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".

History: 1978 Comp., § 24A-1-1, enacted by Laws 2024, ch. 39, § 22.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

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.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

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.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

Temporary provisions. — Laws 2024, ch. 39, § 131 provided:

A. On July 1, 2024:

(1) functions, employees, money, appropriations, records, equipment and other property of the department of health pertaining to the developmental disabilities supports division, health improvement division and health facility licensing and certification bureau are transferred from the department of health to the health care authority;

(2) all contractual obligations pertaining to the developmental disabilities supports division, health improvement division and health facility licensing and certification bureau shall be deemed to be contractual obligations of the health care authority; and

(3) statutory references to the developmental disabilities supports division, health improvement division and health facility licensing and certification bureau or other functions transferred from the department of health to the health care authority shall be deemed to be references to the health care authority.

B. On July 1, 2024, functions, employees, money, appropriations, records, equipment and other property of the office of the superintendent of insurance pertaining to the administration of the health care affordability fund are transferred to the health care authority. Contractual obligations of the office of the superintendent of insurance

pertaining to the health care affordability fund shall be deemed to be contractual obligations of the health care authority.

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.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

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.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

Temporary provisions. — Laws 2024, ch. 39, § 131 provided:

A. On July 1, 2024:

(1) functions, employees, money, appropriations, records, equipment and other property of the department of health pertaining to the developmental disabilities

supports division, health improvement division and health facility licensing and certification bureau are transferred from the department of health to the health care authority;

(2) all contractual obligations pertaining to the developmental disabilities supports division, health improvement division and health facility licensing and certification bureau shall be deemed to be contractual obligations of the health care authority; and

(3) statutory references to the developmental disabilities supports division, health improvement division and health facility licensing and certification bureau or other functions transferred from the department of health to the health care authority shall be deemed to be references to the health care authority.

B. On July 1, 2024, functions, employees, money, appropriations, records, equipment and other property of the office of the superintendent of insurance pertaining to the administration of the health care affordability fund are transferred to the health care authority. Contractual obligations of the office of the superintendent of insurance pertaining to the health care affordability fund shall be deemed to be contractual obligations of the health care authority.

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.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 28 recompiled and amended former 24-1-5.8 NMSA 1978 as 24A-1-7 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted the health care authority for the department of health to correspond with the new powers and duties of the health care authority; in the section heading added "definitions"; substituted "authority" for "department" throughout the section; in Subsection B, deleted former Paragraph B(2), which defined "department" as the department of health, and redesignated former Paragraph B(3) as Paragraph B(2); and in Subsection C, Subparagraph C(5)(a), after "determination of the" deleted "department pursuant to" and added "authority as a final agency decision as provided in".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 29 recompiled and amended former 24-1-5.9 NMSA 1978 as 24A-1-8 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, changed references to the secretary of health or the department of health to the health care authority to correspond with the new powers and duties of the health care authority; substituted "authority" for "secretary" throughout the section; and in Subsection C, Paragraph C(1), after "licensed by the" deleted "department" and added "authority".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 30 recompiled and amended former 24-1-5.10 NMSA 1978 as 24A-1-9 NMSA 1978, effective July 1, 2024.

Cross references. — For Section 340B of the federal Public Health Service Act, *see* 42 U.S.C., §340B.

The 2024 amendment, effective July 1, 2024, effective July 1, 2024, changed references to the human services department and the health department to the health care authority as a result of the enactment of the Health Care Code and to correspond with the new powers and duties of the health care authority; in Subsection A, after "identified by the" deleted "human services department" and added "authority" and after "licensed under the state" deleted "Public Health Act" and added "Health Care Code"; and in Subsection B, after "satisfaction of the" deleted "department of health" and added "authority".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 31 recompiled and amended former 24-1-5.12 NMSA 1978 as 24A-1-10 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, effective July 1, 2024, substituted the health care authority for the department of health to correspond with the new powers and duties of the health care authority; substituted "authority" for "department" throughout the section; and in Subsection E, deleted Paragraph E(1), which defined "department" as the department of health.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 32 recompiled and amended former 24-1-37 NMSA 1978 as 24A-1-11 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted the health care authority for the department of health to correspond with the new powers and duties of the health care authority; and in Subsection K, Paragraph K(3), after "hospital by the" deleted "department of health" and added "authority".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 33 recompiled and amended former 24-1-5.7 NMSA 1978 as 24A-1-12 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted each occurrence of "human services department" with "authority" throughout the section.

The 2007 amendment, effective June 15, 2007, changed "department of health" to "human services department"; eliminated the provision that the department is the state's public health agency and drug abuse agency; and changed "New Mexico citizens" to "New Mexico residents".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 34 recompiled and amended former 24-1-41 NMSA 1978 as 24A-1-13 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted the health care authority for the department of health to correspond with the new powers and duties of the health care authority; and in Subsection C, Paragraph C(4), after "licensed by the" deleted "department of health pursuant to the Public Health Act" and added "authority".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 35 recompiled and amended former 24-1K-3 NMSA 1978 as 24A-1-14 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted the health care authority for the department of health and the secretary of health to correspond with the new powers and duties of the health care authority; in Subsection B, Paragraph B(1), after "one member from the" deleted "department" and added "authority"; and in Subsection F, after "The" deleted "secretary" and added "authority".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 36 recompiled and amended former 24-1-34 NMSA 1978 as 24A-1-15 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, replaced certain references to the department of health to health care authority to correspond with the new powers and duties of the health care authority; substituted "authority" for "department" throughout the section; and in Subsection B, after "bureau of the department" added "of health".

The 2015 amendment, effective June 19, 2015, expanded sources of accreditation for stroke centers and required the emergency medical systems bureau, in coordination with regional emergency medical services authorities statewide, to develop pre-hospitalization protocols related to the treatment of stroke patients; in Subsection A, after "hospital has been accredited", added "by the joint commission or any other nationally recognized accrediting body", after "capable center", deleted "by the joint commission", and after "loses", deleted "joint commission certification" and added "accreditation"; and added Subsection B and redesignated the succeeding subsection accordingly.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 37 recompiled and amended former 24-1-35 NMSA 1978 as 24A-1-16 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, in Subsection C, after "adults by the" deleted "department of health" and added "authority".

