UNANNOTATED

CHAPTER 24A
Health Care Code

ARTICLE 1
Health Care Code

24A-1-1. Short title.

Chapter 24A NMSA 1978 may be cited as the "Health Care Code".

24A-1-2. Definitions.

As used in the Health Care Code:

A. "authority" means the health care authority;

B. "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;

C. "health care provider" means a person licensed to provide health care in the ordinary course of business, except as otherwise defined in the Health Care Code;

D. "health facility" means a public hospital; profit or nonprofit private hospital; general or special hospital; outpatient facility; crisis triage center; freestanding birth center; adult daycare facility; nursing home; intermediate care facility; assisted living facility; boarding home not under the control of an institution of higher learning; shelter care home; diagnostic and treatment center; rehabilitation center; infirmary; community mental health center that serves both children and adults or adults only; or a health service organization operating as a freestanding hospice or a home health agency. The designation of freestanding hospices or home health agencies as health facilities is only for the purposes of definition in the Health Care Code and does not imply that a freestanding hospice or a home health agency is considered a health facility for the purposes of other provisions of state or federal laws. "Health facility" includes those facilities that by federal regulation must be licensed by the state to obtain or maintain full or partial, permanent or temporary federal funding. "Health facility" does not include the offices and treatment rooms of licensed private practitioners; and

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

History: 1978 Comp., § 24A-1-2, enacted by Laws 2024, ch. 39, § 23.

24A-1-3. Powers and duties.

A. The authority may:

(1) bring action in court for the enforcement of laws and rules pertaining to the authority's powers and duties;

(2) enter into joint powers agreements to carry out the powers and duties of the authority;

(3) cooperate and enter into contracts or agreements with the federal government or any other person to carry out the powers and duties of the authority;

(4) cooperate and enter into contracts or agreements with Native American nations, tribes and pueblos and off-reservation groups to coordinate the provision of essential physical, mental and behavioral health services and functions;

(5) adopt, promulgate and enforce such rules as may be necessary to carry out the provisions of the Health Care Code;

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

(7) request and inspect, while maintaining federal and state confidentiality requirements, copies of:

(a) medical and clinical records reasonably required for the authority's quality assurance and quality improvement activities; and

(b) medical and clinical records pertaining to a person whose death is the subject of inquiry by the department of health's mortality review activities; and

(8) do all other things necessary to carry out its duties as defined by law and rules promulgated in accordance with law.

B. The authority shall:

(1) promulgate and enforce rules for the licensure of health facilities under its jurisdiction;

(2) license and inspect health facility premises to ensure compliance with laws, rules and public safety; and

(3) carry out such other duties as provided by law.

C. The authority and the office of the state long-term care ombud shall have prompt access to all files and records in the possession of the department of health that are related to any health facility investigation; provided that a person who discloses confidential information protected by federal or state law is guilty of a petty misdemeanor.

History: 1978 Comp., § 24A-1-3, enacted by Laws 2024, ch. 39, § 24.

24A-1-4. Records confidential.

A. The files and records of the authority giving identifying information about persons who have received or are receiving from the authority treatment, diagnostic services or preventive care for diseases, disabilities or physical injuries are confidential and are not open to inspection except:

(1) where permitted by rule of the authority;

(2) as provided in Subsection B of this section; and

(3) to the secretary or to an employee of the authority authorized by the secretary to obtain such information, but the information shall only be revealed for use in connection with a governmental function of the secretary or the authorized employee.

B. The files and records of the authority are subject to subpoena for use in a pending cause in an administrative proceeding or in any of the courts of the state, unless otherwise provided by law.

C. A person who discloses confidential information in violation of this section is guilty of a petty misdemeanor.

History: 1978 Comp., § 24A-1-4, enacted by Laws 2024, ch. 39, § 25.

24A-1-5. Licensure of health facilities; hearings; appeals.

A. A health facility shall not be operated without a license issued by the authority. If a health facility is found to be operating without a license, in order to protect human health or safety, the secretary may issue a cease-and-desist order. The health facility may request a hearing that shall be held in the manner provided in this section. The authority may also proceed pursuant to the Health Facility Receivership Act [Chapter 24A, Article 2 NMSA 1978].

B. The authority is authorized to make inspections and investigations and to prescribe rules it deems necessary or desirable to promote the health, safety and welfare of persons using health facilities.

C. Except as provided in Subsection F of this section, upon receipt of an application for a license to operate a health facility, the authority shall promptly inspect the health facility to determine if it is in compliance with all rules of the authority. Applications for hospital licenses shall include evidence that the bylaws or rules of the hospital apply equally to osteopathic and medical physicians. The authority shall consolidate the applications and inspections for a hospital that also operates as a hospital-based primary care clinic.

D. Upon inspection of a health facility, if the authority finds a violation of its rules, the authority may deny the application for a license, whether initial or renewal, or it may issue a temporary license. A temporary license shall not be issued for a period exceeding one hundred twenty days, nor shall more than two consecutive temporary licenses be issued.

E. A one-year nontransferable license shall be issued to any health facility complying with all rules of the authority. The license shall be renewable for successive one-year periods, upon filing of a renewal application, if the authority is satisfied that the health facility is in compliance with all rules of the authority or, if not in compliance with a rule, has been granted a waiver or variance of that rule by the authority pursuant to procedures, conditions and guidelines adopted by rule of the authority. Licenses shall be posted in a conspicuous place on the licensed premises.

F. A health facility that has been inspected and licensed by the authority, that has received certification for participation in federal reimbursement programs and that has been fully accredited by a national accrediting organization approved by the federal centers for medicare and medicaid services or the authority shall be granted a license renewal based on that accreditation. A freestanding birth center that has been inspected and licensed by the authority and is accredited by the commission for accreditation of birth centers or its successor accreditation body shall be granted a license renewal based on that accreditation. Health facilities receiving less than full accreditation by an approved accrediting body may be granted a license renewal based on that accreditation. License renewals shall be issued upon application submitted by the health facility upon forms prescribed by the authority. This subsection does not limit in any way the authority's various duties and responsibilities under other provisions of law, including any of the authority's responsibilities for the health and safety of the public.

G. The authority may charge a reasonable fee not to exceed twelve dollars ($12.00) per bed for an inpatient health facility or three hundred dollars ($300) for any other health facility for each license application, whether initial or renewal, of an annual license or the second consecutive issuance of a temporary license. Fees collected shall not be refundable. All fees collected pursuant to licensure applications shall be deposited with the state treasurer for credit in a designated authority recurring account for use in health facility licensure and certification operations.

H. The authority may revoke or suspend the license of a health facility or may impose on a health facility an intermediate sanction and a civil monetary penalty provided in Section 24A-1-6 NMSA 1978 after notice and an opportunity for a hearing before a hearing officer designated by the authority to hear the matter and, except for child care centers and facilities, may proceed pursuant to the Health Facility Receivership Act upon a determination that the health facility is not in compliance with any rule of the authority. If immediate action is required to protect human health and safety, the secretary may suspend a license or impose an intermediate sanction pending a hearing, provided the hearing is held within five working days of the suspension or imposition of the sanction, unless waived by the licensee, and, except for child care centers and facilities, may proceed ex parte pursuant to the Health Facility Receivership Act.

I. The authority shall schedule a hearing pursuant to Subsection H of this section if the authority receives a request for a hearing from a licensee:

(1) within ten working days after receipt by the licensee of notice of suspension, revocation, imposition of an intermediate sanction or civil monetary penalty or denial of an initial or renewal application;

(2) within four working days after receipt by the licensee of an emergency suspension order or emergency intermediate sanction imposition and notice of hearing if the licensee wishes to waive the early hearing scheduled and request a hearing at a later date; or

(3) within five working days after receipt of a cease-and-desist order.

J. The authority shall also provide timely notice to the licensee of the date, time and place of the hearing, identity of the hearing officer, subject matter of the hearing and alleged violations.

K. A hearing held pursuant to provisions of this section shall be conducted in accordance with adjudicatory hearing rules and procedures adopted by rule of the authority. The licensee has the right to be represented by counsel, to present all relevant evidence by means of witnesses and books, papers, documents, records, files and other evidence and to examine all opposing witnesses who appear on any matter relevant to the issues. The hearing officer has the power to administer oaths on request of any party and issue subpoenas and subpoenas duces tecum prior to or after the commencement of the hearing to compel discovery and the attendance of witnesses and the production of relevant books, papers, documents, records, files and other evidence. Documents or records pertaining to abuse, neglect or exploitation of a resident, client or patient of a health facility or other documents, records or files in the custody of the authority or the office of the state long-term care ombudsman at the aging and long-term services department that are relevant to the alleged violations are discoverable and admissible as evidence in any hearing.

L. Any party may appeal the final decision of the authority pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

M. A complaint about a health facility received by the authority pursuant to this section shall be promptly investigated and appropriate action shall be taken if substantiated. The authority shall develop a health facilities protocol in conjunction with the protective services division of the children, youth and families department, the office of the state long-term care ombudsman and other appropriate agencies to ensure the health, safety and rights of individuals in health facilities licensed by the authority. The health facilities protocol shall require:

(1) cross-reference among agencies pursuant to this subsection of an allegation of abuse, neglect or exploitation;

(2) an investigation, within the strict priority time frames established by each protocol member's rules, of an allegation or referral of abuse, neglect or exploitation after the authority has made a good cause determination that abuse, neglect or exploitation occurred;

(3) an agency to share its investigative information and findings with other agencies, unless otherwise prohibited by law; and

(4) require the receiving agency to accept the information provided pursuant to Paragraph (3) of this subsection as potential evidence to initiate and conduct investigations.

N. A complaint received by the authority pursuant to this section shall not be disclosed publicly in a manner as to identify any individuals or health facilities if upon investigation the complaint is unsubstantiated.

O. The name and information regarding the person making a complaint pursuant to this section shall not be disclosed absent the consent of the informant or a court order.

History: 1978 Comp., § 24A-1-5, enacted by Laws 2024, ch. 39, § 26.

24A-1-6. Health facilities; intermediate sanctions; civil penalty.

A. Upon a determination that a health facility is not in compliance with any licensing requirement of the authority, the authority, subject to the provisions of this section and Section 24A-1-5 NMSA 1978, may:

(1) impose any intermediate sanction established by rule, including but not limited to:

(a) a directed plan of correction;

(b) facility monitors;

(c) denial of payment for new medicaid admissions to the facility;

(d) temporary management or receivership; and

(e) restricted admissions;

(2) assess a civil monetary penalty, with interest, for each day the facility is or was out of compliance. Civil monetary penalties shall not exceed a total of five thousand dollars ($5,000) per day. Penalties and interest amounts assessed under this paragraph and recovered on behalf of the state shall be remitted to the state treasurer and deposited to the credit of the current school fund. The civil monetary penalties contained in this paragraph are cumulative and may be imposed in addition to any other fines or penalties provided by law; and

(3) with respect to health facilities other than child care centers or facilities, proceed pursuant to the Health Facility Receivership Act [Chapter 24A, Article 2 NMSA 1978].

