home- and community-based services to adults or children with developmental disabilities or physical disabilities or to the elderly, but excluding a managed care organization unless the employees of the managed care organization provide respite care or deliver home- and community-based services to adults or children with developmental disabilities or physical disabilities or to the elderly;

H. "registry" means an electronic database that provides information on substantiated employee abuse, neglect or exploitation; and

I. "secretary" means the secretary of health.

History: Laws 2005, ch. 256, § 2; 2023, ch. 113, § 6.

27-7A-3. Employee abuse registry.

A. The department shall establish an "employee abuse registry" of employees and enter into the registry names of employees with substantiated abuse, neglect or exploitation charges as determined by the department pursuant to the Employee Abuse Registry Act.

B. Before a provider hires or contracts with an employee, the provider shall inquire of the department's registry as to whether the employee is included in the registry.

C. When the department's registry receives an inquiry, the department shall inform the provider whether an employee is included in the employee abuse registry.

D. Providers that hire employees shall document that they have checked the abuse registry for each applicant being considered for employment or contract.

E. A provider shall not hire or contract with an employee in a direct care setting who is included in the employee abuse registry.

F. The department or other governmental agency may, at its discretion, terminate or not enter into or renew a contract with a provider that fails to comply with the provisions of Subsection E of this section.

G. A provider, including its administrators and employees, is not civilly liable to an applicant or an employee for a good faith decision to employ, not employ or terminate employment pursuant to the Employee Abuse Registry Act.

H. After a period of three years, an employee placed on the employee abuse registry may petition the department for removal of the employee's name from the employee abuse registry. Petitions for removal shall be in writing and mailed or hand delivered to the department. Within thirty days of the department's receipt of a petition, the secretary shall issue a written decision on the petition and provide that decision to the employee in person or by certified mail. If the secretary denies the petition, the employee may, within ten days of receipt of that decision, request a hearing. If an employee requests a hearing, that hearing shall be conducted by an independent hearing officer. An employee aggrieved by the final decision following a hearing shall have the right to judicial review pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 2005, ch. 256, § 3.

27-7A-4. Investigation and substantiation of abuse, neglect or exploitation by the department.

A. In addition to other actions required by law, the department shall review all reports of abuse, neglect or exploitation against employees of providers that are licensed by or under contract with the department and shall investigate such reports as

necessary to determine whether there is a reasonable basis to believe that an employee committed abuse, neglect or exploitation.

B. If the department determines that abuse, neglect or exploitation has occurred, the department shall notify the employee and the provider of that determination, and such determination shall include a determination of whether the abuse, neglect or exploitation was the result of conduct by the employee, the provider or both.

History: Laws 2005, ch. 256, § 4.

27-7A-5. Adult protective services division report of abuse, neglect or exploitation.

A. The adult protective services division of the aging and long-term services department shall investigate allegations of abuse, neglect and exploitation consistent with its statutory responsibilities.

B. If the adult protective services division determines that abuse, neglect or exploitation has occurred, it shall notify the employee and the provider of that determination, and such determination shall include a determination of whether the abuse, neglect or exploitation was the result of conduct by the employee, the provider or both.

C. The adult protective services division shall report to the department of health any substantiated finding of abuse, neglect or exploitation made against an employee of a provider under waiver or other programs administered by the aging and long-term services department and not otherwise licensed by or under contract with the department.

History: Laws 2005, ch. 256, § 5.

27-7A-6. Placement on registry and hearing process.

A. If the department or the adult protective services division of the aging and long-term services department determines that abuse, neglect or exploitation by an employee has occurred, the department making that determination shall notify the employee and the provider, in person or by certified mail, of the following:

(1) the nature of the determination of the abuse, neglect or exploitation;

(2) the date and time of the occurrence;

(3) the employee's right to a hearing;

(4) the department's intent to report the substantiated findings, once the employee has had the opportunity for a hearing, to the registry; and

(5) that the employee's failure to request a hearing in writing within thirty days from the date of the notice shall result in the department reporting substantiated findings to the registry and the provider.

B. If an employee requests a hearing, that hearing shall be conducted by an independent hearing officer of the department that made the determination of abuse, neglect or exploitation.

C. After expiration of the time period for requesting a hearing, or if a determination of abuse, neglect or exploitation is substantiated through the hearing process, the substantiated finding of abuse, neglect or exploitation shall be placed on the registry through a report of the appropriate department.

D. An employee aggrieved by the final decision following a hearing shall have the right to judicial review pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

History: Laws 2005, ch. 256, § 6.

27-7A-7. Adoption of rules.

By January 1, 2006, the department of health and the aging and long-term services department shall jointly establish and adopt rules necessary to carry out the provisions of the Employee Abuse Registry Act, including procedures for determining abuse, neglect and exploitation that consider the severity of the alleged abuse, neglect and exploitation and procedures for reporting for the administrative hearing process and for sanctions for failure to comply with the Employee Abuse Registry Act.

History: Laws 2005, ch. 256, § 7.

27-7A-8. Penalties.

The department shall administer sanctions for a provider's failure to comply with the Employee Abuse Registry Act, including a directed plan of correction or civil monetary penalty not to exceed five thousand dollars ($5,000) per instance.

History: Laws 2005, ch. 256, § 8.

ARTICLE 8
Community Action

27-8-1. Short title.

Chapter 27, Article 8 NMSA 1978 may be cited as the "Community Action Act".

History: Laws 1983, ch. 139, § 1; 2024, ch. 39, § 111.

27-8-2. Policy; purpose.