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.

ANNOTATIONS

Cross references. — For Title 19 of the federal Social Security Act, see 42 U.S.C. 1396 et seq.

Effective dates. — Laws 2024, ch. 39, § 134 made Laws 2024, ch. 39 effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1-23 NMSA 1978 as 24A-1-18 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1-39 NMSA 1978 as 24A-1-19 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1-42 NMSA 1978 as 24A-1-20 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 39 recompiled and amended former 24-1E-1 NMSA 1978 as 24A-2-1 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, changed "Chapter 24, Article 1E" to "Chapter 24A, Article 2".

The 2001 amendment, effective June 15, 2001, substituted "Chapter 24, Article 1E NMSA 1978" for "Sections 24-1E-1 through 24-1E-6".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 40 recompiled and amended former 24-1E-2 NMSA 1978 as 24A-2-2 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, removed the definitions of "department", "person" and "secretary" and revised the definition of "health facility" as used in the Health Facility Receivership Act; deleted former Subsection A, which defined

"department", and redesignated former Subsection B as Subsection A; in Subsection A, deleted Paragraph (1); deleted Subsection C, which defined "person" and redesignated former Subsection D as Subsection B; and deleted Subsection E, which defined "secretary".

The 2001 amendment, effective June 15, 2001, added the Paragraph (1) designation in Subsection B, and in that paragraph, substituted "state of New Mexico; or" for "department"; and added Paragraph B(2).

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 41 recompiled and amended former 24-1E-3 NMSA 1978 as 24A-2-3 NMSA 1978, effective July 1, 2024.

Cross references. — For application for appointment of a receiver, *see* 44-8-5 NMSA 1978.

For Rules of Civil Procedure for the District Courts, *see* Rules 1-001 to 1-127 NMRA.

The 2024 amendment, effective July 1, 2024, substituted the health care authority for the public health division to correspond with the new powers and duties of the health care authority; and in Subsection A, Paragraph A(1), after "from the" deleted "division" and added "authority".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 42 recompiled and amended former 24-1E-3.1 NMSA 1978 as 24A-2-4 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, deleted "No later than December 31, 2001".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1E-4 NMSA 1978 as 24A-2-5 NMSA 1978, effective July 1, 2024.

The 2001 amendment, effective June 15, 2001, inserted the last sentence of Subsection D.

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.

ANNOTATIONS

Bracketed material. — The bracketed material in Subsection B was inserted by the compiler to correct a typographical error and is not part of the law.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1E-5 NMSA 1978 as 24A-2-6 NMSA 1978, effective July 1, 2024.

The 2007 amendment, effective June 15, 2007, added new Subsections B and C to permit a court to set reasonable amounts to be paid during a receivership by a receiver who holds property that is necessary for the operation of a health facility; relieved a receiver of liability for nonpayment of debts that the receiver determines are not related to a health facility’s operations or for providing care for residents; and provided that nonpayment of the full amount of debts by the receiver does not relieve the health facility of liability for payment upon the termination of the receivership.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1E-6 NMSA 1978 as 24A-2-7 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1E-7 NMSA 1978 as 24A-2-8 NMSA 1978, effective July 1, 2024.

ARTICLE 3
Interagency Behavioral Health Purchasing

24A-3-1. Repealed.

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; repealed by Laws 2025, ch. 3, § 11.

ANNOTATIONS

Repeals. — Laws 2025, ch. 3, § 11 repealed 24A-3-1 NMSA 1978, as enacted by Laws 2004, ch. 46, § 8, relating to interagency behavioral health purchasing collaborative, effective June 20, 2025. For provisions of former section, *see* the 2024 NMSA 1978 on *NMOneSource.com*.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 44 recompiled and amended former 24-1-28 NMSA 1978 as 24A-3-2 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, replaced the secretary of human services with the secretary of health care authority as the chair of the medicaid subcommittee, and replaced the secretary of health with the secretary of health care authority as the chair of the adult subcommittee; and in Subsection C, Paragraph C(4), after "Section" changed "9-7-6.4" to "24A-3-1", in Paragraph C(6), Subparagraph C(6)(a), after "secretary of" deleted "human services" and added "health care authority" and in Subparagraph C(6)(c), after "secretary of health" added "care authority".

The 2005 amendment, effective June 17, 2005, eliminated the requirement that Native American appointees to the behavioral health planning council be consumers of behavioral health services and consumers of substance abuse services and provides for the creation a Native American subcommittee of the council.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 45 recompiled and amended former 9-8-7.3 NMSA 1978 as 24A-3-3 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted each occurrence of "department" with "authority".

The 2023 amendment, effective June 16, 2023, substituted each occurrence of "individuals" with "persons" throughout the section.

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.

ANNOTATIONS

Effective dates. — Laws 2024, ch. 45 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective May 15, 2024, 90 days after adjournment of the legislature.

Compiler's notes. – Laws 2024, ch. 45, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

24A-3-5. Behavioral health trust fund.

A. The "behavioral health trust fund" is created as a nonreverting fund in the state treasury. The fund consists of distributions, appropriations, gifts, grants and donations. Income from investment of the fund shall be credited to the fund. Money in the fund shall be expended only as provided in this section.

B. The state investment officer shall invest money in the fund in accordance with the prudent investor rule as set forth in Chapter 6, Article 8 NMSA 1978 and in consultation with the health care authority.

C. The state investment officer shall report quarterly to the legislative finance committee and the state investment council on the investments made pursuant to this section. An annual report shall be submitted no later than October 1 of each year to the legislative finance committee, the revenue stabilization and tax policy committee and any other appropriate interim committees.