B. The secretary shall adopt and promulgate rules specifying the criteria for imposition of any intermediate sanction and civil monetary penalty. The criteria shall provide for more severe sanctions for a violation that results in any abuse, neglect or exploitation of residents, clients or patients as defined in the rules or that places one or more residents, clients or patients of a health facility at substantial risk of serious physical or mental harm.

C. The provisions of this section for intermediate sanctions and civil monetary penalties shall apply to certified nursing facilities except when a federal agency has imposed the same remedies, sanctions or penalties for the same or similar violations.

D. Rules adopted by the authority shall permit sanctions pursuant to Paragraphs (1) and (2) of Subsection A of this section for a specific violation in a certified nursing facility if:

(1) the state statute or rule is not duplicated by a federal certification rule; or

(2) the authority determines intermediate sanctions are necessary if sanctions permitted pursuant to Paragraphs (1) and (2) of Subsection A of this section do not duplicate a sanction imposed under the authority of 42 U.S.C. 1395 or 1396 for a particular deficiency.

E. A health facility is liable for the reasonable costs of a directed plan of correction, facility monitors, temporary management or receivership imposed pursuant to this section and Section 24A-1-5 NMSA 1978. The authority may take all necessary and appropriate legal action to recover these costs from a health facility. All money

recovered from a health facility pursuant to this subsection shall be paid into the general fund.

History: 1978 Comp., § 24A-1-6, enacted by Laws 2024, ch. 39, § 27.

24A-1-7. Legislative findings; definitions; licensing requirements for certain hospitals.

A. The legislature finds that:

(1) acute care general hospitals throughout New Mexico operate emergency departments and provide vital emergency medical services to patients requiring immediate medical care; and

(2) federal and state laws require hospitals that operate an emergency department to provide certain emergency services and care to any person, regardless of that person's ability to pay. Accordingly, these hospitals encounter significant financial losses when treating uninsured or underinsured patients.

B. As used in this section:

(1) "limited service hospital" means a hospital that limits admissions according to medical or surgical specialty, type of disease or medical condition, or a hospital that limits its inpatient hospital services to surgical services or invasive diagnostic and treatment procedures; provided, however, that a "limited service hospital" does not include:

(a) a hospital licensed by the authority as a special hospital;

(b) an eleemosynary hospital that does not bill patients for services provided; or

(c) a hospital that has been granted a license prior to January 1, 2003; and

(2) "low-income patient" means a patient whose family or household income does not exceed two hundred percent of the federal poverty level.

C. The authority shall issue a license to an acute-care or general hospital or a limited services hospital that agrees to:

(1) continuously maintain and operate an emergency department that provides emergency medical services as determined by the authority;

(2) participate in the medicaid, medicare and county indigent care programs;

(3) require a physician owner to disclose a financial interest in the hospital before referring a patient to the hospital;

(4) comply with the same quality standards applied to other hospitals;

(5) provide emergency services and general health care to nonpaying patients and low-income reimbursed patients in the same proportion as the patients are treated in acute-care general hospitals in the local community, as determined by the authority in consultation with a statewide hospital organization, the government of the county in which the facilities are located and the affected hospitals; provided that:

(a) a hospital may appeal the determination of the authority as a final agency decision as provided in Section 39-3-1.1 NMSA 1978; and

(b) the annual cost of the care required to be provided pursuant to this paragraph shall not exceed an amount equal to five percent of the hospital's annual revenue; and

(6) require a health care provider to disclose a financial interest before referring a patient to the hospital.

History: Laws 2003, ch. 426, § 1; § 24-1-5.8, recompiled and amended as § 24A-1-7 by Laws 2024, ch. 39, § 28.

24A-1-8. Reporting requirements.

A. A hospital, a long-term care facility or a primary care clinic shall provide information sufficient for the authority to make a reasonable assessment based on clear and convincing evidence of its financial viability, sustainability and potential impact on health care access. Information provided to the authority pursuant to this section shall remain confidential, is exempt from the Inspection of Public Records Act [Chapter 14, Article 3 NMSA 1978], unless disclosure or use is mandated by the state or federal law, and shall not be used as a basis for suspension, revocation or issuance of a license. The hospital, long-term care facility or primary care clinic shall provide this information to the authority at least sixty days before the anticipated effective date of a proposed licensure, closure, disposition or acquisition of the hospital, the long-term care facility or the primary care clinic or its essential services.

B. The secretary shall issue a notice of finding to the facility within sixty days of receiving information from the facility.

C. For the purposes of this section:

(1) "hospital" means a facility providing emergency or urgent care, inpatient medical care and nursing care for acute illness, injury, surgery or obstetrics. "Hospital" includes a facility licensed by the authority as a critical access hospital, general hospital,

long-term acute care hospital, psychiatric hospital, rehabilitation hospital, limited services hospital and special hospital;

(2) "long-term care facility" means a nursing home licensed by the authority to provide intermediate or skilled nursing care; and

(3) "primary care clinic" means a community-based clinic that provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services and, if integrated into the clinic's service array, mental health services.

History: Laws 2004, ch. 44, § 2; 2004, ch. 50, § 2; § 24-1-5.9, recompiled and amended as § 24A-1-8 by Laws 2024, ch. 39, § 29.

24A-1-9. Federal participation required; exception.

A. Except as provided in Subsection B of this section, all programs, clinics, hospitals and other health-related centers and entities, including those identified by the authority pursuant to Paragraph (3) of Subsection A of Section 27-2-12.13 NMSA 1978, that are eligible under Section 340B of the federal Public Health Service Act, including hospitals and clinics licensed under the state Health Care Code, shall participate in that Section 340B federal prescription drug price discount program.

B. If an entity described in Subsection A of this section can demonstrate to the satisfaction of the authority that the prescription drug price discount it receives other than through the Section 340B program results in greater savings to the state, the entity may be granted an exception to the requirements of this section.

History: Laws 2004, ch. 47, § 1; § 24-1-5.10 recompiled and amended as § 24A-1-9 by Laws 2024, ch. 39, § 30.

24A-1-10. Rural emergency hospital licensure; licensing requirements.

A. The authority shall promulgate rules to establish a rural emergency hospital license that enables certain hospitals to apply to receive federal health care reimbursement as rural emergency hospitals.

B. The authority shall only issue a rural emergency hospital license to a health facility that:

(1) on December 27, 2020, was:

(a) designated as a critical access hospital by the centers for medicare and medicaid services; or

(b) licensed as a hospital with less than fifty licensed beds and located in a county in a rural area as defined in Section 1886(d)(2)(D) or Section 1886(d)(8)(E) of the federal Social Security Act;

(2) provides rural emergency hospital services in the facility twenty-four hours per day and is staffed twenty-four hours per day, seven days per week with a physician, nurse practitioner, clinical nurse specialist or physician assistant;

(3) has a transfer agreement in effect with a level 1 or level 2 trauma center;

(4) does not have an annual average patient length of stay over twenty-four hours; and

(5) meets any other requirements that the authority finds necessary to implement state licensure and satisfy centers for medicare and medicaid services requirements for reimbursement as a rural emergency hospital.

C. A health facility that applies to the authority for licensure as a rural emergency hospital shall include with the licensure application:

(1) an action plan for initiating rural emergency hospital services, including a detailed transition plan that lists the specific services that the facility will retain, modify, add and discontinue;

(2) a description of services that the facility intends to provide on an outpatient basis; and

(3) any other information required by rules of the authority.

D. A rural emergency hospital shall not have inpatient beds, but a rural emergency hospital may have a unit that is a distinct part of the hospital that is licensed as a skilled nursing facility and provides post-hospital extended care services.

E. For the purposes of this section,"rural emergency hospital" means a health facility that provides emergency and observational care and meets the licensure requirements outlined in Subsection B of this section.

History: Laws 2023, ch. 109, § 1; § 24-1-5.12, recompiled and amended as § 24A-1-10 by Laws 2024, ch. 39, § 31.

24A-1-11. Lay caregiver; aftercare; designation.

A. A hospital shall provide each patient or the patient's legal guardian with an opportunity to designate one lay caregiver following the patient's admission into a hospital and before the patient's discharge to the patient's residence.

B. As soon as practicable, a hospital shall attempt to consult with a designated lay caregiver to prepare the lay caregiver to provide aftercare. The hospital shall provide the lay caregiver with a discharge plan for the patient that describes the patient's aftercare needs. This discharge plan:

(1) may include, but is not limited to:

(a) culturally competent training on how to provide care and tasks;

(b) medication management guidelines;

(c) aftercare guidelines; and

(d) an identification of tasks that the discharging health care provider specifies;

(2) shall reflect the active engagement of a patient or lay caregiver in the discharge planning process and incorporate a patient's goals and preferences as much as possible; and

(3) shall educate a lay caregiver in a manner that is consistent with current accepted practices and is based on an assessment of the lay caregiver's learning needs.

C. A hospital shall allow a patient to change the patient's designation of a lay caregiver in the event that the originally designated lay caregiver becomes unavailable, unwilling or unable to care for the patient.

D. Designation of an individual as a lay caregiver pursuant to this section does not obligate that person to accept the role of lay caregiver for the patient.

E. The provisions of this section shall not be construed to require a patient to designate a lay caregiver.

F. In the event that a patient or a patient's legal guardian declines to designate a lay caregiver pursuant to this section, a hospital shall promptly document this refusal to designate a lay caregiver in the patient's medical record.

G. A hospital shall not allow the process of appointing or refusal or failure to appoint a lay caregiver for a patient to interfere with, delay or otherwise affect the services that the hospital provides to a patient.

H. In the event that a hospital is unable to contact a designated lay caregiver, this lack of contact shall not interfere with or otherwise affect an appropriate discharge of the patient.

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

(1) create a private right of action against a hospital, hospital employee, contractor having a contractual relationship with a hospital or duly authorized agent of a hospital; or

(2) remove the obligation of a third-party payer to cover any health care item or service that the third-party payer is obligated to provide to a patient pursuant to the terms of a valid agreement, insurance policy, plan or certificate of coverage or health maintenance organization contract.

J. A hospital, hospital employee, contractor having a contractual relationship with a hospital or duly authorized agent of a hospital shall not be held liable in any way for an act or omission of a lay caregiver.