Although in recent years New Mexico has shown improvement in indices such as personal income and the number of families below the poverty level, the state continues to compare poorly with other states. New Mexico has risen from 48th in 1974 to 41st in per capita personal income; however, poverty continues to be the lot of a substantial number of New Mexicans. New Mexico can achieve its full economic and social potential only if every individual has the opportunity to contribute to the full extent of his capabilities and to participate in the working of our society. It is, therefore, the policy of this state to eliminate the paradox of poverty in the midst of plenty in this state by opening to everyone the opportunity to live in decency and dignity. It is the purpose of the Community Action Act to strengthen, supplement and coordinate efforts in furtherance of that policy.

History: Laws 1983, ch. 139, § 2.

27-8-3. Definitions.

As used in the Community Action Act:

A. "poverty level" means the official poverty level established by the federal director of the office of management and budget and revised periodically by the United States secretary of health and human services; and

B. "secretary" means the secretary of health care authority.

History: Laws 1983, ch. 139, § 3; 2024, ch. 39, § 112.

27-8-4. Financial assistance for community action agencies.

A. The secretary may provide financial assistance to community action agencies for the planning, conduct, administration and evaluation of community action programs as described in the Community Action Act in accordance with state and federal law and regulations.

B. No funds provided pursuant to Subsection A of this section shall be distributed to a community action agency unless the agency has submitted to the secretary a plan on the proposed use of the funds and the secretary has approved that plan.

C. Subject to applicable federal law or regulation, community action agencies shall be eligible to receive federal funds, including but not limited to community services block grant funds, which have been previously designated as antipoverty funds.

D. Each community action agency receiving funds pursuant to this section shall report annually to the secretary concerning the use of the funds.

E. The secretary shall provide annually for an audit of funds distributed pursuant to this section to community action agencies and shall make any requirements necessary to insure fiscal responsibility and accountability and effective, efficient handling of funds.

History: Laws 1983, ch. 139, § 4.

27-8-5. Community action agencies; designation; powers.

A. A community action agency is a political subdivision of the state, a combination of political subdivisions or a public or private nonprofit agency that:

(1) has the power and authority to enter into contracts with public and private nonprofit agencies and organizations in fulfilling the purposes of the Community Action Act;

(2) is capable of planning, conducting, administering and evaluating a community action program;

(3) has a service area at least equivalent to the geographic boundaries of a county; and

(4) is designated a community action agency by the governor or by federal law or was officially designated a community action agency, community action program or limited purpose agency under the provisions of the federal Economic Opportunity Act of 1964 on September 30, 1981.

B. The governor is empowered to declare that an entity designated as a community action agency under Subsection A of this section is no longer a community action agency upon a determination that such entity is unable or unwilling to carry out its responsibilities under the Community Action Act.

C. A community action agency is empowered to:

(1) receive, administer and transfer funds in support of a community action program under the Community Action Act; and

(2) delegate powers to other agencies and programs subject to the powers of its governing board and its overall program responsibilities.

History: Laws 1983, ch. 139, § 5.

27-8-6. Community action agencies; board; local participation.

A. Each community action agency shall administer its community action program through a community action board. Board members shall be selected as follows:

(1) one-third of the members of the board shall be elected public officials currently holding office in the geographical area to be served by the community action agency or their representatives, except that if the number of elected officials reasonably available and willing to serve is less than one-third of the membership of the board, membership on the board of appointive officials may be counted in meeting this one-third requirement;

(2) at least one-third of the members shall be persons chosen in accordance with democratic selection procedures adequate to ensure that they are representative of the poor in the area served; and

(3) the other members shall be officials or members of business, industry, labor, religious, welfare, education or other major groups and interests in the community.

B. Each member of the board selected to represent a specific geographic area within a community shall reside in the area represented.

C. No person selected under Paragraph (2) or (3) of Subsection A of this section shall serve for more than five consecutive years.

History: Laws 1983, ch. 139, § 6; 2021, ch. 105, § 1

27-8-7. Community action programs.

Each community action agency shall use available funds for a community action program which:

A. provides a range of services and activities which have a measurable and potentially major impact on causes of poverty in the community;

B. provides activities designed to assist low-income participants, including the elderly poor, to:

(1) secure and retain meaningful employment;

(2) attain an adequate education;

(3) make better use of available income;

(4) provide and maintain adequate housing and a suitable living environment;

(5) obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing and employment-related assistance;

(6) remove obstacles and solve problems which block the achievement of self-sufficiency;

(7) achieve greater participation in the affairs of the community; and

(8) make more effective use of other programs related to the purposes of the Community Action Act;

C. provides on an emergency basis for the provision of such supplies and services, nutritious food and related services as may be necessary to counteract conditions of starvation and malnutrition among the poor;

D. coordinates and establishes linkages between governmental and other social services programs to assure the effective delivery of such services to low-income individuals;

E. encourages the use of entities in the private sector of the community in efforts to alleviate poverty in the community; and

F. furthers any other purpose consistent with federal or state law or regulations.

History: Laws 1983, ch. 139, § 7.

27-8-8. Regulations.

The secretary shall adopt such rules and regulations as may be necessary to carry out the provisions of the Community Action Act.

History: Laws 1983, ch. 139, § 8.

27-8-9. Financial assistance; limitations.

The secretary, consistent with federal law, shall make grants of not less than ninety percent of the annual allocation of funds available under the community services block grant to community action agencies defined in Subsection A of Section 5 [27-8-5 NMSA 1978] of the Community Action Act. The human services department [health care authority department] is authorized to implement, by regulation or contract, a limitation on the amount of community services block grant funds allocated to administrative costs.

History: Laws 1983, ch. 139, § 9.

ARTICLE 9
Community Care

27-9-1. Program; demonstrations.