D. On July 1, 2026 and each July 1 thereafter, a distribution shall be made from the behavioral health trust fund to the behavioral health program fund in an amount equal to five percent of the average of the year-end market values of the trust fund for the immediately preceding three calendar years. If, on July 1 of a year, the trust fund has been in effect for less than three calendar years, the distribution shall be in an amount equal to five percent of the average of the year-end market values of the trust fund for the immediately preceding number of calendar years that the trust fund has been in effect. For fiscal years 2026 and 2027, any unexpended or unencumbered balance remaining after the distribution is made in that fiscal year shall be included in the calculation of state reserves.

History: Laws 2025, ch. 2, § 1.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 2 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 20, 2025, 90 days after adjournment of the legislature.

24A-3-6. Behavioral health program fund.

A. The "behavioral health program fund" is created in the state treasury. The fund consists of distributions, appropriations, gifts, grants, donations and income from investment of the fund. The health care authority shall administer the fund. Money in the fund is subject to appropriation by the legislature to provide money for services and programs related to behavioral health, including:

(1) mental health and substance misuse treatment, intervention and prevention;

(2) necessary infrastructure, technology and workforce supports that facilitate the delivery of behavioral health services and programs;

(3) matching funds for federal, local and private money and grants related to behavioral health services and programs;

(4) offsetting costs incurred to comply with federal requirements related to behavioral health services and programs; and

(5) implementation of regional behavioral health plans throughout the state.

B. 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. Any unexpended or unencumbered balance remaining at the end of a fiscal year shall revert to the behavioral health trust fund.

History: Laws 2025, ch. 2, § 2.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 2 contained no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, was effective June 20, 2025, 90 days after adjournment of the legislature.

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.

ANNOTATIONS

Bracketed material. — The bracketed material was inserted by the compiler and is not part of the law. Laws 2024, ch. 39, § 132 recompiled former Chapter 24, Article 1I NMSA 1978 as Chapter 24A, Article 4 NMSA 1978.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1I-1 NMSA 1978 as 24A-4-1 NMSA 1978, effective July 1, 2024.

The 2023 amendment, effective April 4, 2023, included psychologists, physician assistants, and pharmacists in the definition of "health care practitioners"; and in Subsection B, added Paragraphs B(8) through B(10).

The 2017 amendment, effective April 6, 2017, included certified nurse practitioners and certified nurse-midwives in the definition of "health care practitioner"; in the introductory clause, after "As used in", deleted "this act" and added "Chapter 24, Article 1I NMSA 1978"; and in Subsection B, added new Paragraphs B(6) and B(7).

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1I-2 NMSA 1978 as 24A-4-2 NMSA 1978, effective July 1, 2024.

The 2017 amendment, effective April 6, 2017, made certain provisions in clinical health care services agreements void and unenforceable; in the catchline, added "other provisions void"; added the subsection designation "A." to the previously undesignated first sentence and redesignated former Subsections A through C as Paragraphs A(1) through A(3), respectively; and in Subsection A, in the introductory sentence, after "health care services", added "in this state"; and added Subsection B.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1I-3 NMSA 1978 as 24A-4-3 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1I-4 NMSA 1978 as 24A-4-4 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Bracketed material. — The bracketed material was inserted by the compiler and is not part of the law. Laws 2024, ch. 39, § 132 recompiled former Chapter 24, Article 1I NMSA 1978 as Chapter 24A, Article 4 NMSA 1978.

Laws 2024, ch. 39, § 132 recompiled former 24-1I-5 NMSA 1978 as 24A-4-5 NMSA 1978.

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-1I-5 NMSA 1978 as 24A-4-5 NMSA 1978, effective July 1, 2024.

The 2023 amendment, effective April 4, 2023, included psychologists, physician assistants, and pharmacists within the scope of Chapter 24, Article 1I NMSA 1978 for the purpose of making certain provisions in health care practitioner agreements void, unenforceable and against public policy; in Subsection B, added "and D"; in Subsection C, after "on or after", deleted "the effective date of this 2017 act" and added "April 6, 2017"; and added Subsection D.

The 2017 amendment, effective April 6, 2017, made certain non-compete provisions in Section 24-1I-2(B) NMSA 1978 effective immediately; in Subsections A and B, changed "This act" to "Chapter 24, Article 1I NMSA 1978"; in Subsection B, added "Except as provided by Subsection C of this section"; and added Subsection C.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 46 recompiled and amended former 24-17A-1 NMSA 1978 as 24A-5-1 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, changed "This act" to "Chapter 24A, Article 5 NMSA 1978".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-17A-2 NMSA 1978 as 24A-5-2 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 47 recompiled and amended former 24-17A-3 NMSA 1978 as 24A-5-3 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, added the head of the health care authority as a member of the interagency committee on long-term care, removed the head of the human services department from the interagency committee on long-term care, and made technical amendments; and in Subsection B, added a new paragraph B(1) and redesignated former Paragraph B(1) as Paragraph B(2), in Paragraph B(2), deleted "state agency on" and after "aging" added "and long-term services department", deleted former Paragraph B(2), which provided "the human services department", in Paragraph B(6), after "the governor's" deleted "committee on concerns of the handicapped" and added "commission on disability", and in Paragraph B(8), deleted "department" and added "office of superintendent".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-17A-4 NMSA 1978 as 24A-5-4 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 132 recompiled former 24-17A-5 NMSA 1978 as 24A-5-5 NMSA 1978, effective July 1, 2024.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 48 recompiled and amended former 24-17B-1 NMSA 1978 as 24A-6-1 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, changed "This act" to "Chapter 24A, Article 6 NMSA 1978".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 49 recompiled and amended former 24-17B-2 NMSA 1978 as 24A-6-2 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, removed the definition of "department" as used in the Long-Term Care Facility Dementia Training Act, and substituted a reference to the Public Health Act with a reference to the Health Care Code; deleted former Subsection A and redesignated former Subsections B through D as Subsections A through C, respectively; and in Subsection C, after "pursuant to the" deleted "Public Health Act" and added Health Care Code".