K. As used in this section:

(1) "aftercare" means assistance provided in a private home by a designated lay caregiver to a patient after the patient's discharge from a hospital. "Aftercare" includes exclusively those tasks related to a patient's condition at the time of discharge that do not require the lay caregiver performing the tasks to be a licensed, certified or otherwise authorized health care provider;

(2) "discharge" means a patient's exit or release from a hospital to that patient's residence following an inpatient stay;

(3) "hospital" means a health facility licensed as a general acute hospital by the authority;

(4) "lay caregiver" means a person who is eighteen years of age or older, who has been designated as a lay caregiver pursuant to this section and who provides aftercare to a patient in the patient's residence; and

(5) "residence" means a dwelling considered by a patient to be the patient's home, not including a hospital, nursing home or group home or assisted living facility.

History: Laws 2015, ch. 155, § 1; § 24-1-37, recompiled and amended as § 24A-1-11 by Laws 2024, ch. 39, § 32.

24A-1-12. Methadone clinics; regulation by the authority.

A. The federal government requires the state to approve the establishment of all new methadone clinics. In an effort to maintain compliance with the federal requirement, the authority shall regulate the establishment and continuance of methadone clinics in New Mexico in accordance with its powers and duties.

B. In regulating methadone clinics, the authority shall perform an assessment of the need for clinics and develop clinical and administrative standards as required by federal law. The authority may consider other factors it deems necessary to ensure the provision of drug abuse treatment services and the protection of the health and safety of New Mexico residents.

C. For the purposes of this section, "methadone clinic" means a public or private facility that dispenses methadone for the detoxification treatment or maintenance treatment of narcotic addicts.

History: Laws 2003, ch. 190, § 1; 2007, ch. 325, § 7; § 24-1-5.7, recompiled and amended as § 24A-1-12 by Laws 2024, ch. 39, § 33.

24A-1-13. Health facilities; certified nurse practitioners; certified nurse-midwives; privileges; parity with physicians.

A. Unless required by federal law, a health facility shall establish the same criteria for granting patient admitting or discharge privileges or in authorizing continuing patient care for certified nurse practitioners, certified nurse-midwives and clinical nurse specialists as the health facility has established for physicians.

B. A health facility shall ensure that certified nurse practitioners, certified nurse-midwives and clinical nurse specialists acting in accordance with these professionals' respective scopes of practice under New Mexico law are:

(1) eligible to serve on the health facility's medical staff;

(2) credentialed under the same procedures as the health facility has established for physicians; and

(3) authorized to conduct peer review of their professional colleagues.

C. As used in this section:

(1) "certified nurse-midwife" means a person licensed as a registered nurse pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978] and licensed by the department of health as a certified nurse-midwife;

(2) "certified nurse practitioner" means a registered nurse who is licensed by the board of nursing for advanced practice as a certified nurse practitioner pursuant to the Nursing Practice Act;

(3) "clinical nurse specialist" means a registered nurse who is licensed by the board of nursing for advanced practice as a clinical nurse specialist and whose name and pertinent information are entered on the list of clinical nurse specialists maintained by the board of nursing;

(4) "health facility" means a health facility licensed by the authority; and

(5) "physician" means a person licensed to practice as a medical doctor or an osteopathic physician.

History: Laws 2019, ch. 129, § 1; § 24-1-41, recompiled and amended as § 24A-1-13 by Laws 2024, ch. 39, § 34.

24A-1-14. Primary care council created; duties.

A. The secretary shall create the "primary care council" to:

(1) develop a shared description of primary care practitioners and services;

(2) analyze annually the proportion of health care delivery expenditures allocated to primary care statewide;

(3) review national and state models of optimal primary care investment with the objectives of increasing access to primary care, improving the quality of primary care services and lowering the cost of primary care delivery statewide;

(4) review New Mexico state and county data and information about barriers to accessing primary care services faced by New Mexico residents;

(5) recommend policies, rules and legislation to increase access to primary care, improve the quality of primary care services and lower the cost of primary care delivery while reducing overall health care costs;

(6) coordinate efforts with the graduate medical education expansion review board and other primary care workforce development initiatives to devise a plan that addresses primary care workforce shortages within the state;

(7) report annually to the interim legislative health and human services committee and the legislative finance committee on ways that primary care investment could increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs; and

(8) develop and present to the secretary a five-year plan to determine how primary care investment could increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs.

B. The primary care council shall include nine voting members and thirteen advisory members, appointed by the secretary, and shall consist of:

(1) one member from the authority;

(2) one member from the department of health;

(3) one member from the office of superintendent of insurance;

(4) one member from a statewide organization representing federally qualified health centers in New Mexico;

(5) five members from statewide organizations representing primary care providers or statewide health professional societies or associations; and

(6) thirteen nonvoting members representing health care and other stakeholders, in an advisory capacity.

C. The chair of the primary care council shall be elected by the voting members of the council.

D. The council shall meet at the call of the chair.

E. Members of the council shall not be paid per diem and mileage or other compensation for their services.

F. The authority shall provide staff support for the council in the performance of its duties.

G. A simple majority of the voting members of the council constitutes a quorum.

H. The council shall hold its first meeting no later than October 1, 2021.

History: Laws 2021, ch. 87, § 3; § 24-1K-3, recompiled and amended as § 24A-1-14 by Laws 2024, ch. 39, § 35.

24A-1-15. Primary stroke centers; comprehensive stroke centers; acute stroke capable centers; authority certification; rulemaking.

A. In accordance with authority rules, the authority shall certify any acute care hospital as a primary stroke center, comprehensive stroke center or acute stroke capable center if that hospital has been accredited by the joint commission or any other nationally recognized accrediting body as a primary stroke center, comprehensive stroke center or acute stroke capable center. The authority shall post information regarding certification on the authority's website. If a hospital loses accreditation as a primary stroke center, comprehensive stroke center or acute stroke capable center, the secretary shall also remove that hospital's certification.

B. In accordance with authority rules, the emergency medical systems bureau of the department of health shall work in coordination with all local and regional emergency medical services authorities statewide on the development of pre-hospitalization protocols related to the assessment, treatment and transport of stroke patients by licensed emergency medical services providers. These protocols shall include, at a minimum, plans for the triage and transport of stroke patients to the closest comprehensive or primary stroke center or, when appropriate, to an acute stroke capable center.

C. The secretary may adopt rules to assist and encourage primary stroke centers to enter into coordinated stroke care agreements with other health care facilities throughout the state to provide appropriate access to care for acute stroke patients.

History: Laws 2012, ch. 4, § 1; 2015, ch. 90, § 1; § 24-1-34, recompiled and amended as § 24A-1-15 by Laws 2024, ch. 39, § 36.

24A-1-16. Assisted living facilities contracts; limit on charges after resident death.

A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.

B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.

C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the authority.

History: Laws 2013, ch. 114, § 1; § 24-1-35, recompiled and amended as § 24A-1-16 by Laws 2024, ch. 39, § 37.

24A-1-17. Rural health care delivery fund; grants; applications; awards.

A. The "rural health care delivery fund" is created as a nonreverting fund in the state treasury. The fund consists of appropriations, gifts, grants, donations, income from investment of the fund and any other revenue credited to the fund. The authority shall administer the fund, and money in the fund is appropriated to the authority to carry out the provisions of this section. Expenditures shall be by warrant of the secretary of finance and administration pursuant to vouchers signed by the secretary or the secretary's authorized representative.

B. A rural health care provider or rural health care facility may apply to the authority for a grant to defray operating losses, including rural health care provider or rural health care facility start-up costs, incurred in providing inpatient, outpatient, primary, specialty or behavioral health care services to New Mexico residents. The authority may award a grant from the rural health care delivery fund to a rural health care provider or rural health care facility that is providing a new or expanded health care service as approved by the authority that covers operating losses for the new or expanded health care service, subject to the following conditions and limitations:

(1) the rural health care provider or rural health care facility meets state licensing requirements to provide health care services and is an enrolled medicaid provider that actively serves medicaid recipients;

(2) grants are for one year and for no more than the first five years of operation as a newly constructed rural health care facility or the operation of a new or expanded health care service;

(3) grants are limited to covering operating losses for which recognized revenue is not sufficient;

(4) the rural health care provider or rural health care facility provides adequate cost data, as defined by rule of the authority, based on financial and statistical records that can be verified by qualified auditors and which data are based on an approved method of cost finding and the accrual basis of accounting and can be confirmed as having been delivered through review of claims;

(5) grant award amounts shall be reconciled by the authority to audited operating losses after the close of the grant period;

(6) in the case of a rural health care provider, the provider commits to:

(a) a period of operation equivalent to the number of years grants are awarded; and

(b) actively serve medicaid recipients throughout the duration of the grant period; and

(7) in prioritizing grant awards, the authority shall consider the health needs of the state and the locality and the long-term sustainability of the new or expanded service.

C. As used in this section:

(1) "allowable costs" means necessary and proper costs defined by rule of the authority based on medicare reimbursement principles, including reasonable direct expenses, but not including general overhead and management fees paid to a parent corporation;

(2) "health care services" means services for the diagnosis, prevention, treatment, cure or relief of a physical, dental, behavioral or mental health condition, substance use disorder, illness, injury or disease and for medical or behavioral health ground transportation;

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

(4) "medicaid provider" means a person that provides medicaid-related services to medicaid recipients;

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

(6) "operating losses" means the projected difference between recognized revenue and allowable costs for a grant request period;

(7) "recognized revenue" means operating revenue, including revenue directly related to the rendering of patient care services and revenue from nonpatient care services to patients and persons other than patients; the value of donated commodities; supplemental payments; distributions from the safety net care pool fund; and distributions of federal funds;

(8) "rural health care facility" means a health care facility licensed in the state that provides inpatient or outpatient physical or behavioral health services or programmatic services in a county that has a population of one hundred thousand or fewer according to the most recent federal decennial census;

(9) "rural health care provider" means an individual health professional licensed by the appropriate board, a medical or behavioral health ground transportation entity licensed by the public regulation commission or a health facility organization licensed by the authority to provide health care diagnosis and treatment of physical or behavioral health or programmatic services in a county that has a population of one hundred thousand or fewer according to the most recent federal decennial census; and

(10) "start-up costs" means the planning, development and operation of rural health care services, including legal fees; accounting fees; costs associated with leasing equipment, a location or property; depreciation of equipment costs; and staffing costs. "Start-up costs" does not mean the construction or purchase of land or buildings.

History: 1978 Comp., § 24A-1-17, enacted by Laws 2024, ch. 39, § 38.

24A-1-18. Disclosure by medicare health care providers; limitation on charges to recipient of services.

A. As used in this section:

(1) "health care provider" means any person who provides health care services the charges for which either he or the recipient of the services is eligible for payment or reimbursement of under provisions of the federal medicare program; and

(2) "recipient" means a person who is eligible under the federal medicare program provisions for reimbursement to him or payment on his behalf for charges for health care services.