The health care authority, in cooperation with the aging and long-term services department, is authorized to administer demonstration programs that provide in-home and coordinated community care services to the frail elderly and to persons with disabilities who would otherwise require institutionalization. The programs authorized by this section shall serve both those eligible and not eligible for federal medical assistance programs.

History: Laws 1983, ch. 323, § 1; 2007, ch. 46, § 22; 2024, ch. 39, § 113.

27-9-2. Implementation.

The secretary of health care authority shall, by rule, specify the areas in which the programs shall operate, specify the services to be provided, establish eligibility criteria of persons to be served and provide for cost sharing, where possible, with persons and participating communities.

History: Laws 1983, ch. 323, § 2; 2024, ch. 39, § 114.

ARTICLE 10
Statewide Health Care

27-10-1. Short title.

Chapter 27, Article 10 NMSA 1978 may be cited as the "Statewide Health Care Act".

History: Laws 1991, ch. 212, § 1; 2024, ch. 39, § 115.

27-10-2. Findings and purpose.

A. Access to health care reduces long-term medical and social costs. The effectiveness of statewide health care has been decreased by excessive fragmentation and failure to maximize the use of existing in-state revenues and to develop effective ways of drawing upon potential federal revenue sources. An effective statewide health care system must retain local health care efforts, stimulate local innovations for meeting particular health care needs and use existing resources to expand health care options, especially for those citizens unable to pay for their own care.

B. The purpose of the county-supported medicaid fund is to leverage existing resources to better address the state's health care needs. The county-supported medicaid fund will be used to accomplish this purpose by using local revenues to support the state medicaid program and to institute or support primary care health care services pursuant to Section 24-1A-3.1 NMSA 1978. Money appropriated from the

county-supported medicaid fund to institute or support primary care health care services pursuant to Section 24-1A-3.1 NMSA 1978 shall be supplemental to general fund appropriations.

History: Laws 1991, ch. 212, § 2; 1993, ch. 321, § 19; 1996, ch. 29, § 5.

27-10-3. County-supported medicaid fund created; use; appropriation by the legislature.

A. The "county-supported medicaid fund" is created as a nonreverting fund in the state treasury. The fund shall be invested by the state treasurer as other state funds are invested. Income earned from investment of the fund shall be credited to the county-supported medicaid fund.

B. Money in the county-supported medicaid fund is subject to appropriation by the legislature to support the state medicaid program and to institute or support primary care health care services pursuant to Subsections D and E of Section 24-1A-3.1 NMSA 1978. Of the amount appropriated each year, nine percent shall be appropriated to the health care authority to institute or support primary care health care services pursuant to Subsections D and E of Section 24-1A-3.1 NMSA 1978.

C. Up to three percent of the county-supported medicaid fund each year may be expended for administrative costs related to medicaid or developing new primary care health care centers or facilities.

D. In the event federal funds for medicaid are not received by New Mexico for any eighteen-month period, the unencumbered balance remaining in the county-supported medicaid fund and the safety net care pool fund at the end of the fiscal year following the end of any eighteen-month period shall be paid within a reasonable time to each county for deposit in the county health care assistance fund in proportion to the payments made by each county through tax revenues or transfers in the previous fiscal year as certified by the local government division of the department of finance and administration. The department will provide for budgeting and accounting of payments to the fund.

History: Laws 1991, ch. 212, § 3; 1992, ch. 31, § 2; 1993, ch. 321, § 20; 1996, ch. 29, § 6; 2014, ch. 79, § 17; 2024, ch. 39, § 116.

27-10-4. Alternative revenue source to imposition of county health care gross receipts tax; transfer to county-supported medicaid fund.

A. In the event a county does not enact an ordinance imposing a county health care gross receipts tax pursuant to Section 7-20D-3 [7-20E-18] NMSA 1978, the county shall, by ordinance to be effective July 1, 1993, dedicate to the county-supported

medicaid fund an amount equal to a gross receipts tax rate of one-sixteenth of one percent applied to the taxable gross receipts reported during the prior fiscal year by persons engaging in business in the county. For purposes of this subsection, a county may use funds from any existing authorized revenue source of the county.

B. For each county that has in effect an ordinance enacted pursuant to Subsection A of this section on July 1 of each year, the taxation and revenue department shall certify to the county by September 15, 1993 and by September 15 of each subsequent fiscal year the amount of gross receipts reported for the county for purposes of the gross receipts tax during the prior fiscal year. Upon certification by the department, any county enacting an ordinance pursuant to Subsection A of this section shall transfer to the county-supported medicaid fund by the last day of March, June, September and December of each year an amount equal to a rate of one-sixty-fourth of one percent applied to the certified amount.

C. The requirements of an ordinance enacted pursuant to this section may be terminated for a county only on the effective date of an ordinance enacted by the county imposing the county health care gross receipts tax; provided that if the effective date of the ordinance imposing the tax is January 1, the termination does not apply to the payments required for September and December of that year.

History: Laws 1991, ch. 212, § 4; 1992, ch. 31, § 3; 1993, ch. 321, § 21.

ARTICLE 11
Medicaid Providers

27-11-1. Short title.

Chapter 27, Article 11 NMSA 1978 may be cited as the "Medicaid Provider and Managed Care Act".

History: Laws 1998, ch. 30, § 1; 2019, ch. 215, § 1.

27-11-2. Definitions.

As used in the Medicaid Provider and Managed Care Act:

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

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

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

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

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

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

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

E. "department" or "authority" means the health care authority;

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

G. "managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements with the authority to provide health care and related services;

H. "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

I. "medicaid provider" means a person that provides medicaid-related services to recipients;

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

K. "person" means an individual or other legal entity;

L. "recipient" means a person whom the authority has determined to be eligible to receive medicaid-related services;

M. "secretary" means the secretary of health care authority; and

N. "subcontractor" means a person that contracts with a medicaid provider or a managed care organization to provide medicaid-related services to recipients.