The 2023 amendment, effective June 16, 2023, revised the definitions of "direct care service staff member," and "long-term care facility"; in Subsection C, after "with a long-term care facility", deleted "either directly or through a third-party agreement", and added "'Direct care service staff member' does not include a registered nurse licensed pursuant to the Nursing Practice Act or a physician licensed pursuant to the Medical Practice Act who has received specialized training or education in geriatric care", and deleted Paragraph C(2); and in Subsection D, added "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 Public Health Act as an intermediate care facility for individuals with intellectual disabilities.".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 50 recompiled and amended former 24-17B-3 NMSA 1978 as 24A-6-3 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted references to "department" with the health care authority, and made technical changes; in Subsection B, substituted each occurrence of "department" with "authority"; redesignated former Subsection F as Subsection E; and in Subsection D, in the introductory paragraph, after "certificate", deleted "as provided in Subsection E of this section" and in Paragraph D(3), after "set forth in" deleted "the Long-Term Care Facility Dementia Training" and added "that".

The 2023 amendment, effective June 16, 2023, updated training program requirements; in Subsection A, in the introductory clause, after "Each long-term care facility", deleted "and long-term care facility contractor", after "shall provide", deleted "training from the department's current list of approved standardized" and added "at least four hours of dementia", and after "training", deleted "programs and continuing education as prescribed by the department"; in Paragraph A(1), deleted "standards approved by the department for"; in Paragraph A(4), deleted "any other subjects within the scope of long-term care facility dementia training identified by the department pursuant to the Long-Term Care Facility Dementia Training Act" and added "an overview of the different types of dementia"; and added Paragraphs A(5) and A(6); in Subsection B, after "at least four hours", deleted "and approved by the department pursuant to Section 5 of the Long-Term Care Facility Dementia Training Act" and added "Each long-term care facility shall submit the training program that it uses or proposes to use to the department for review. If the department 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."; in Subsection C, after "A person", deleted "conducting" and added "designing"; and deleted Paragraph C(2); in Subsection D, after "obtain", deleted "certification" and added "a training certificate"; in Subsection E, Paragraph E(1), after "within", deleted "sixty" and added "ninety"; in Paragraph E(2), after "received training", deleted "within the past twenty-four months"; and in Paragraph E(3), after "training certificate by the", deleted "department" and added "long-term care facility that employs the direct care service staff member"; and in Subsection F, deleted "contractor that is subject to the Long-Term Care Facility Dementia Training Act shall provide a copy of every direct care service staff member's dementia training certificate obtained pursuant to Paragraph (3) of Subsection E of this section or Section 5 of the Long-Term Care Facility Dementia

Training Act to every long-term care facility where that staff member provides direct care service" and added "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 has received dementia care training that satisfies the requirements of the Long-Term Care Facility Dementia Training Act.".

Applicability. — Laws 2023, ch. 163, § 6 provided that the provisions of Subsection F[E] of Section 24-17B-3 [24A-6-3] NMSA 1978 apply to agreements, or renewals or extensions of agreements, executed on or after June 16, 2023.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 51 recompiled and amended former 24-17B-4 NMSA 1978 as 24A-6-4 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted references to "department" with the health care authority, and required the health care authority, in consultation with the aging and long-term services department, to promulgate rules to carry out the provisions of the Long-Term Care Facility Dementia Training Act; in the section heading and introductory clause, substituted "Department" with "Authority"; and in Subsection C, added "to carry out the provisions of the Long-Term Care Facility Dementia Training Act, including" and deleted Paragraph C(3).

The 2023 amendment, effective June 16, 2023, required the department of health to promulgate rules requiring 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, and revised the department's duties related to long-term care facility dementia training; in Subsection A, after "identify", deleted "approve"; in Subsection B, after "develop", deleted "or approve"; in Subsection C, added a new Paragraph C(2) and redesignated former Paragraph C(2) as Paragraph C(3); in Subsection E, deleted "oversee and approve" and added "review"; deleted former Subsection F; and redesignated former Subsection G as new Subsection F.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 52 recompiled and amended former 24-17B-5 NMSA 1978 as 24A-6-5 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted a reference to "department" with the health care authority, and made technical changes; after the first occurrence of "The" added "training" and deleted "of training conducted pursuant to the Long-Term Care Facility Dementia Training Act", after "set forth by the" deleted "department" and

added "authority" and after "subject to" deleted "the Long-Term Care Facility Dementia Training" and added "that".

The 2023 amendment, effective June 16, 2023, after "certificate holder meets the", deleted "continuing education", and after "dementia training and evaluation", deleted "and continuing education".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 53 recompiled and amended former 24-33-1 NMSA 1978 as 24A-7-1 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, changed "This act" to "Chapter 24A, Article 7 NMSA 1978".

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 54 recompiled and amended former 24-33-2 NMSA 1978 as 24A-7-2 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, deleted the definitions of "department" and "secretary"; redesignated former Paragraphs A(1) through A(5) as Subsections A through E respectively; in the introductory clause, deleted "'department' means the human services department"; and deleted Subsection C, which defined "secretary" as the secretary of human services.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 55 recompiled and amended former 24-33-3 NMSA 1978 as 24A-7-3 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, provided additional sources for money in the graduate medical education expansion grant program fund, substituted the secretary of human services with the health care authority as the administrator of the graduate medical education expansion grant program fund, substituted the human services department with the health care authority as the administrator of the graduate medical education expansion grant program, and made technical changes; and in Subsection A, after "created" added "as a nonreverting fund", deleted "money appropriated by the legislature. Money in the fund shall not revert to any other fund at the end of a fiscal year" and added "appropriations, gifts, grants and donations"; and substituted "secretary" with "authority" and substituted "department" with "authority" throughout the section.

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.