B. A health care provider shall disclose to a recipient before providing services the provider's policy regarding whether or not the provider accepts assignment of medicare benefits.

History: Laws 1987, ch. 157, § 1; § 24-1-23, recompiled as § 24A-1-18 by Laws 2024, ch. 39, § 132.

24A-1-19. Mammograms; health facilities; breast density disclosure.

A. A health facility that performs a mammogram examination shall include in the summary of the mammography report that is required pursuant to federal law to be provided to a patient information that identifies the patient's individual breast density classification based on the breast imaging reporting and data system established by the American college of radiology. If the health facility determines that a patient has heterogeneously dense or extremely dense breast tissue, the summary of the mammography report shall include the following notice:

"Your mammogram indicates that you have dense breast tissue. Dense breast tissue is common and is not abnormal. However, dense breast tissue may make it harder to evaluate the results of your mammogram. It may also be associated with an increased risk of breast cancer. This information is being provided to raise your awareness and to inform your conversation with your health care provider. Together, you can decide if additional screening options may be right for you. A report of your results was sent to your health care provider.".

B. A health facility may direct a patient who receives a diagnostic or screening mammogram to information about breast density, which may include:

(1) the American college of radiology's most current brochure on the subject of breast density available on the American college of radiology's website;

(2) materials related to cancer or mammography produced by an educational institution; or

(3) materials related to cancer or mammography produced by an advocacy organization.

C. Nothing in this section shall be deemed to create a duty of care or other legal obligation beyond the duty to provide notice as set forth in Subsection A of this section. Nothing in this section shall be deemed to require a notice that is inconsistent with the provisions of the federal Mammography Quality Standards Act of 1992 or any regulations promulgated pursuant to that act.

History: Laws 2019, ch. 4, § 1; § 24-1-39, recompiled as § 24A-1-19 by Laws 2024, ch. 39, § 132.

24A-1-20. Eligibility for state or local health benefits.

A. A state or local health benefit shall be provided to all non-citizens, regardless of immigration status, if they meet all other qualifying criteria for such benefit.

B. For purposes of this section:

(1) "health care services" means treatment and services designed to promote improved health, including primary care, prenatal care, dental care, behavioral health care, provision of prescription drugs, preventive care or health outreach services, provided by a state agency, county, local government or state educational institution named in Article 12, Section 11 of the constitution of New Mexico or an entity with which the state agency, county, local government or state educational institution named in Article 12, Section 11 of the constitution of New Mexico contracts to provide such services; and

(2) "state or local health benefit" means any health benefit for which payments, assistance or health care services are provided to an individual, household or family eligibility unit by an agency of the state, a county, a local government or a state educational institution named in Article 12, Section 11 of the constitution of New Mexico or by appropriated funds of the state, a county, a local government or a state educational institution named in Article 12, Section 11 of the constitution of New Mexico, as permitted by federal law. "State or local health benefit" includes care or services for indigent persons or patients provided or funded pursuant to the Hospital Funding Act

[Chapter 4, Article 48B NMSA 1978] or the Indigent Hospital and County Health Care Act [Chapter 27, Article 5 NMSA 1978].

History: Laws 2021, ch. 127, § 1; § 24-1-42, recompiled as § 24A-1-20 by Laws 2024, ch. 39, § 132.

ARTICLE 2
Health Facility Receivership

24A-2-1. Short title.

Chapter 24A, Article 2 NMSA 1978 may be cited as the "Health Facility Receivership Act".

History: 1978 Comp., § 24-1E-1, enacted by Laws 1996, ch. 35, § 4; 2001, ch. 225, § 1; recompiled and amended as § 24A-2-1 by Laws 2024, ch. 39, § 39.

24A-2-2. Definitions.

As used in the Health Facility Receivership Act:

A. "health facility" includes community-based programs providing services funded, directly or indirectly, in whole or in part, by the home and community-based medicaid waiver program or by developmental disabilities, traumatic brain injury or other medical disabilities programs; and

B. "receiver" means the secretary, upon appointment pursuant to the Health Facility Receivership Act."

History: 1978 Comp., § 24-1E-2, enacted by Laws 1996, ch. 35, § 5; 2001, ch. 225, § 2; recompiled and amended as § 24A-2-2 by Laws 2024, ch. 39, § 40.

24A-2-3. Health facility receiverships authorized; venue.

A. The secretary may file a verified petition in the district court seeking appointment as receiver of a health facility if the facility:

(1) is being operated without a valid license from the authority;

(2) will be closed within sixty days and adequate arrangements to relocate its residents have not been submitted to and approved by the secretary;

(3) has been abandoned, its residents have been abandoned or such abandonment is imminent; or

(4) presents a situation, physical condition, practice or method of operation that the secretary finds presents an imminent danger of death or significant mental or physical harm to its residents or other persons.

B. The proceedings shall be governed by, and the receiver's powers and duties shall be as specified in, the Receivership Act [44-8-1 to 44-8-10 NMSA 1978], supplemented as provided in the Health Facility Receivership Act.

C. Venue shall be laid in the district court for Santa Fe county or any other county in which the health facility or any of its satellite facilities is located.

D. Service of process shall be made in any manner provided by the Rules of Civil Procedure for the District Courts. If personal service cannot practicably or promptly be made as so provided, service may be made by delivery of the summons with the petition attached to any person in charge of the health facility at the time service is made.

E. The health facility shall file a responsive pleading within ten days after the date service is made or within such time as directed by the district court.

History: 1978 Comp., § 24-1E-3, enacted by Laws 1996, ch. 35, § 6; recompiled and amended as § 24A-2-3 by Laws 2024, ch. 39, § 41.

24A-2-4. Rulemaking.

The secretary shall promulgate rules to implement the provisions of the Health Facility Receivership Act. As a minimum, the rules shall establish:

A. conditions under which a petition for a health facility receivership may be filed;

B. the duties, authority and responsibilities of the deputy receiver and the health facility;

C. the specific authority of the deputy receiver to impose financial conditions and requirements on the health facility;

D. minimum qualifications for deputy receivers; and

E. provisions that will be requested for inclusion in district court orders entered pursuant to the Health Facility Receivership Act.

History: Laws 2001, ch. 225, § 4; § 24-1E-3.1, recompiled and amended as § 24A-2-4 by Laws 2024, ch. 39, § 42.

24A-2-5. Hearing on petition.

A. Except in the case of an ex parte hearing under the Receivership Act [44-8-1 to 44-8-10 NMSA 1978], the district court shall hold a hearing on the petition within ten days after the petition is filed or as soon thereafter as practicable. The health facility shall be given notice of the hearing at least five days before the hearing date.

B. In the case of an ex parte hearing under the Receivership Act, the district court may enter an order appointing the secretary as temporary receiver, with all the rights and responsibilities of a receiver, for ten days or until a hearing can be held on the petition.

C. Following hearing, the district court shall appoint the secretary as receiver if it finds that any of the conditions of Subsection A of Section 24-1E-3 NMSA 1978 exists.

D. Following any regular or ex parte hearing, the district court may appoint a qualified person, experienced in health facility management, to act as deputy receiver. The person appointed as deputy receiver shall be free of conflict of interest with the health facility that is in receivership.

E. The receiver's bond shall be deemed satisfied by his bond under the Surety Bond Act [10-2-13 to 10-2-16 NMSA 1978]. If a deputy receiver is not a public employee covered under the Surety Bond Act, he shall obtain a fidelity and performance bond in an amount determined by the court. The cost of the bond shall be paid from the receivership estate.

History: 1978 Comp., § 24-1E-4, enacted by Laws 1996, ch. 35, § 7; 2001, ch. 225, § 3; recompiled as § 24A-2-5 by Laws 2024, ch. 39, § 132.

24A-2-6. Receiver's powers and duties.

A. In addition to the receiver's powers and duties under the Receivership Act [44-8-1 to 44-8-10 NMSA 1978], the secretary as receiver and any deputy receiver under the Health Facility Receivership Act shall, except as the district court may otherwise order:

(1) perform all acts that are necessary to:

(a) correct or remedy each condition on which the receiver's appointment was based;

(b) ensure adequate care and necessary services for each resident or other person in the health facility;

(c) bring the facility into compliance with all applicable state and federal laws, rules and regulations; and

(d) manage and operate the health facility, including closing down, expanding or initiating new operations, hiring and firing officers and employees, contracting for

necessary services, personnel, supplies, equipment, facilities and all other appropriate things, purchasing, selling, marshaling and otherwise managing its property and assets, paying the facility's obligations that are directly related to the health facility's operations or for providing adequate care and necessary services to residents or for other persons in the health facility, borrowing money and property and giving security for these and expending funds of the facility;

(2) give notice of establishment of the receivership to interested persons and publish notice in a newspaper of general circulation in each county in which the health care facility and any of its satellite facilities is located;

(3) if a resident or other person in the health facility is to be discharged or transferred, discuss the options for alternative placement with the resident, other person in the health facility or the guardian of that resident or other person in the health facility, as applicable, and arrange to transfer the records and personal property of the resident or other person in the health facility to the alternative placement facility; and

(4) with the court's approval, void any lease, mortgage, secured transaction, contract or other agreement made prior to the appointment of the receiver or any transfer of money or property made within one year prior to the filing of the petition if such lease, mortgage, secured transaction, contract, agreement or other transfer of money or property was made without fair consideration, including excessive interest rate, was made with actual intent to hinder, delay or defraud either future or existing creditors, was made with shareholders or owners of the health facility or persons otherwise having an interest in the health facility or was unrelated to the normal and expected maintenance and operation of the health facility.

B. If, in the exercise of the receiver's powers pursuant to this section, the receiver is in possession of real estate, real or personal property or other goods or services subject to a lease, mortgage, secured transaction, contract or other agreement subject to being voided by the receiver pursuant to Paragraph (4) of Subsection A of this section, and such real estate, real or personal property or other goods or services are necessary for the continued operation of the health facility during the receivership, the receiver may, in lieu or [of] seeking to void such lease, mortgage, secured transaction, contract or other agreement, apply to the court to set a reasonable price, rate or rate of interest to be paid by the receiver under such lease, mortgage, secured transaction, contract or other agreement during the duration of the receivership. The receiver shall send notice of such an application to any known parties of the property, services or goods involved and shall publish the notice once at least thirty days prior to the hearing date in a newspaper of general circulation, and the court shall hold a hearing on the receiver's application within thirty days after the filing of the application by the receiver. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or possession of the real estate, real or personal property or other goods or services, or to revocation of such services subject to the lease, mortgage, secured transaction, contract or other agreement. Payment by the receiver of the amount determined by the court to be reasonable shall not relieve

the health facility from any liability upon termination of the receivership for the difference between the amount paid by the receiver and the amount due under the original lease, mortgage, secured transaction, contract or other agreement.