History: Laws 1998, ch. 30, § 2; 2019, ch. 215, § 2; 2024, ch. 39, § 117.

27-11-3. Review of medicaid provider or managed care organization; contract remedies; penalties.

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

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

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

(2) violated any provision of the Public Assistance Act [27-2-1 to 27-2-34 NMSA 1978] or the Medicaid Provider and Managed Care Act or any rules issued pursuant to those acts;

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

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

(5) hindered or prevented the secretary from performing any duty imposed by the Public Assistance Act, the Human Services Department [health care authority department] Act [Health Care Authority Act] [Chapter 9, Article 8 NMSA 1978] or the Medicaid Provider and Managed Care Act or any rules issued pursuant to those acts; or

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

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

(1) impose an administrative penalty of not more than five thousand dollars ($5,000) for engaging in any practice described in Subsection B of this section; provided that each separate occurrence of such practice shall constitute a separate offense;

(2) issue an administrative order requiring the medicaid provider or managed care organization 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 service that it has agreed or is otherwise obligated to make available; or

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

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

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

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

History: Laws 1998, ch. 30, § 3; 1999, ch. 229, § 1; 2019, ch. 215, § 3.

27-11-3.1. Hospital payment rates; managed care organizations; negotiated rates. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

The department shall not reduce hospital payment rates made pursuant to medicaid below those in effect on the date this 2024 act takes effect. A managed care organization shall not reduce negotiated rates paid to a hospital pursuant to medicaid below the hospital payment rates in effect on the date this 2024 act takes effect.

History: *Laws 2024, ch. 41, § 11.*

27-11-4. Retention and production of records.

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

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

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

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

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

B. Upon written request by the department to a medicaid provider, managed care organization or any subcontractor for copies or inspection of records pursuant to the Public Assistance Act [27-2-1 to 27-2-34 NMSA 1978], the medicaid provider, managed care organization or subcontractor shall provide the copies or permit the inspection, as applicable within two business days after the date of the request unless the records are held by a subcontractor, agent or satellite office, in which case the records shall be made available within ten business days after the date of the request.

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

History: Laws 1998, ch. 30, § 4; 1999, ch. 229, § 2; 2019, ch. 215, § 4.

27-11-5. Rules.

The secretary shall adopt and promulgate rules appropriate to administer, carry out and enforce the provisions of the Medicaid Provider Act.

History: Laws 1998, ch. 30, § 5.

27-11-6. Repealed.

History: Laws 2004, ch. 4, § 1; repealed by Laws 2006, ch. 25, § 2.

27-11-7. Determination of overpayments or credible allegation of fraud; audit findings; sampling; extrapolation limited; notice of

right to informal conference and expedited adjudicatory proceeding.

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

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

C. Prior to reaching either a final determination of overpayment or a credible allegation of fraud, the department shall serve the medicaid provider or subcontractor with a written preliminary finding of overpayment.

D. The preliminary finding of overpayment shall:

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

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

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

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

History: Laws 2019, ch. 215, § 5.

27-11-8. Informal conference; corrective action; requirements.

A. A medicaid provider or subcontractor seeking an informal conference pursuant to this section shall serve the department with a written request for such conference no later than thirty calendar days following the service of a preliminary determination of overpayment by the department on the medicaid provider or subcontractor. Upon receipt of a request for an informal conference, the department shall set a date for the conference to occur no later than fourteen business days following receipt of the request.

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

History: Laws 2019, ch. 215, § 6.

27-11-9. Expedited adjudicatory proceedings; requirements.

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

B. The chief hearing officer of the administrative hearings office shall appoint or contract with a hearing officer qualified pursuant to Section 8 [27-11-10 NMSA 1978] of this 2019 act no later than thirty calendar days after service upon the administrative hearings office of a request for an expedited adjudicatory proceeding pursuant to the Medicaid Provider and Managed Care Act by a medicaid provider or subcontractor.

C. The expedited adjudicatory proceeding requested by a medicaid provider or subcontractor in accordance with the Medicaid Provider and Managed Care Act shall commence no later than thirty calendar days following the appointment of the hearing officer or as stipulated by the parties or as otherwise ordered by the hearing officer upon a showing of good cause. The evidentiary hearing of an expedited adjudicatory proceeding pursuant to this section shall not exceed ten business days in length and shall be conducted in accordance with Section 12-8-11 NMSA 1978.

D. After affording the parties the opportunity to submit proposed findings and conclusions of law, and based solely upon the record in accordance with the Medicaid Provider and Managed Care Act and the Administrative Procedures Act [12-8-1 to 12-8-

25 NMSA 1978], the hearing officer shall make findings of fact and conclusions of law on all material issues of fact, law or discretion, stating the basis for each. In addition, the hearing officer shall determine the amount of overpayment with respect to each disputed claim submitted for payment, if any. The findings of fact and conclusions of law of the hearing officer shall be made and served upon all parties of record within thirty calendar days following the hearing officer's receipt of the record.

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

History: Laws 2019, ch. 215, § 7.

27-11-10. Qualifications and selection of hearing officer for expedited adjudicatory proceedings.

A. The hearing officer presiding over the expedited adjudicatory proceeding held pursuant to the Medicaid Provider and Managed Care Act shall:

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

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

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

(4) not be related within the third degree of consanguinity to a person currently employed by the department, currently doing business with the department or currently employed by an organization doing business with the department.