ANNOTATIONS

Recompilations. — Laws 2024, ch. 39, § 56 recompiled and amended former 24-33-4 NMSA 1978 as 24A-7-4 NMSA 1978, effective July 1, 2024.

The 2024 amendment, effective July 1, 2024, substituted the human services department with the health care authority to appoint members to the graduate medical education expansion review board, substituted secretary of human services with the health care authority to assist the graduate medical education expansion review board in developing a strategic plan for the expansion of graduate medical education training programs, and made technical changes; in Subsection A, in the introductory clause, deleted "Prior to October 1, 2019, the department shall create", and after "board"' added "is created"; in Subsection B, substituted each occurrence of "department" with "authority"; in Subsection E, substituted "secretary" with "authority"; and in Subsection G, deleted "secretary of human services" and added "health care authority", after "and the" deleted "secretary of" and after "higher education" added "department".

ARTICLE 8
Health Care Delivery and Access

24A-8-1. Short title. (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.

ANNOTATIONS

Contingent effective dates. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-1 NMSA 1978, effective July 1, 2030.

Compiler's notes. – Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

Temporary provisions. — Laws 2024, ch. 41, § 12 provided that no later than July 15, 2024, the secretary of the health care authority shall seek a waiver, a state plan amendment or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act.

24A-8-2. Definitions. (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;

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 authority, 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 authority 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 24A-8-5 NMSA 1978 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 24A-8-5 NMSA 1978;

V. "rehabilitation hospital" means a facility licensed as a rehabilitation hospital by the authority;

W. "rural emergency hospital" means a facility licensed as a rural emergency hospital by the authority;

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 authority; 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; 2025, ch. 130, § 149.

ANNOTATIONS

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-2 NMSA 1978, effective July 1, 2030.

Compiler's notes. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

Cross references. — For Title 18 of the federal Social Security Act, *see* 42 U.S.C. §§ 1395 to 1395.

For Title 19 of the federal Social Security Act, *see* 42 U.S.C. § 1396 et seq.

The 2025 amendment, effective June 20, 2025, made certain technical amendments; replaced references to the "department of health" with the "health care authority" throughout the section; and in Subsection O and U, after "Section" deleted "5 of the Health Care Delivery and Access Act" and added "24A-8-5 NMSA 1978".

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

A. Except as otherwise provided in Subsection C of this section, an assessment is imposed on inpatient hospital services and outpatient hospital services provided by an eligible hospital. The assessment rate and assessment amounts 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 health care delivery and access 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 health care delivery and access 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 health care delivery and access 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 and the taxation and revenue department of the health care delivery and access assessment amount for the eligible hospital pursuant to the following schedule:

(1) by November 1, 2024 for the period beginning on July 1, 2024 and ending on December 31, 2024; provided that the assessment amount shall be based on assessed days and assessed outpatient revenue for a full year; and

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

F. 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.

G. The authority shall determine how the health care delivery and access assessment is applied to newly created hospitals and hospitals that are merged, acquired or closed.

H. A hospital shall not specifically list the cost of the health care delivery and access 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; 2025, ch. 130, § 150.

ANNOTATIONS

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-3 NMSA 1978, effective July 1, 2030.

Compiler's notes. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

The 2025 amendment, effective June 20, 2025, required the health care authority to notify the taxation and revenue department of the health care delivery and access assessment amounts for eligible hospitals, and made certain technical amendments; in Subsection A, after "provided in" added "Subsection C of"; added "health care delivery and access" preceding each occurrence of "assessment"; in Subsection E, after "eligible hospital" added "and the taxation and revenue department", in Paragraph E(1), after "December 1, 2024", added "provided that the assessment amount shall be based on assessed days and assessed outpatient revenue for a full year"; deleted former Subsection F and redesignated former Subsections G through I as Subsections F through H, respectively.

Temporary provisions. — Laws 2024, ch. 41, § 12 provided that no later than July 15, 2024, the secretary of the health care authority shall seek a waiver, a state plan amendment or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act.

24A-8-4. Health care delivery and access fund; created. (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.

ANNOTATIONS

Contingent effective dates. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-4 NMSA 1978, effective July 1, 2030.

Compiler's notes. – Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

Temporary provisions. — Laws 2024, ch. 41, § 12 provided that no later than July 15, 2024, the secretary of the health care authority shall seek a waiver, a state plan amendment or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act.

24A-8-5. Health care delivery and access medicaid-directed payment program. (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.

ANNOTATIONS

Contingent effective dates. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-5 NMSA 1978, effective July 1, 2030.

Compiler's notes. – Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

Temporary provisions. — Laws 2024, ch. 41, § 12 provided that no later than July 15, 2024, the secretary of the health care authority shall seek a waiver, a state plan amendment or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act.

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

A. Except as provided in Subsection B of this section, a hospital shall pay the health care delivery and access assessment to the taxation and revenue department as follows:

(1) for the period from July 1, 2024 through December 31, 2024:

(a) sixty percent of the assessment by March 10, 2025; and

(b) forty percent of the assessment by May 10, 2025; and

(2) for calendar year 2025 and thereafter:

(a) fifteen percent of the assessment seventy days after the end of each calendar quarter; and

(b) forty percent of the assessment by May 10 of the subsequent year.

B. If approval by the centers for medicare and medicaid services of the medicaid-directed payment program for that year has not been received by the health care delivery and access assessment's due date, the due date for the assessment shall be forty-five days after such approval is received.

C. In the event that approval by the centers for medicare and medicaid services has not been received in time for a hospital to pay the health care delivery and access assessment by the dates set out in Subsection A of this section, the authority shall notify the taxation and revenue department of the date that such approval is received, of the dates on which the assessments are now due and that no interest or penalty on the assessment shall accrue prior to those due dates.

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. 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; 2025, ch. 130, § 151.

ANNOTATIONS

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-6 NMSA 1978, effective July 1, 2030.