C. Nonpayment by the receiver of any debt of the health facility under a lease, mortgage, secured transaction, contract or other agreement reasonably deemed by the receiver not to be directly related to the health facility's operations or for providing adequate care and necessary services to residents or other persons in the health facility shall not subject the receiver to liability for payment. Nonpayment of any lease, mortgage, secured transaction, contract or other agreement reasonably deemed by the receiver not to be directly related to the health facility's operations or for providing adequate care and necessary services to residents or other persons in the health facility shall not relieve the health facility from any liability upon termination of the receivership for payment of the full amount due under the lease, mortgage, secured transaction, contract or other agreement.

D. A deputy receiver shall have the same powers and duties as the receiver, unless the court orders otherwise.

History: 1978 Comp., § 24-1E-5, enacted by Laws 1996, ch. 35, § 8; 2007, ch. 58, § 1; recompiled as § 24A-2-6 by Laws 2024, ch. 39, § 132.

24A-2-7. Termination of receivership.

The receivership shall terminate when the conditions that led to its establishment, and any other conditions that constitute grounds for establishment of a receivership, have ceased to exist. If the health facility is insolvent or otherwise financially distressed, the receivership shall terminate upon filing of federal bankruptcy proceedings, unless the district court orders otherwise.

History: 1978 Comp., § 24-1E-6, enacted by Laws 1996, ch. 35, § 9; recompiled as § 24A-2-7 by Laws 2024, ch. 39, § 132.

24A-2-8. Facility may seek modification or termination.

A health facility under receivership may petition the court at any time for modification or termination of the order of receivership.

History: Laws 2001, ch. 225, § 5; § 24-1E-7, recompiled as § 24A-2-8 by Laws 2024, ch. 39, § 132.

ARTICLE 3
Interagency Behavioral Health Purchasing

24A-3-1. Interagency behavioral health purchasing collaborative.

A. The "interagency behavioral health purchasing collaborative" is created, consisting of the secretaries of health care authority, aging and long-term services, Indian affairs, health, corrections, children, youth and families, early childhood education and care, finance and administration, workforce solutions, public education and transportation or their designees; the directors of the administrative office of the courts, the retiree health care authority, the governor's commission on disability, the developmental disabilities council, the instructional support and vocational education division of the public education department and the New Mexico health policy commission or their designees; and the governor's health policy coordinator. The collaborative shall be chaired by the secretary of health care authority with the respective secretaries of health and children, youth and families alternating annually as co-chairs.

B. The collaborative shall meet regularly and at the call of either co-chair and shall:

(1) identify behavioral health needs statewide, with an emphasis on that hiatus between needs and services set forth in the authority's gap analysis and in ongoing needs assessments, and develop a master plan for statewide delivery of services;

(2) give special attention to regional differences, including cultural, rural, frontier, urban and border issues;

(3) inventory all expenditures for behavioral health, including mental health and substance abuse;

(4) plan, design and direct a statewide behavioral health system, ensuring both availability of services and efficient use of all behavioral health funding, taking into consideration funding appropriated to specific affected departments; and

(5) contract for operation of one or more behavioral health entities to ensure availability of services throughout the state.

C. The plan for delivery of behavioral health services shall include specific service plans to address the needs of infants, children, adolescents, adults and seniors, as well as to address workforce development and retention and quality improvement issues. The plan shall be revised every two years and shall be adopted by the authority as part of the statewide health plan.

D. The plan shall take the following principles into consideration, to the extent practicable and within available resources:

(1) services should be individually centered and family-focused based on principles of individual capacity for recovery and resiliency;

(2) services should be delivered in a culturally responsive manner in a home- or community-based setting, where possible;

(3) services should be delivered in the least restrictive and most appropriate manner;

(4) individualized service planning and case management should take into consideration individual and family circumstances, abilities and strengths and be accomplished in consultation with appropriate family, caregivers and other persons critical to the individual's life and well-being;

(5) services should be coordinated, accessible, accountable and of high quality;

(6) services should be directed by the individual or family served to the extent possible;

(7) services may be consumer- or family-provided, as defined by the collaborative;

(8) services should include behavioral health promotion, prevention, early intervention, treatment and community support; and

(9) services should consider regional differences, including cultural, rural, frontier, urban and border issues.

E. The collaborative shall seek and consider suggestions of Native American representatives from Indian nations, tribes and pueblos and the urban Indian population, located wholly or partially within New Mexico, in the development of the plan for delivery of behavioral health services.

F. Pursuant to the State Rules Act [Chapter 14, Article 4 NMSA 1978], the collaborative shall adopt rules through the authority for:

(1) standards of delivery for behavioral health services provided through contracted behavioral health entities, including:

(a) quality management and improvement;

(b) performance measures;

(c) accessibility and availability of services;

(d) utilization management;

(e) credentialing of providers;

(f) rights and responsibilities of consumers and providers;

(g) clinical evaluation and treatment and supporting documentation; and

(h) confidentiality of consumer records; and

(2) approval of contracts and contract amendments by the collaborative, including public notice of the proposed final contract.

G. The collaborative shall, through the authority, submit a separately identifiable consolidated behavioral health budget request. The consolidated behavioral health budget request shall account for requested funding for the behavioral health services program at the authority and any other requested funding for behavioral health services from agencies identified in Subsection A of this section that will be used pursuant to Paragraph (5) of Subsection B of this section. Any contract proposed, negotiated or entered into by the collaborative is subject to the provisions of the Procurement Code [13-1-28 to 13-1-199 NMSA 1978].

H. The collaborative shall, with the consent of the governor, appoint a "director of the collaborative". The director is responsible for the coordination of day-to-day activities of the collaborative, including the coordination of staff from the collaborative member agencies.

I. The collaborative shall provide a quarterly report to the legislative finance committee on performance outcome measures. The collaborative shall submit an annual report to the legislative finance committee and the interim legislative health and human services committee that provides information on:

(1) the collaborative's progress toward achieving its strategic plans and goals;

(2) the collaborative's performance information, including contractors and providers; and

(3) the number of people receiving services, the most frequently treated diagnoses, expenditures by type of service and other aggregate claims data relating to services rendered and program operations.

History: Laws 2004, ch. 46, § 8; 2008, ch. 69, § 1; 2022, ch. 30, § 1; § 9-7-6.4, recompiled and amended as § 24A-3-1 by Laws 2024, ch. 39, § 43.

24A-3-2. Behavioral health planning council created; powers and duties; membership.

A. The "behavioral health planning council" is created. The council consists of the following members, all of whom shall be appointed by and serve at the pleasure of the governor:

(1) consumers of behavioral health services and consumers of substance abuse services, as follows:

(a) adults with serious mental illness;

(b) seniors;

(c) family members of adults with serious mental illness and of children with serious emotional or neurobiological disorders; and

(d) persons with co-occurring disorders;

(2) Native American representatives from a pueblo, an Apache tribe, the Navajo Nation and an urban Native American population;

(3) providers;

(4) state agency representation from agencies responsible for:

(a) adult mental health and substance abuse;

(b) children's mental health and substance abuse;

(c) education;

(d) vocational rehabilitation;

(e) criminal justice;

(f) juvenile justice;

(g) housing;

(h) medicaid and social services;

(i) health policy planning;

(j) developmental disabilities planning; and

(k) disabilities issues and advocacy;

(5) such other members as the governor may appoint to ensure appropriate cultural and geographic representation; and

(6) advocates.

B. Providers and state agency representatives together may not constitute more than forty-nine percent of the council membership.

C. The council shall:

(1) advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;

(2) report annually to the governor and the legislature on the adequacy and allocation of mental health services throughout the state;

(3) encourage and support the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;

(4) advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in Section 24A-3-1 NMSA 1978;

(5) meet regularly and at the call of the chair, who shall be selected by the council membership from among its members;

(6) establish subcommittees, to meet at least quarterly, as follows:

(a) a medicaid subcommittee, chaired by the secretary of health care authority or a designee, which may also serve as a subcommittee of the medicaid advisory committee;

(b) a child and adolescent subcommittee, chaired by the secretary of children, youth and families or a designee;

(c) an adult subcommittee, chaired by the secretary of health care authority or a designee;

(d) a substance abuse subcommittee, chaired by the secretary of health or a designee, which shall include DWI issues and shall include representation from local DWI councils;

(e) a Native American subcommittee, chaired by the secretary of Indian affairs or a designee; and

(f) other subcommittees as may be established by the chair of the council to address specific issues. All subcommittees may include nonvoting members appointed by the chair for purposes of providing expertise necessary to the charge of the respective subcommittee;

(7) review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for medicaid services and any other plan or application for federal or foundation funding for behavioral health services; and

(8) replace the governor's mental health planning council and act in accordance with Public Law 102-321 of the federal Public Health Service Act.

History: Laws 2004, ch. 46, § 2; 2005, ch. 7, § 1; § 24-1-28, recompiled and amended as § 24A-3-2 by Laws 2024, ch. 39, § 44.

24A-3-3. Incarcerated persons; behavioral health services; county funding program.

To carry out the provisions of Subsection E of Section 9-8-7.1 NMSA 1978 and to provide behavioral health services to persons who are incarcerated in a county correctional facility:

A. the secretary shall adopt and promulgate rules:

(1) pursuant to which a county may apply for and be awarded funding through the authority; and

(2) to establish priorities and guidelines for the award of funding to counties; and

B. the authority shall distribute funds, as funding permits, to the county health care assistance funds of those counties:

(1) that apply for behavioral health services funding in accordance with authority rules; and

(2) whose proposed utilization of funding pursuant to this section meets the priorities and guidelines for the awarding of behavioral health services funding established in authority rules.

History: Laws 2019, ch. 222, § 2; 2023, ch. 205, § 10; § 9-8-7.3, recompiled and amended as § 24A-3-3 by Laws 2024, ch. 39, § 45.

24A-3-4. Residential behavioral health facilities; family notification; civil penalties.

A. A residential behavioral health facility shall not admit a patient for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient. If the patient provides the

contact information, the residential behavioral health facility shall make immediate efforts to provide the patient with the opportunity to notify the patient's family member that the patient has been admitted. The residential behavioral health facility shall continue to make efforts to provide the patient with the opportunity to notify the patient's family member until the patient's family member is notified that the patient has been admitted.

B. A residential behavioral health facility that fails to comply with the requirements of this section shall be assessed a civil penalty not to exceed seven hundred fifty dollars ($750). For any subsequent violation of this section, the residential behavioral health facility shall be assessed a civil penalty not to exceed one thousand dollars ($1,000).