B. The hearing officer shall not be:

(1) a lobbyist registered under the Lobbyist Regulation Act [Chapter 2, Article 11 NMSA 1978] who currently represents, or has in the prior calendar year represented, a client in matters before the department; or

(2) affiliated with, or the spouse of, a lobbyist registered under the Lobbyist Regulation Act who currently represents, or has in the prior calendar year represented, a client in matters before the department.

C. The chief hearing officer of the administrative hearings office shall select the hearing officer to preside over an expedited adjudicatory proceeding held pursuant to the Medicaid Provider and Managed Care Act and the Administrative Procedures Act [12-8-1 to 12-8-25 NMSA 1978].

History: Laws 2019, ch. 215, § 8.

27-11-11. Costs of expedited adjudicatory proceeding.

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

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

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

History: Laws 2019, ch. 215, § 9.

27-11-12. Rights of medicaid provider or subcontractor; preliminary or final determination of overpayment.

A. A medicaid provider or subcontractor may challenge:

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

(a) exceeding statutory authority;

(b) arbitrary or capricious;

(c) a failure to follow department procedure; or

(d) not supported by substantial evidence;

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

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

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

History: Laws 2019, ch. 215, § 10.

27-11-13. Release of suspended payment for services previously rendered; prepayment review; remedial training and education; temporary assistance.

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

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

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

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

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

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

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

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

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

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

History: Laws 2019, ch. 215, § 11.

27-11-14. Maintenance of services; payment for ongoing services.

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

(1) submits to a prepayment review of claims for ongoing services;

(2) demonstrates that its employees have completed remedial training or education required by the department to prevent the submission of claims for payment to which the medicaid provider or subcontractor is not entitled; and

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

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

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

History: Laws 2019, ch. 215, § 12.

27-11-15. Disposition of recovered medicaid funds.

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

B. The department shall not enter into a contract to pay any portion of funds recovered by the state from a medicaid provider, a managed care organization or a subcontractor to any other person unless expressly authorized or required to do so by state or federal law.

History: Laws 2019, ch. 215, § 13.

27-11-16. Credible allegation of fraud; judicial review; substantial evidence required.

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

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

(1) it has followed its own procedures; and

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

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

History: Laws 2019, ch. 215, § 14.

27-11-17. Award of costs, fees and interest.

A. If a medicaid provider or subcontractor is the prevailing party in any expedited adjudicatory or court proceeding brought by the medicaid provider or subcontractor pursuant to the Medicaid Provider and Managed Care Act on or after January 1, 2020 in connection with a preliminary or final determination of overpayment or a determination of credible allegation of fraud, the medicaid provider or subcontractor shall be entitled to:

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

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

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

B. As used in this section:

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

(2) "reasonable administrative costs" means actual charges for preparation for and conduct of an administrative proceeding, including:

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

(b) the services of expert witnesses;

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

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

(3) "reasonable litigation costs" means:

(a) reasonable court costs; and

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

C. For purposes of this section:

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

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

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

(2) the medicaid provider or subcontractor shall not be treated as the prevailing party if the hearing officer finds that the position of the department in the proceeding was based upon a reasonable application of the law to the facts of the case. For purposes of this paragraph, the position of the department shall be presumed not to be based upon a reasonable application of the law to the facts of the case if:

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

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

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

(a) by agreement of the parties;

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

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

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

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

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

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

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

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

History: Laws 2019, ch. 215, § 15.

27-11-18. Applicability of Administrative Procedures Act.

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

B. Sections 12-8-2, 12-8-10 through 12-8-13, 12-8-15 and 12-8-16 NMSA 1978 apply to Sections 5 [22-11-7 NMSA 1978], 7 [27-11-9 NMSA 1978] through 11 [27-11-13 NMSA 1978] and 14 [27-11-16 NMSA 1978] of this 2019 act.

History: Laws 2019, ch. 215, § 16.

ARTICLE 12
Child Health (Repealed.)

27-12-1 to 27-12-7. Repealed.

ARTICLE 13
Consumer Direction

27-13-1. Short title.

This act [27-13-1 to 27-13-6 NMSA 1978] may be cited as the "Consumer Direction Act".

History: Laws 2003, ch. 210, § 1.

27-13-2. Purpose.

The purpose of the Consumer Direction Act is to ensure a consumer the right to direct his personal assistance services if he so chooses by selecting an attendant appropriate to his needs and to maximize personal assistance service availability and satisfaction.

History: Laws 2003, ch. 210, § 2.

27-13-3. Definitions.

As used in the Consumer Direction Act:

A. "attendant" means a person, including an allowable family member, who provides personal assistance services;

B. "consumer" means a person receiving personal assistance services through any personal assistance programs offered by the state of New Mexico;

C. "department" means any department or agency of the state offering personal assistance service to individuals;

D. "fiscal intermediary" means a person or entity selected by agreement between the consumer and the department under contract to the department to assist the consumer to perform certain employment functions, including payroll responsibilities for the attendant and filing necessary eligibility information with the department;

E. "personal assistance services" means a prescribed course of regular personal care, including hygiene, mobility and daily living assistance that permits a person to live in his home rather than an institution, including bathing, dressing, grooming, eating, toileting, shopping, transporting, cueing medication administration and communicating;

F. "plan" means a written and signed agreement between a consumer or surrogate and the department for the provision of personal assistance services; and

G. "surrogate" means a family member, legal guardian or other person approved by the consumer and identified in the personal assistance services plan to assist in direction of personal assistance services and choice of attendant.

History: Laws 2003, ch. 210, § 3.

27-13-4. Consumer direction programs authorized.