Compiler's notes. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

The 2025 amendment, effective June 20, 2025, provided the proportionate amount of the health care delivery and access assessment that is due on the due dates, and revised language regarding late payments of the health care delivery and access assessment; in Subsection A, after the subsection designation, deleted "For the period from July 1, 2024 through December 31, 2024" and added "Except as provided in Subsection B of this section", added new paragraph designation "(1)", redesignated former Paragraphs A(1) and A(2) as Subparagraphs A(1)(a) and A(1)(b), respectively, redesignated former Subsection B as Paragraph A(2) and redesignated former Paragraphs B(1) and B(2) as Subparagraphs A(2)(a) and A(2)(b), respectively, in Paragraph A(1), after the paragraph designation, added "for the period from July 1, 2024 through December 31, 2024", in Subparagraph A(1)(a), after the subparagraph designation, added "sixty percent of the assessment", in Subparagraph A(1)(b), after the subparagraph designation, added "forty percent of the assessment", in Paragraph A(2), after "thereafter", deleted "a hospital shall pay the assessment to the taxation and

revenue department as follows," in Subparagraph A(2)(a), after the subparagraph designation, added "fifteen percent of the assessment" and in Subparagraph A(2)(b), after the subparagraph designation, added "forty percent of the assessment"; added new subsection designation "B"; completely rewrote Subsection C; and deleted former Subsection E and redesignated former Subsection F as Subsection E.

Temporary provisions. — Laws 2024, ch. 41, § 12 provided that no later than July 15, 2024, the secretary of the health care authority shall seek a waiver, a state plan amendment or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act.

24A-8-7. Subsequent approvals for managed care rating period; promulgation of rules. (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.

ANNOTATIONS

Contingent effective dates. — Laws 2024, ch. 41, § 14, provided that the provisions of 24A-8-1 to 24A-8-7 NMSA 1978 shall become effective on the first day of the month subsequent to the health care authority receiving the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act. Upon this occurring, the secretary of health care authority shall immediately notify the New Mexico compilation commission, the director of the legislative council service and the secretary of taxation and revenue.

Pursuant to Laws 2024, ch. 41, § 14, the effective date of Laws 2024, ch. 41 is December 1, 2024. On November 25, 2024, the New Mexico health care authority received the necessary federal authorizations and approvals of waivers required to implement and administer the Health Care Delivery and Access Act.

Delayed repeals. — Laws 2024, ch. 41, § 13 repealed 24A-8-7 NMSA 1978, effective July 1, 2030.

Compiler's notes. – Laws 2024, ch. 41, § 1 was not enacted as part of the Health Care Code, but was compiled there for the convenience of the user.

Temporary provisions. — Laws 2024, ch. 41, § 12 provided that no later than July 15, 2024, the secretary of the health care authority shall seek a waiver, a state plan amendment or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act.

ARTICLE 9
Health Care Consolidation Oversight

24A-9-1. Short title.

Chapter 24A, Article 9 NMSA 1978 may be cited as the "Health Care Consolidation Oversight Act".

History: Laws 2024, ch. 40, § 1; 1978 Comp., § 59A-63-1, recompiled and amended as § 24A-9-1 by Laws 2025, ch. 50, § 1.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 1 recompiled and amended former 59A-63-1 NMSA 1978 as 24A-9-1 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-1 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, changed "This act" to "Chapter 24A, Article 9 NMSA 1978".

24A-9-2. Definitions.

As used in the Health Care Consolidation Oversight Act:

A. "acquisition" means the direct or indirect purchase or other procurement in any manner, including through a lease, a license, a transfer, an exchange, an option, a proxy, a conveyance or a joint venture, of all or substantially all of the assets, equity or operations of a person;

B. "affiliation" means a business arrangement in which one person, directly or indirectly, is controlled by, is under common control with or controls another person;

C. "authority" means the health care authority;

D. "control" means the power to direct or cause the direction of the management and policies of a hospital, directly or indirectly, including through the ownership of voting securities, through licensing, lease or franchise agreements or by contract other than a

commercial contract for goods or nonmanagement services, unless the power is the result of a public appointment, general election or corporate office held by an individual;

E. "essential services" means health care services covered by the state medicaid program, health care services that are required to be included in health plans pursuant to state or federal law and health care services that are required to be included in qualified health plans offered through the New Mexico health insurance exchange;

F. "health care provider" means a person certified, licensed, registered or otherwise authorized under state law to perform or provide health care services in New Mexico;

G. "health care provider organization" means a person that is in the business of delivering or managing the delivery of health care services, whether incorporated or not, including physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations, dental services organizations and any other organization that contracts with health insurers for payment for health care services but does not include hospitals;

H. "health insurer" means a person required to be licensed or subject to the New Mexico Insurance Code or the insurance laws of any other state in connection with the business of health insurance, excluding insurance producers;

I. "hospital" means a hospital licensed by the authority or its successor health facility licensing agency, but "hospital" does not include a state university teaching hospital or a state-owned special hospital;

J. "independent health care practice" means a health care provider organization entirely owned or controlled by one or more health care providers who are individuals and who provide health care services through the health care provider organization to patients in New Mexico;

K. "management services organization" means a person that provides all or substantially all of the administrative or management services under contract with a hospital, including administering contracts with health plans, third-party administrators and pharmacy benefit managers, on behalf of the hospital;

L. "office" means the office of superintendent of insurance;

M. "party" means a person that is a party to a transaction subject to the Health Care Consolidation Oversight Act;

N. "person" means an individual, association, organization, partnership, firm, syndicate, trust, corporation or other legal entity;

O. "secretary" means the secretary of health care authority; and

P. "transaction" means any of the following:

(1) a merger of a hospital in New Mexico with another hospital or with a person controlling a hospital;

(2) an acquisition of one or more hospitals or a person controlling a hospital in New Mexico;

(3) any affiliation or contract or other agreement that results in a change of control of a hospital in New Mexico, including with a management services organization or health insurer;

(4) a formation of a new corporation, partnership, joint venture, trust, parent organization or management services organization that results in a change of control of an existing hospital in New Mexico;

(5) a sale, mortgage, purchase, lease, new affiliation or other agreement that results in a change of control of a hospital in New Mexico or the real estate on which the hospital is located; and

(6) an acquisition of one or more independent health care practices by a health care provider organization that is owned or affiliated with a health insurer.