C. For the purposes of this section, "residential behavioral health facility" means a licensed health facility that provides residential treatment to patients with behavioral health issues.

History: Laws 2024, ch. 45, § 1.

ARTICLE 4
Health Care Practitioner Agreements

24A-4-1. Definitions.

As used in Chapter 24, Article 1I NMSA 1978 [Chapter 24A, Article 4 NMSA 1978]:

A. "agreement" means a written contract to which a health care practitioner is a party; and

B. "health care practitioner" means:

(1) a dentist;

(2) an osteopathic physician;

(3) a physician;

(4) a podiatrist;

(5) a certified registered nurse anesthetist;

(6) a certified nurse practitioner;

(7) a certified nurse-midwife;

(8) a psychologist;

(9) a physician assistant; and

(10) a pharmacist.

History: Laws 2015, ch. 96, § 1; 2017, ch. 123, § 1; 2023, ch. 97, § 1; § 24-1I-1, recompiled as § 24A-4-1 by Laws 2024, ch. 39, § 132.

24A-4-2. Enforceability of a non-compete provision; other provisions void.

A. A non-compete provision in an agreement, which provision restricts the right of a health care practitioner to provide clinical health care services in this state, shall be unenforceable upon the termination of:

(1) the agreement;

(2) a renewal or extension of the agreement; or

(3) a health care practitioner's employment with a party seeking to enforce the agreement.

B. A provision in an agreement for clinical health care services to be rendered in this state is void, unenforceable and against public policy if the provision:

(1) makes the agreement subject to the laws of another state; or

(2) requires any litigation arising out of the agreement to be conducted in another state.

History: Laws 2015, ch. 96, § 2; 2017, ch. 123, § 2; § 24-1I-2, recompiled as § 24A-4-2 by Laws 2024, ch. 39, § 132.

24A-4-3. Enforceability of other provisions.

Nothing in this act shall be construed to limit the enforceability of:

A. a provision in an agreement requiring a health care practitioner who has worked for an employer for an initial period of less than three years to repay all or a portion of:

(1) a loan;

(2) relocation expenses;

(3) a signing bonus or other remuneration to induce the health care practitioner to relocate or establish a health care practice in a specified geographic area; or

(4) recruiting, education and training expenses;

B. a nondisclosure provision relating to confidential information and trade secrets;

C. a nonsolicitation provision with respect to patients and employees of the party seeking to enforce the agreement for a period of one year or less after the last date of employment; or

D. any other provision of an agreement that is not in violation of law, including a provision for liquidated damages.

History: Laws 2015, ch. 96, § 3; § 24-1I-3, recompiled as § 24A-4-3 by Laws 2024, ch. 39, § 132.

24A-4-4. Liquidated damages.

A. An agreement may provide for liquidated damages in an amount that is reasonable at the time the agreement is executed and in light of anticipated harm and difficulty of proving the amount of loss resulting from breach of the agreement by any party.

B. A provision in an agreement fixing unreasonably large liquidated damages is void as a penalty.

History: Laws 2015, ch. 96, § 4; § 24-1I-4, recompiled as § 24A-4-4 by Laws 2024, ch. 39, § 132.

24A-4-5. Applicability.

A. Chapter 24, Article 1I NMSA 1978 [Chapter 24A, Article 4 NMSA 1978] does not apply to agreements between health care practitioners who are shareholders, owners, partners or directors of a health care practice.

B. Except as provided by Subsections C and D of this section, the provisions of Chapter 24, Article 1I NMSA 1978 [Chapter 24A, Article 4 NMSA 1978] apply to agreements, or renewals or extensions of agreements, executed on or after July 1, 2015.

C. The provisions of Subsection B of Section 24-1I-2 NMSA 1978 [24A-4-2 NMSA 1978] apply to agreements, or renewals or extensions of agreements, executed on or after April 6, 2017.

D. For psychologists, physician assistants and pharmacists, the provisions of Chapter 24, Article 1I NMSA 1978 [Chapter 24A, Article 4 NMSA 1978] apply to agreements, or renewals or extensions of agreements, executed on or after the effective date of this 2023 act.

History: Laws 2015, ch. 96, § 5; 2017, ch. 123, § 3; 2023, ch. 97, § 2; § 24-1I-5 , recompiled as § 24A-4-5 by Laws 2024, ch. 39, § 132.

ARTICLE 5
Long-Term Care Services

24A-5-1. Short title.

Chapter 24A, Article 5 NMSA 1978 may be cited as the "Long-Term Care Services Act".

History: Laws 1998, ch. 82, § 1; § 24-17A-1, recompiled and amended as § 24A-5-1 by Laws 2024, ch. 39, § 46.

24A-5-2. Definitions.

As used in the Long-term Care Services Act:

A. "consumer" means a long-term care service recipient who has a physical or mental illness, injury or disability or who suffers from any cognitive impairment that restricts or limits the person's activities of daily living or instrumental activities of daily living and who is under the care of a provider;

B. "long-term care" means home- or community-based care provided to a consumer that is designed to maintain the consumer's independence and autonomy in the consumer's residence and includes support services such as personal, respite, attendant, residential or institutional care; case management; services such as meals, homemaker, home repair, transportation, companion, adult day health care, emergency response or day habilitation; physical, occupational or speech therapy; nursing; or help with chores;

C. "residence" means a consumer's home, an independent living center, an adult day health care facility, a community center, an assisted living facility, an adult residential care facility, a nursing home or a senior citizen center; and

D. "service delivery system" means a unified statewide, comprehensive home- and community-based service delivery system that integrates and coordinates all health, medical and social services that meet the individual needs of consumers and support them in remaining in their own homes and communities.

History: Laws 1998, ch. 82, § 2; § 24-17A-2, recompiled as § 24A-5-2 by Laws 2024, ch. 39, § 132.

24A-5-3. Interagency committee created; coordinated service delivery system; lead agency; service delivery system.

A. The "interagency committee on long-term care" is created.

B. Members of the interagency committee on long-term care shall be the heads of the following agencies or their designated representatives:

(1) the authority;

(2) the aging and long-term services department;

(3) the department of health;

(4) the children, youth and families department;

(5) the workforce solutions department;

(6) the governor's commission on disability;

(7) the developmental disabilities council; and

(8) the office of superintendent of insurance.

C. The interagency committee on long-term care shall design and implement a coordinated service delivery system that fulfills the legislative mandate to develop a coordinated long-term care system.

D. The governor shall appoint a chairperson from the membership of the interagency committee on long-term care.

History: Laws 1998, ch. 82, § 3; § 24-17A-3, recompiled and amended as § 24A-5-3 by Laws 2024, ch. 39, § 47.

24A-5-4. Service delivery system; components; principles.

The interagency committee on long-term care shall take into consideration, within available resources, the following principles in the design, development and implementation of the integrated long-term care delivery system to:

A. ensure the dignity and respect of consumers in the treatment and support provided;

B. tailor home- and community-based long-term care services and programs to provide full access and coordination to meet the individual needs of consumers;

C. develop and provide home- and community-based long-term care services and programs of the highest quality;

D. provide for consumer self-determination by providing options for individual choice and consumer input in home- and community-based long-term care;

E. implement a state policy that defines the state's obligation regarding long-term care by integrating applicable state and federal mandates related to long-term care services;

F. diversify institutional care options that explore and enhance appropriate alternatives to institutional care; and

G. integrate various funding sources to provide quality, affordable services to the consumer.

History: Laws 1998, ch. 82, § 4; § 24-17A-4, recompiled as § 24A-5-4 by Laws 2024, ch. 39, § 132.

24A-5-5. Report.

The chairperson shall present a report to the legislature on the progress of the interagency committee on long-term care and the status of the coordinated service delivery system. The report shall include conclusions and recommendations to further the work of the interagency committee on long-term care and to complete the process of integrating the service delivery system in the state.

History: Laws 1998, ch. 82, § 4; § 24-17A-5, recompiled as § 24A-5-5 by Laws 2024, ch. 39, § 132.

ARTICLE 6
Long-Term Care Facility Dementia Training

24A-6-1. Short title.

Chapter 24A, Article 6 NMSA 1978 may be cited as the "Long-Term Care Facility Dementia Training Act".

History: Laws 2021, ch. 111, § 1; § 24-17B-1, recompiled and amended as § 24A-6-1 by Laws 2024, ch. 39, § 48.

24A-6-2. Definitions.

As used in the Long-Term Care Facility Dementia Training Act:

A. "direct care service" means services provided to long-term care facility residents that maintain or improve the health and quality of life of the residents;

B. "direct care service staff member" means a person employed by or contracted with a long-term care facility to provide in-person direct care services to long-term care facility residents. "Direct care service staff member" does not include a registered nurse licensed pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978] or a physician licensed pursuant to the Medical Practice Act [Chapter 61, Article 6 NMSA 1978] who has received specialized training or education in geriatric care; and

C. "long-term care facility" means a long-term care facility licensed by the state that is not otherwise required to provide at least four hours of dementia care training under state or federal law. "Long-term care facility" does not include a facility licensed pursuant to the Health Care Code [Chapter 24A NMSA 1978] as an intermediate care facility for persons with intellectual disabilities.

History: Laws 2021, ch. 111, § 2; 2023, ch. 163, § 1; § 24-17B-2, recompiled and amended as § 24A-6-2 by Laws 2024, ch. 39, § 49.

24A-6-3. Training required.

A. Each long-term care facility that is subject to the Long-Term Care Facility Dementia Training Act shall provide at least four hours of dementia training to each direct care service staff member that it employs on:

(1) recognizing and treating Alzheimer's disease and dementia;

(2) person-centered care;

(3) activities of daily living;

(4) an overview of the different types of dementia;

(5) strategies to manage the behavior of people who have dementia; and

(6) strategies to effectively communicate with people who have dementia.

B. Training may be online or in-person and shall be a training program of at least four hours. Each long-term care facility shall submit the training program that it uses or proposes to use to the authority for review. If the authority finds that the training program does not satisfy the purposes of the Long-Term Care Facility Dementia Training Act, it shall require the long-term care facility to submit a new proposed training program.

C. A person designing the training shall have at least two years of work experience related to Alzheimer's disease, dementia, health care, gerontology or other related field.

D. Every direct care service staff member shall complete the requirements for and obtain a training certificate. A direct care service staff member:

(1) hired after January 1, 2022 shall complete the training required within ninety days of the start of employment;

(2) hired prior to January 1, 2022 who has not received training equivalent to the requirements set forth in the Long-Term Care Facility Dementia Training Act shall complete training within sixty days of January 1, 2022;

(3) hired prior to January 1, 2022 who received training within the past twenty-four months equivalent to the requirements set forth in that act shall be issued a training certificate by the long-term care facility that employs the direct care service staff member; and

(4) who has successfully obtained a training certificate but has had a lapse of dementia-related direct care service employment for twenty-four consecutive months or more shall complete training within ninety days of the start of employment.