Consistent with the federal Social Security Act and subject to the appropriation and availability of federal and state funds, each administering department or agency shall by rule provide a program permitting a consumer or surrogate to direct personal assistance services through the hiring, supervision and training of an attendant or attendants paid through a fiscal intermediary under contract with the department.

History: Laws 2003, ch. 210, § 4.

27-13-5. Department duties.

A department shall:

A. establish by rule the criteria and procedures for developing and amending a personal assistance services plan with a consumer;

B. develop criteria and procedures for selection of a fiscal intermediary to contract with the department to provide fiscal intermediary services to a consumer; and

C. establish rates for reimbursement of an attendant providing personal assistance services to a consumer and for the compensation of a fiscal intermediary.

History: Laws 2003, ch. 210, § 5.

27-13-6. Report.

Annually by October 1, each department shall deliver a report to the legislative finance committee and the legislative health and human services committee on services provided pursuant to the Consumer Direction Act and a comparison of those services and services provided by the department through other means and an evaluation of the effectiveness and consumer satisfaction with the respective means of service delivery.

History: Laws 2003, ch. 210, § 6.

27-13-7. Fiscal intermediary; exemptions; workers' compensation.

A. A fiscal intermediary shall not be subject to vicarious liability as an employer or principal for a wrongful act committed by a personal care attendant if the attendant:

(1) is not a current or former employee of the fiscal intermediary;

(2) has not received training or instruction from the fiscal intermediary with respect to providing personal care services to a person with a disability, not including administrative paper work;

(3) has been hired by and received training or instruction from the consumer or the consumer's authorized representative to provide personal care to the consumer; and

(4) provides basic assistance with daily living activities that do not require the education, certification or training of a licensed health care practitioner.

B. A fiscal intermediary may identify a personal care attendant as a covered employee with the fiscal intermediary's workers' compensation carrier solely to provide workers' compensation coverage in the event of a work-related injury. Nothing in this subsection shall be construed to create an employer-employee relationship between the fiscal intermediary and the personal care attendant.

C. Nothing in this section shall be construed to provide the fiscal intermediary with immunity from a claim for a wrongful act committed by the fiscal intermediary or its employees.

D. As used in this section:

(1) "consumer" means a person who is eligible for and receives state-funded or -operated services based on the person's disabilities;

(2) "fiscal intermediary" means a provider that furnishes administrative assistance for a consumer who selects a consumer-directed, rather than consumer-delegated, personal care program;

(3) "personal care attendant" means a person who provides assistance to a consumer with activities of daily living, including bathing, dressing, eating, transportation, shopping and similar activities; and

(4) "personal care program" means a state-funded or -operated support program, including medicaid, that provides the services of a personal care attendant for certain persons with a disability.

History: Laws 2003, ch. 207, § 1; 2007, ch. 46, § 23.

ARTICLE 14
Medicaid False Claims Act

27-14-1. Short title.

Chapter 27, Article 14 NMSA 1978 may be cited as the "Medicaid False Claims Act".

History: Laws 2004, ch. 49, § 1; 2024, ch. 39, § 118.

27-14-2. Purpose.

The purpose of the Medicaid False Claims Act is to deter persons from causing or assisting to cause the state to pay medicaid claims that are false and to provide remedies for obtaining treble damages and civil recoveries for the state when money is obtained from the state by reason of a false claim.

History: Laws 2004, ch. 49, § 2.

27-14-3. Definitions.

As used in the Medicaid False Claims Act:

A. "claim" means a written or electronically submitted request for payment of health care services pursuant to the medicaid program;

B. "department" or "authority" means the health care authority;

C. "medicaid" means the federal-state program administered by the health care authority pursuant to Title 19 or Title 21 of the federal Social Security Act;

D. "medicaid recipient" means a person on whose behalf a person claims or receives a payment from the medicaid program, regardless of whether the person was eligible for the medicaid program; and

E. "qui tam" means an action brought under a statute that allows a private person to sue for a recovery, part of which the state will receive.

History: Laws 2004, ch. 49, § 3; 2024, ch. 39, § 119.

27-14-4. False claims against the state; liability for certain acts.

A person commits an unlawful act and shall be liable to the state for three times the amount of damages that the state sustains as a result of the act if the person:

A. presents, or causes to be presented, to the state a claim for payment under the medicaid program knowing that such claim is false or fraudulent;

B. presents, or causes to be presented, to the state a claim for payment under the medicaid program knowing that the person receiving a medicaid benefit or payment is not authorized or is not eligible for a benefit under the medicaid program;

C. makes, uses or causes to be made or used a record or statement to obtain a false or fraudulent claim under the medicaid program paid for or approved by the state knowing such record or statement is false;

D. conspires to defraud the state by getting a claim allowed or paid under the medicaid program knowing that such claim is false or fraudulent;

E. makes, uses or causes to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the medicaid program, knowing that such record or statement is false;

F. knowingly applies for and receives a benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, under the medicaid program and converts that benefit or payment to his own personal use;

G. knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the medicaid program; or

H. knowingly makes a claim under the medicaid program for a service or product that was not provided.

History: Laws 2004, ch. 49, § 4.

27-14-5. Documentary material in possession of state agency.

A. The department shall have access to all documentary materials of persons and medicaid recipients to which a state agency has access. Documentary material provided pursuant to this subsection is provided to allow investigation of an alleged unlawful act or for use or potential use in an administrative or judicial proceeding.

B. Except for disclosure to any person under investigation or who is the subject of allegations made pursuant to the Medicaid False Claim Act [27-14-1 NMSA 1978] or as ordered by a court for good cause shown, the department shall not produce for inspection or copying or otherwise disclose the contents of documentary material obtained pursuant to this section to a person other than:

(1) an authorized employee of the attorney general;

(2) an agency of this state, the United States or another state;

(3) a district attorney, city attorney or county attorney of this state;

(4) the United States attorney general; or

(5) a state or federal grand jury.