History: Laws 2024, ch. 40, § 2; 1978 Comp., § 59A-63-2, recompiled and amended as § 24A-9-2 by Laws 2025, ch. 50, § 2.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 2 recompiled and amended former 59A-63-2 NMSA 1978 as 24A-9-2 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-2 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, defined "health care provider organization", "independent health care practice" and "secretary", and revised the definitions of terms as used in the Health Care Consolidation Oversight Act; in Subsection A, after "means" deleted "an agreement or activity the consummation of which results in a person acquiring, directly or indirectly, the control of a hospital in New Mexico and includes the acquisition of voting securities, membership interests, equity interests or assets" and added the remainder of the subsection; in Subsection D, after "the result of" deleted "an official position with" and added "a public appointment, general election"; in Subsection F, after " a person" deleted "qualified or licensed" and added "certified, licensed, registered or otherwise authorized", and after "provide health care services" added "in New Mexico"; added a new Subsection G and redesignated former Subsections G and H as Subsections H and I, respectively; in Subsection H,

after "New Mexico Insurance Code" added "or the insurance laws of any other state", and after "business of health insurance" deleted "or health care" and added "excluding insurance producers"; added a new Subsection J and redesignated former Subsections I through L as Subsections K through N, respectively; added a new Subsection O; deleted former Subsection M, which defined "superintendent"; and in Subsection P, Paragraph P(1), after "another hospital" added "or with a person controlling a hospital", in Paragraph P(2), after "more hospitals" added "or a person controlling a hospital", in Paragraph P(5), after "a sale" added "mortgage", after "New Mexico" added "or the real estate on which the hospital is located; and", and added Paragraph P(6).

24A-9-3. Applicability; provisions additional; control presumptions.

A. The oversight power of the authority pursuant to the Health Care Consolidation Oversight Act applies to proposed transactions.

B. Being subject to the Health Care Consolidation Oversight Act does not preclude or negate any person regulated pursuant to the Insurance Holding Company Law.

C. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds fifteen percent or more of the power to vote or holds proxies representing fifteen percent or more of the voting securities of any other person. The presumption may be rebutted by a showing in the manner provided by Section 59A-37-19 NMSA 1978 that control does not in fact exist.

History: Laws 2024, ch. 40, § 3; 1978 Comp., § 59A-63-3, recompiled and amended as § 24A-9-3 by Laws 2025, ch. 50, § 3.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 3 recompiled and amended former 59A-63-3 NMSA 1978 as 24A-9-3 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-3 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, transferred oversight power from the office of superintendent of insurance to the health care authority; in Subsection A, after "power of the" deleted "office" and added "authority", and after "proposed transactions" deleted "that involve a New Mexico hospital".

24A-9-4. Confidentiality.

Except for the information provided pursuant to Paragraphs (2) through (6) of Subsection E of Section 24A-9-6 NMSA 1978, all documents, materials or other information in the possession or control of the authority that are obtained by or disclosed to the authority, the authority's contracted experts, the attorney general, the

office or any other governmental entity in the course of a review under the Health Care Consolidation Oversight Act are confidential.

History: Laws 2024, ch. 40, § 4; 1978 Comp., § 59A-63-4, recompiled and amended as § 24A-9-4 by Laws 2025, ch. 50, § 4.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 4 recompiled and amended former 59A-63-4 NMSA 1978 as 24A-9-4 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-4 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, provided certain exceptions to the confidentiality provisions of the Health Care Consolidation Oversight Act, and substituted references to the office of superintendent of insurance with references to the "health care authority"; after the section heading, added "Except for the information provided pursuant to Paragraphs (2) through (6) of Subsection E of Section 24A-9-6 NMSA 1978", after "control of the" deleted "office" and added "authority", after "disclosed to the" deleted "office or" and added "authority, the authority's contracted experts, the attorney general", and after the next occurrence of "the," deleted "authority" and added "office or any other governmental entity".

24A-9-5. Timing of review of notice and tolling.

A. A notice of a proposed transaction shall be deemed complete by the authority on the date when all the information required by the Health Care Consolidation Oversight Act is submitted by all the parties to the transaction, as applicable.

B. Within thirty days after the notice of a proposed transaction is filed, the authority shall notify the parties in writing if the notice is complete or, if the notice is incomplete, specify what additional information must be submitted.

C. Should the scope of the proposed transaction be significantly modified from that outlined in the initial notice, the time periods set out in the Health Care Consolidation Oversight Act shall be restarted by the authority.

D. The time periods shall be tolled during any time in which the authority has requested and is awaiting further information from the parties to a transaction necessary to complete its review.

History: Laws 2024, ch. 40, § 5; 1978 Comp., § 59A-63-5, recompiled and amended as § 24A-9-5 by Laws 2025, ch. 50, § 5.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 5 recompiled and amended former 59A-63-5 NMSA 1978 as 24A-9-5 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-5 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, required the health care authority to notify the parties whether the notice of a proposed transaction is complete within thirty days of the filing of the notice, and substituted references to the office of superintendent of insurance with references to the "health care authority"; in Subsection A, after "complete by the" deleted "office" and added "authority" and after "Health Care Consolidation Oversight Act" deleted "or requested by the office"; added a new Subsection B and redesignated former Subsections B and C as Subsections C and D, respectively; and in Subsection D, after "time in which the" deleted "office" and added "authority".

24A-9-6. Notice of proposed transaction; general provisions; requirements; consultations; experts; payment of costs.