E. A long-term care facility that contracts for the services of a direct care service staff member may include a requirement in the contract that the direct care service staff member is required to receive dementia care training that satisfies the requirements of the Long-Term Care Facility Dementia Training Act.

History: Laws 2021, ch. 111, § 3; 2023, ch. 163, § 2; § 24-17B-3, recompiled and amended as § 24A-6-3 by Laws 2024, ch. 39, § 50.

24A-6-4. Authority oversight and rulemaking.

In consultation with the aging and long-term services department, the authority shall:

A. identify, publish a list of and periodically review online or in-person standardized training programs that meet the requirements of the Long-Term Care Facility Dementia Training Act;

B. develop and periodically review required evaluation instruments that demonstrate competency and knowledge gained in training topics;

C. promulgate rules to carry out the provisions of the Long-Term Care Facility Dementia Training Act, including:

(1) for evaluation on the training topics for treatment and care of persons with Alzheimer's disease or dementia; and

(2) requiring one hour of dementia care training to be included as part of an annual continuing education training requirement for direct care service staff members

at long-term care facilities, unless additional time is necessitated to address changing standards of care;

D. issue interpretative guidance as necessary to ensure compliance with the Long-Term Care Facility Dementia Training Act;

E. review all long-term care facility dementia training programs related to the Long-Term Care Facility Dementia Training Act; and

F. give notice of the requirements of the Long-Term Care Facility Dementia Training Act to long-term care facilities within ninety days of June 18, 2021.

History: Laws 2021, ch. 111, § 4; 2023, ch. 163, § 3; § 24-17B-4, recompiled and amended as § 24A-6-4 by Laws 2024, ch. 39, § 51.

24A-6-5. Dementia training certificates.

The training provider shall issue a certificate to staff upon completion of initial training. The certificate shall be valid so long as the certificate holder meets the requirements set forth by the authority pursuant to the Long-Term Care Facility Dementia Training Act and the certificate holder has not had a lapse of dementia-related direct care service employment for twenty-four consecutive months or more. The certificate shall be valid among long-term care facilities. Each long-term care facility and long-term care facility contractor that is subject to that act shall be responsible for maintaining documentation regarding completed dementia training and evaluation for each direct care service staff member.

History: Laws 2021, ch. 111, § 5; 2023, ch. 163, § 4; § 24-17B-5, recompiled and amended as § 24A-6-5 by Laws 2024, ch. 39, § 52.

ARTICLE 7
Graduate Medical Education Expansion Grant Program

24A-7-1. Short title.

Chapter 24A, Article 7 NMSA 1978 may be cited as the "Graduate Medical Education Expansion Grant Program Act".

History: Laws 2019, ch. 141, § 1; § 24-33-1, recompiled and amended as § 24A-7-1 by Laws 2024, ch. 39, § 53.

24A-7-2. Definition.

As used in the Graduate Medical Education Expansion Grant Program Act, "graduate medical education training program" means a program that has received approval or is in the process of seeking approval to operate as a graduate medical education training program sponsor from the appropriate professional association that evaluates and accredits medical residency and internship programs, including:

A. a licensed and accredited hospital;

B. an academic medical education institution;

C. a new freestanding graduate medical education program;

D. an established or new graduate medical education training consortium; and

E. a federally qualified health center.

History: Laws 2019, ch. 141, § 2; § 24-33-2, recompiled and amended as § 24A-7-2 by Laws 2024, ch. 39, § 54.

24A-7-3. Graduate medical education expansion grant program; fund; distributions; application requirements; priorities for awards; reporting requirements.

A. The "graduate medical education expansion grant program fund" is created as a nonreverting fund in the state treasury. The fund consists of appropriations, gifts, grants and donations. The authority shall administer the fund, and money in the fund is appropriated to the authority to administer the provisions of the Graduate Medical Education Expansion Grant Program Act. Money in the fund may be used to secure federal and private matching funds as determined by the secretary. Money in the fund shall be disbursed on warrants signed by the secretary of finance and administration pursuant to vouchers signed by the secretary of health care authority or the secretary's authorized representative.

B. To receive a grant, a graduate medical education training program shall apply to the graduate medical education expansion grant program as provided by rules promulgated by the authority. Grant amounts shall be determined by each applicant's grant application. Funds from the graduate medical education expansion grant program fund shall be distributed to graduate medical education training programs to develop and implement graduate medical education training programs. The application shall include the applicant's plan to receive accreditation for the positions within the graduate medical education training program.

C. The authority may provide one-time planning grants to graduate medical education training programs as provided by rule.

D. The authority may provide graduate medical education grants to:

(1) establish new graduate medical education training programs with first-year positions;

(2) fund unfilled, accredited first-year positions within a graduate medical education training program;

(3) expand the number of first-year positions within an existing graduate medical education training program; and

(4) fund existing graduate medical education training programs.

E. The authority may prioritize applications that emphasize the following:

(1) developing new or expanded programs with specialties of psychiatry, family medicine, pediatric medicine and internal medicine;

(2) increasing positions for medical specialities having shortages within the state, with preference being given to the primary care specialties of family medicine, pediatric medicine and internal medicine; and

(3) increasing primary care positions in medically underserved areas within the state.

F. Each award recipient shall report annually to the graduate medical education expansion review board on the:

(1) expenditures of grant funds; and

(2) plans for unexpended funds.

History: Laws 2019, ch. 141, § 3; § 24-33-3, recompiled and amended as § 24A-7-3 by Laws 2024, ch. 39, § 55.

24A-7-4. Graduate medical education expansion review board; created; duties.

A. The "graduate medical education expansion review board" is created to:

(1) develop a state strategic plan for expanding graduate medical education training programs;

(2) review grant applications; and

(3) review the grants awarded pursuant to the Graduate Medical Education Expansion Grant Program Act.

B. The graduate medical education expansion review board shall consist of nine members who shall be appointed by the authority. The review board shall include representation from each accredited osteopathic and allopathic medical school and from the following groups:

(1) the authority;

(2) the higher education department;

(3) hospitals, primary care consortiums and medical organizations; and

(4) osteopathic and allopathic medical professional societies and associations.

C. The chair of the review board shall be elected by the review board. The review board shall meet at the call of the chair.

D. Members of the review board shall not be paid per diem and mileage or other compensation for their services.

E. The authority shall provide staff support for the review board in the performance of its duties.

F. A simple majority of the review board members constitutes a quorum. A member of the review board shall abstain from voting or the member's vote shall be disqualified on any matter in which the member has a pecuniary interest.

G. The health care authority and the higher education department shall assist the graduate medical education expansion review board in developing a strategic plan for the expansion of graduate medical education training programs, which shall include the following:

(1) a statement describing the objectives and goals of the review board, the strategies by which those goals will be achieved and a time line for achieving those goals;

(2) a summary of the current graduate medical education training programs throughout the state;

(3) a five-year plan for expanding graduate medical education training programs in the state;

(4) an evaluation of the standards and curriculum guidelines for graduate medical education training programs;

(5) an ongoing evaluation process of funds distributed through the graduate medical education expansion grant program that is overseen by the review board; and

(6) a plan to ensure long-term sustainability.

H. The graduate medical education expansion review board shall review applications to the graduate medical education expansion grant program and provide recommendations to the secretary.

History: Laws 2019, ch. 141, § 4; § 24-33-4, recompiled and amended as § 24A-7-4 by Laws 2024, ch. 39, § 56.

ARTICLE 8
Health Care Delivery and Access

24A-8-1. Short title. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

Sections 1 through 7 [24A-8-1 to 24A-8-7 NMSA 1978] of this act may be cited as the "Health Care Delivery and Access Act".

History: *Laws 2024, ch. 41, § 1.*

24A-8-2. Definitions. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

As used in the Health Care Delivery and Access Act:

A. "assessed days" means the number of inpatient hospital days exclusive of medicare days for each eligible hospital, with data sources to be defined by the authority and updated no less frequently than every three years;

B. "assessed outpatient revenue" means net patient revenue exclusive of medicare outpatient revenue for outpatient services, with data sources to be defined by the authority and updated no less frequently than every three years;

C. "assessment" means the health care delivery and access assessment;

D. "assessment amount" means the assessment amount owed by an eligible hospital;

E. "assessment rate" means the amount per assessed day and the percentage of assessed outpatient revenue calculated by the authority;

F. "authority" means the health care authority department;

G. "average commercial rate" means the average rate paid by commercial insurers as provided by the centers for medicare and medicaid services;

H. "centers for medicare and medicaid services" means the centers for medicare and medicaid services of the United States department of health and human services;

I. "eligible hospital" means a non-federal facility licensed as a hospital by the department of health, excluding a state university teaching hospital or a state-owned special hospital;

J. "general acute care hospital" means a hospital other than a special hospital;

K. "hospital" means a facility providing emergency or urgent care, inpatient medical care and nursing care for acute illness, injury, surgery or obstetrics. "Hospital" includes a facility licensed by the department of health as a critical access hospital, rural emergency hospital, general hospital, long-term acute care hospital, psychiatric hospital, rehabilitation hospital, limited services hospital or special hospital;

L. "inpatient hospital services" means services that:

(1) are ordinarily furnished in a hospital for the care and treatment of inpatients;

(2) are furnished under the direction of a physician, advanced practice clinician or dentist;

(3) are furnished in an institution that:

(a) is maintained primarily for the care and treatment of patients;

(b) is licensed or formally approved as a hospital by an officially designated authority for state standard-setting;

(c) meets the requirements for participation in medicare as a hospital; and

(d) has in effect a utilization review plan, applicable to all medicaid patients, that meets federal requirements; and

(4) are not skilled nursing facility services or immediate care facility services furnished by a hospital with a swing-bed approval;

M. "managed care organization" means a person or organization that has entered into a comprehensive risk-based contract with the authority to provide health care services, including inpatient and outpatient hospital services, to medicaid beneficiaries;

N. "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations promulgated pursuant to that act;

O. "medicaid-directed payment program" means the health care delivery and access medicaid-directed payment program created pursuant to Section 5 [24A-8-5 NMSA 1978] of the Health Care Delivery and Access Act providing additional medicaid funding for hospital services provided through medicaid managed care organizations, as directed by the authority and approved by the centers for medicare and medicaid services;

P. "medicare days" means the number of inpatient days provided by an eligible hospital during the year to patients covered under Title 18 of the federal Social Security Act;

Q. "medicare outpatient revenue" means the amount of net revenue received by an eligible hospital for outpatient hospital services provided to patients covered under Title 18 of the federal Social Security Act;

R. "net patient revenue" means total net revenue received by a hospital for inpatient and outpatient hospital services in a year, as determined by the authority;

S. "New Mexico medicaid program" means the medicaid program established pursuant to Section 27-2-12 NMSA 1978;

T. "outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished:

(1) to outpatients;

(2) by or under the direction of a physician, advanced practice clinician or dentist; and

(3) by an institution that:

(a) is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(b) meets the requirements for participation in medicare as a hospital;

U. "quality incentive payments" means the portion of the medicaid-directed payment program paid to hospitals based on value-based quality measurements and performance evaluation criteria, as established by the authority pursuant to Section 5 of the Health Care Delivery and Access Act;

V. "rehabilitation hospital" means a facility licensed as a rehabilitation hospital by the department of health;

W. "rural emergency hospital" means a facility licensed as a rural emergency hospital by the department of health;

X. "rural hospital" means a hospital that is located in a county that has a population of one hundred twenty-five thousand or fewer according to the most recent federal decennial census;

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

Z. "small urban hospital" means a hospital that is located in a county that has a population greater than one hundred twenty-five thousand and that has fewer than fifteen licensed inpatient beds as of January 1, 2024;

AA. "special hospital" means a facility licensed as a special hospital by the department of health; and

BB. "uniform rate increase" means the portion of the medicaid-directed payment program paid to hospitals as a uniform dollar or percentage increase.