History: Laws 2004, ch. 49, § 5.

27-14-6. Immunity.

Notwithstanding any other law, a person is not civilly or criminally liable for providing access to documentary material pursuant to the Medicaid False Claims Act [27-14-1 NMSA 1978] to a person identified in Subsection B of Section 5 of that act.

History: Laws 2004, ch. 49, § 6.

27-14-7. Civil action for false claims.

A. The department shall diligently investigate suspected violations. If the department finds that a person has violated or is violating the provisions of the Medicaid False Claims Act, the department may bring a civil action pursuant to Subsection F of this section.

B. A private civil action may be brought by an affected person for a violation of the Medicaid False Claims Act on behalf of the person bringing suit and for the state. The action shall be brought in the name of the state. The action may be dismissed if the court and the department, pursuant to Subsection F of this section, give written consent to the dismissal and their reasons for consenting.

C. For private civil actions, a copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the department. The complaint shall be filed in writing and shall remain under seal for at least sixty days. The complaint shall not be served on the defendant until the expiration of sixty days or any extension approved. Within sixty days after receiving a copy of the complaint, the department shall conduct an investigation of the factual allegations and legal contentions made in the complaint, shall make a written determination of whether there is substantial evidence that a violation has occurred and shall provide the person against which a complaint has been made with a copy of the determination. If the department determines that there is not substantial evidence that a violation has occurred, the complaint shall be dismissed.

D. The department may, for good cause shown, move the court for extensions of time during which the complaint remains under seal. Any such motion may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to a complaint filed pursuant to this section until twenty days after the complaint is unsealed and served to the defendant. The complaint shall be deemed unsealed at the expiration of the sixty-day period in the absence of a court-approved extension.

E. Before the expiration of the sixty-day period or any extensions obtained, the department, pursuant to Subsection F of this section, shall:

(1) proceed with the action, in which case the action shall be conducted by the department; or

(2) notify the court and the person who brought the action that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action if the department determined that there is substantial evidence that a violation of the Medicaid False Claims Act has occurred.

F. The department shall notify the attorney general prior to filing a civil action pursuant to the Medicaid False Claims Act and shall not proceed with the action except with the written approval of the attorney general. The attorney general shall, within twenty working days from the notification by the department, notify the department whether it may proceed with the civil action. Failure by the attorney general to notify the department of its determination within the specified time period shall be construed as consent to proceed. The department shall, after filing the civil action, notify the attorney general of any proposed dismissal or settlement and the department shall not proceed with the dismissal or settlement except with the written approval of the attorney general.

History: Laws 2004, ch. 49, § 7.

27-14-8. Rights of the parties to qui tam actions.

A. If the department proceeds with the action, it shall have the exclusive responsibility for prosecuting the action and shall not be bound by an act of the person bringing the action. The person bringing the action shall have the right to continue as a nominal party to the action and shall not have the right to participate in the litigation except as a witness.

B. The department may dismiss the action, pursuant to Subsection F of Section 7 of the Medicaid False Claims Act [27-14-7 NMSA 1978], notwithstanding the objections of the person bringing the action if the person has been notified by the department of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

C. The department may settle the action with the defendant, pursuant to Subsection F of Section 7 of the Medicaid False Claims Act, notwithstanding the objections of the person bringing the action if the court determines, after the hearing, that the proposed settlement is fair, adequate and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

D. If the state elects not to proceed with the action, the person bringing the action shall have the right to conduct the action. If the department requests, it shall be served with copies of the pleadings filed in the action and shall be supplied with copies of all deposition transcripts at the department's expense. When a person proceeds with the action, the court, without limiting the status and rights of the person bringing the action, may allow the department to intervene at a later date upon a showing of good cause.

E. Whether or not the department proceeds with the action, upon a showing by the department that certain actions of discovery by the person bringing the action would interfere with the department's investigation or prosecution of a civil matter arising out of the same facts, the court may stay such discovery for a period not to exceed sixty days. Such a showing shall be conducted in camera. The court may extend the sixty-day period upon a further showing in camera that the department has pursued the civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing civil investigation or proceedings.

History: Laws 2004, ch. 49, § 8.

27-14-9. Award to qui tam plaintiff.

A. If the department proceeds with an action brought by a person pursuant to the Medicaid False Claims Act, the person shall, subject to the limitations in this subsection, receive at least fifteen percent but not more than twenty-five percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one that the court finds to be based primarily on disclosures of specific information other than information provided by the party bringing the action relating to allegations or transactions in a criminal, civil or administrative hearing or from the news media, the court shall award a sum as it considers appropriate; provided that the sum does not exceed ten percent of the proceeds and takes into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. A payment to a person pursuant to this subsection shall be made from the proceeds. The person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney fees and costs. In determining the amount of reasonable attorney fees and costs, the court shall consider whether such fees and costs were necessary to the prosecution of the action, were incurred for activities that were duplicative of the activities of the department in prosecuting the case or were repetitious, irrelevant or for purposes of harassment or caused the defendant undue burden or unnecessary expense. All such expenses, fees and costs shall be awarded against the defendant.

B. If the department does not proceed with an action pursuant to the Medicaid False Claims Act, the person bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil recovery and damages recoverable by the state. The amount shall be not less than twenty-five percent and not more than thirty percent of the proceeds of the action or settlement and shall be paid out of such proceeds. The person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney fees and costs. In determining the amount of reasonable attorney fees and costs, the court shall consider whether such fees and costs were necessary to the prosecution of the action, were incurred for activities, which were repetitious, irrelevant or for purposes of harassment or caused the defendant undue burden or unnecessary expense. All such expenses, fees and costs shall be awarded against the defendant.