History: *Laws 2024, ch. 41, § 2.*

24A-8-3. Health care delivery and access assessment; rate and calculation; notification. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

A. Except as otherwise provided in this section, an assessment is imposed on inpatient hospital services and outpatient hospital services provided by an eligible hospital. The assessment rate shall be annually calculated by the authority pursuant to Subsection D of this section and the taxation and revenue department shall collect the assessment. The inpatient assessment shall be based on assessed days and the outpatient assessment shall be based on assessed outpatient revenue. The assessment provided by this section may be referred to as the "health care delivery and access assessment".

B. The rate of the assessment on a rural hospital and special hospital shall be reduced by fifty percent, and the rate of the assessment on a small urban hospital shall be reduced by ninety percent; provided that the amount of the assessment qualifies for a waiver of the uniformity requirement for provider assessment from the centers for medicare and medicaid services. The authority may adjust these percentages and establish eligibility requirements as necessary to qualify for the waiver.

C. The assessment shall not be imposed for any period for which the centers for medicare and medicaid services has not approved a necessary waiver or other applicable authorization required to ensure that the assessment is a permissible source of non-federal funding for medicaid program expenditures, or for which the centers for

medicare and medicaid services has not approved the distribution of the medicaid-directed payment program payments.

D. The authority shall annually calculate the assessment amount to be paid by each eligible hospital and shall annually notify the taxation and revenue department and all hospitals of the applicable rates. The authority shall calculate the assessment amount by applying the assessment rate to an eligible hospital's assessed days and assessed outpatient revenue so that total revenue from the assessment will equal the lesser of:

(1) the amount needed, in combination with other funds deposited or expected to be deposited in the health care delivery and access fund for the subsequent fiscal year, including unexpended and unencumbered money in the fund, to provide sufficient funding for:

(a) the non-federal share of medicaid-directed payment program payments for inpatient and outpatient hospital services for eligible hospitals at a level such that the total reimbursement for medicaid managed care patients, including any other inpatient or outpatient hospital directed payments, is equivalent to the average commercial rate or such other maximum level as may be set by the centers for medicare and medicaid services; and

(b) the purposes of the health care delivery and access fund; or

(2) the amount specified in Section 1903(w)(4)(C)(ii) of the federal Social Security Act, above which an indirect guarantee is determined to exist, with such amount determined each year based on the most recent available net patient revenue data.

E. The authority shall notify an eligible hospital of its applicable assessment amount pursuant to the following schedule:

(1) by November 1, 2024 for the period beginning on July 1, 2024 and ending on December 31, 2024; and

(2) by November 1 of the preceding calendar year for each calendar year thereafter.

F. The assessment imposed for the six-month period identified in Paragraph (1) of Subsection E of this section shall be based on assessed days and assessed outpatient revenue for a full year.

G. The authority may require hospitals, regardless of whether they are eligible hospitals, to report information or data necessary to implement and administer the Health Care Delivery and Access Act. If the authority requires such reporting, it shall specify the frequency and due dates.

H. The authority shall determine how the assessment is applied to newly created hospitals and hospitals that are merged, acquired or closed.

I. A hospital shall not specifically list the cost of the assessment on any invoice, claim or statement sent to a patient, insurer, self-insured employer program or other responsible party.

History: *Laws 2024, ch. 41, § 3.*

24A-8-4. Health care delivery and access fund; created. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

A. The "health care delivery and access fund" is created as a nonreverting fund in the state treasury. The fund consists of distributions, appropriations, transfers, gifts, grants, donations, bequests and income from investment of the fund. The authority shall administer the fund. Money in the fund is appropriated to the authority for the purposes of the fund provided in Subsection B of this section. Expenditures from the fund shall be by warrant of the secretary of finance and administration pursuant to vouchers signed by the secretary of health care authority or the secretary's authorized representative.

B. Money in the health care delivery and access fund shall be used only for the following purposes:

(1) at least ninety percent for the non-federal share of the medicaid-directed payment program;

(2) not more than ten percent for the non-federal share of costs incurred by the authority to administer the Health Care Delivery and Access Act; and

(3) for refunds to eligible hospitals, in proportion to the assessment amounts paid by the hospitals, if there is a final determination that the assessment is not a permissible source of non-federal medicaid program expenditures or if a substantial portion of the federal funding for the directed payments is disallowed.

History: *Laws 2024, ch. 41, § 4.*

24A-8-5. Health care delivery and access medicaid-directed payment program. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

A. The "health care delivery and access medicaid-directed payment program" is created in the authority pursuant to the provisions of this section, to be approved by the centers for medicare and medicaid services.

B. The authority shall:

(1) determine the amount of funds required for disproportionate share hospital payments but for the impact of the medicaid-directed payment program on the limit established by Section 1923(g) of the federal Social Security Act and direct a like amount of funds otherwise appropriated for the New Mexico medicaid program to fund the medicaid-directed payment program;

(2) determine the total funding for the medicaid-directed payment program, including the amount pursuant to Paragraph (1) of this subsection, and the associated matching federal funds;

(3) set aside forty percent of the medicaid-directed payment program funding for quality incentive payments for eligible hospitals, to replace the targeted access fee-for-service supplemental payment program and the hospital value-based directed payment program, including the hospital access payment program and the hospital quality improvement initiative;

(4) establish quality measurements and performance evaluation criteria based on hospital grouping classifications, after soliciting input from key stakeholders of the New Mexico hospital industry, for eligible hospitals using quality measurements and performance evaluation criteria:

(a) that have been endorsed by a nationally recognized quality organization;

(b) that align with the New Mexico medicaid strategic plan; or

(c) that align with the department of health's state health improvement plan;

(5) ensure that a quality incentive payment made to an eligible general acute care hospital:

(a) prior to calendar year 2026, is distributed based only on quality measurements and not performance evaluation; and

(b) for calendar year 2026 and subsequent years, is distributed based on quality measurements and performance evaluation;

(6) ensure that a quality incentive payment made to an eligible special hospital:

(a) prior to calendar year 2027, is distributed based only on quality measurements and not performance evaluation; and

(b) for calendar year 2027 and subsequent years, is distributed based on quality measurements and performance evaluation;

(7) after soliciting input from key stakeholders of New Mexico's hospital industry, structure payments to hospitals for the portion of the funding not used for the quality incentive payments as a uniform rate increase, to be paid to eligible hospitals through medicaid managed care organizations separately and in addition to capitation payments made to such organizations; and

(8) to the extent permitted by federal law, require, no more frequently than annually, that each eligible hospital submit to the authority, upon request, a report demonstrating that the increase in payment for medicaid managed care patients provided through the medicaid-directed payment program has enabled it to invest an amount equal to at least seventy-five percent of its net new funding into the delivery of and access to health care services in New Mexico, including investments in hospital operational costs, workforce recruitment and retention, staff and provider compensation increases, on-call physician coverage, precepting incentives, creation or expansion of services, community benefit activities or capital investments.

History: *Laws 2024, ch. 41, § 5.*

24A-8-6. Due dates; health care delivery and access assessment; directed payments. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

A. For the period from July 1, 2024 through December 31, 2024, a hospital shall pay the assessment to the taxation and revenue department as follows:

(1) by March 10, 2025 for the uniform rate increase; and

(2) by May 10, 2025 for the quality incentive payment.

B. For calendar year 2025 and thereafter, a hospital shall pay the assessment to the taxation and revenue department as follows:

(1) seventy days after the end of each calendar quarter for the uniform rate increase for that quarter; and

(2) by May 10 of the subsequent year for the quality incentive payment, unless approval by the centers for medicare and medicaid services of the medicaid-directed payment program for that year has not been received by the assessment's due date, in which case the due date for that assessment shall be forty-five days after such approval is received.

C. An assessment shall not be due earlier than forty-five days after the date the centers for medicare and medicaid services approves the necessary authorization sought by the secretary pursuant to Section 12 of this 2024 act for the applicable period.

D. The authority shall make directed payments to a managed care organization as follows:

(1) for the period beginning on July 1, 2024 and ending on December 31, 2024, the authority shall transfer the uniform rate increase funding to a managed care organization in one installment by March 15, 2025 and the quality incentive payment by May 15, 2025; and

(2) for calendar years 2025 and thereafter, the authority shall transfer the uniform rate increase funding to the managed care organization on a quarterly basis no later than seventy-five days after the end of the quarter and the quality incentive payment by May 15 of the subsequent calendar year.

E. If the assessment due date has been postponed due to a delay in approval by the centers for medicare and medicaid services, the payments shall be due five days after the extended assessment due date.

F. The authority shall require a managed care organization to make directed payments to hospitals no more than fifteen days after receipt of such payments from the authority.

History: *Laws 2024, ch. 41, § 6.*

24A-8-7. Subsequent approvals for managed care rating period; promulgation of rules. (Contingent effective date. See note below. Repealed effective July 1, 2030.)

A. The secretary shall seek subsequent approvals of the medicaid-directed payment program from the centers for medicare and medicaid services for each managed care rating period by submitting required information to the centers for medicare and medicaid services ninety days prior to the start of such rating period.

B. The authority and the department shall promulgate rules as necessary to carry out the provisions of the Health Care Delivery and Access Act.

History: *Laws 2024, ch. 41, § 7.*