C. Whether or not the department proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action that the party would otherwise receive pursuant to Subsection A or B of this section, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from the person's role in the violation of the Medicaid False Claims Act, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the state to continue the action represented by the department. If the department does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorney fees and costs if the defendant prevails in the action and the court finds that the claim of the party bringing the action was:

(1) filed for an improper purpose;

(2) not warranted by existing law or by a nonfrivolous argument for the extension, modification or reversal of existing law or the establishment of new law; or

(3) was based on allegations or factual contentions not supported.

History: Laws 2004, ch. 49, § 9.

27-14-10. Certain actions barred.

A. A court shall not have jurisdiction of an action brought pursuant to the Medicaid False Claims Act against a department official if the action is substantially based on evidence or information known to the department when the action was brought.

B. A person shall not bring an action pursuant to the Medicaid False Claims Act that is substantially based upon allegations or transactions that are the subject of a civil suit or an administrative proceeding in which the department is already a party.

C. A court shall not have jurisdiction over an action pursuant to the Medicaid False Claims Act substantially based upon the public disclosure of allegations or actions in a criminal, civil or administrative hearing or from the news media, unless the action is brought by the department or the person bringing the action is an original source of the information. For the purposes of this subsection, "original source" means the person bringing suit that has independent knowledge, including knowledge based on the person's own investigation of the defendant's conduct, of the information on which the allegations are based and has voluntarily provided or verified the information on which the allegations are based or has voluntarily provided the information to the department before filing an action pursuant to this section that is based on the information.

History: Laws 2004, ch. 49, § 10.

27-14-11. Department not liable for certain expenses.

The department shall not be liable for expenses that a person incurs in bringing an action pursuant to the Medicaid False Claims Act.

History: Laws 2004, ch. 49, § 11.

27-14-12. Employee protection.

Any employee who is discharged, demoted, suspended, threatened, harassed or otherwise discriminated against in the terms and conditions of employment by the employer because of lawful acts done by the employee on behalf of the employee or others in disclosing information to the department or in furthering a false claims action pursuant to the Medicaid False Claims Act, including investigation for, initiation of, testimony for or assistance in an action filed or to be filed pursuant to that act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status that the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees. An employee may bring an action in the appropriate court of the state for the relief provided in this subsection.

History: Laws 2004, ch. 49, § 12.

27-14-13. False claims and reporting procedure.

A. A civil action shall be brought within the limitations set forth in Section 37-1-4 NMSA 1978.

B. In any action brought pursuant to the Medicaid False Claims Act, the department or the person bringing the action shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

C. Notwithstanding any other provision of law, a final judgment rendered in favor of the department in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty, shall preclude the defendant from denying the essential elements of the offense in any action that involves the same transaction as in the criminal proceeding and that is brought pursuant to the Medicaid False Claims Act.

History: Laws 2004, ch. 49, § 13.

27-14-14. Application of other law.

The application of a civil remedy pursuant to this law does not preclude the application of other laws, statutes or regulatory remedy, except that a person may not be liable for a civil remedy pursuant to the Medicaid False Claims Act and civil damages or recovery pursuant to the Medicaid Fraud Act [30-44-1 NMSA 1978] if the civil remedy and the civil damages or recoveries are assessed for the same conduct by another government agency.

History: Laws 2004, ch. 49, § 14.

27-14-15. Use of funds.

A. Damages collected pursuant to the Medicaid False Claims Act on behalf of the state shall be remitted to the state treasurer for deposit in the general fund to be used for the state's medicaid program.

B. Penalties, legal fees or costs of investigation recovered pursuant to the Medicaid False Claims Act on behalf of the state shall be remitted to the state treasurer for deposit in the general fund to be used for the state's medicaid program.

C. Pursuant to Subsection C of Section 30-44-8 NMSA 1978, penalties recovered pursuant to the Medicaid False Claims Act on behalf of the state may be claimed by the attorney general pursuant to procedures established by the department and the attorney general.

History: Laws 2004, ch. 49, § 15.

ARTICLE 15
Money Follows the Person in New Mexico

27-15-1. Short title.

This act [27-15-1 to 27-15-5 NMSA 1978] may be cited as the "Money Follows the Person in New Mexico Act".

History: Laws 2006, ch. 112, § 1.

27-15-2. Definition.

As used in the Money Follows the Person in New Mexico Act, "department" means the aging and long-term services department [9-23-4 NMSA 1978].

History: Laws 2006, ch. 112, § 2.

27-15-3. Community-based living; choice of options.

An elderly or disabled individual who is identified and assessed as eligible for community-based living shall be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. The individual's medical assistance funds shall be made available for the individual for the service option the individual selects, not to exceed the cost of the service. The department shall apply for federal approval as necessary, and upon federal approval, implement this section under existing or future federal legislation.

History: Laws 2006, ch. 112, § 3.

27-15-4. Information.

The department shall identify and provide adequate information to a medicaid-eligible individual residing in a nursing home and, if appropriate, the individual's representative, of the opportunity for the individual to receive community-based services and support pursuant to the Money Follows the Person in New Mexico Act.

History: Laws 2006, ch. 112, § 4.

27-15-5. Quality improvement.

The department shall develop and implement a quality improvement system of performance indicators and outcome measures to evaluate the level and effectiveness of participation of individuals who are eligible for community-based services and to ensure that the services and support that an individual receives pursuant to the Money Follows the Person in New Mexico Act are adequate.

History: Laws 2006, ch. 112, § 5.