A. At least one person that is a party to a proposed transaction shall submit to the authority a written notice of the proposed transaction in the form and manner prescribed by the authority. The parties shall pay the reasonable costs and expenses incurred by the authority in the performance of the authority's duties pursuant to the Health Care Consolidation Oversight Act for costs associated with the authority's contracts with experts, unless determined otherwise by the secretary. The authority shall notify parties before any costs are incurred when a transaction review requires the use of outside experts, including the estimated cost of their services.

B. Upon receipt of a complete notice of a proposed transaction, the authority shall determine if the transaction is urgently necessary to maintain the solvency of a hospital or if there is an emergency that threatens the continued provision of immediate health care services. In such circumstances, the authority may agree to an immediate approval of a transaction with or without conditions.

C. Entry into a binding agreement before a transaction is effectuated is not a violation of the Health Care Consolidation Oversight Act if the transaction remains subject to regulatory review and approval.

D. If a party to the proposed transaction is a health insurer, the notice shall be submitted as an addendum to any filing required by Sections 59A-37-4 through 59A-37-10 NMSA 1978.

E. The notice of the proposed transaction shall include:

(1) the terms of the proposed transaction and copies of all transaction agreements between any of the parties;

(2) a list of the parties and business addresses;

(3) a statement describing the proposed transaction, the goals of the proposed transaction and whether and how the proposed transaction affects health care services in New Mexico;

(4) the geographic service area affected by the proposed transaction;

(5) a description of the groups or individuals likely to be affected by the transaction; and

(6) a summary of the health care services currently provided by any of the parties and any health care services that will be added, reduced or eliminated, including an explanation of why any services will be reduced or eliminated in the service area in which they are currently provided.

F. The authority may consult with the office about the potential effect of the proposed transaction and incorporate the office's recommendations into the authority's final determination.

G. The authority may retain actuaries, accountants, attorneys or other professionals who are qualified and have expertise in the type of transaction under review as necessary to assist the authority in conducting its review of the proposed transaction.

H. The parties shall not effectuate a transaction without the written approval of the secretary. The submitting party shall notify the authority in a form and manner prescribed by the authority when the transaction has been effectuated.

I. Parties to a proposed transaction may request a pre-notice conference to determine if they are required to file a notice or to discuss the potential extent of the review.

J. The authority shall provide all notices and documents received from any of the parties to a proposed transaction to the office and the attorney general. The attorney general may provide input to the authority about the potential effect of a proposed transaction relative to the Antitrust Act [57-1-1 through 57-1-15 NMSA 1978], the Unfair Practices Act [Chapter 57, Article 12 NMSA 1978] or other state or federal law.

K. Nothing in the Health Care Consolidation Oversight Act shall amend, modify, abrogate or otherwise affect the applicability or obligations of a party to a transaction or acquisition under any other state or federal law. The filing obligations under that act are in addition to any other obligation that may be required under other laws.

History: Laws 2024, ch. 40, § 6; 1978 Comp., § 59A-63-6, recompiled and amended as § 24A-9-6 by Laws 2025, ch. 50, § 6.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 6 recompiled and amended former 59A-63-6 NMSA 1978 as 24A-9-6 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-6 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, added that the notice of the proposed transaction shall include business addresses for the parties to the proposed transaction and a statement describing the proposed transaction, provided that the health care authority shall provide all notices and documents received from any of the parties to a proposed transaction to the office of the superintendent of insurance and the attorney general, provided that the Health Care Consolidation Oversight Act does not amend, modify, abrogate or affect the applicability or obligations of a party to a transaction or acquisition under any other state or federal law, and substituted references to the "office of superintendent of insurance" with references to the "health care authority," in Subsection E, Paragraph E(1), after the paragraph designation, deleted "a list of the parties" added a new Paragraph E(2) and redesignated former Paragraphs E(2) through E(5) as Paragraphs E(3) through E(6), respectively, in Paragraph E(3), after "describing the" added "proposed transaction, the"; and added Subsections J and K.

24A-9-6.1. Posting public information; public comment; public comment forums.

A. Within ten days of receipt of a complete notice of a proposed transaction, the authority shall post the information provided pursuant to Paragraphs (2) through (6) of Subsection E of Section 24A-9-6 NMSA 1978.

B. The authority shall publish a statement briefly describing a notice of proposed transaction in at least one newspaper of general circulation or other media that is prevalent in the area affected by the transaction. The authority shall also provide the statement to the following in the affected area:

(1) municipal and county officials;

(2) county health councils;

(3) Indian nations, tribes and pueblos;

(4) military installation commands;

(5) state legislators;

(6) the state's congressional delegation; and

(7) any labor organization that represents employees of the impacted hospital or health care provider organization.

C. With respect to website, newspaper and other disseminations and communications described in Subsection B of this section, the authority shall provide details on how the public can provide comments and offer multiple methods to provide comments on a notice of a proposed transaction by telephone or in writing by mail or electronic mail, anonymously or by a third party, and such methods shall provide opportunities to submit comments in languages other than English.

D. If the authority conducts a review, at least one public comment forum shall be held in the New Mexico service area or areas of the hospital or health care provider organization that is party to or the subject of the proposed transaction.

E. At least ten calendar days prior to the public comment forum, the authority shall post to the authority's website information about the public comment forum and a link on the website to publicly available materials relevant to the proposed transaction. The forum notice and the materials shall be in a format that is easy to find and easy to read and shall include information on how to submit comments.

F. The authority shall publish a notice of a public comment forum in at least one newspaper of general circulation or other media that is prevalent in the area affected by the transaction and provide the notice to the officials and other persons specified in Subsection B of this section.

G. Public comment on a proposed transaction that is subject to review shall be provided in the same manner as provided in Subsection C of this section.

H. The authority shall consider public comments and input received during the public comment forum on a proposed transaction in the authority's determination.

History: 1978 Comp., § 24A-9-6.1, enacted by Laws 2025, ch. 50, § 7.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 50, § 16 made Laws 2025, ch. 50, § 7 effective July 1, 2025.

24A-9-7. Review of proposed transaction.

A. Within one hundred twenty days of receiving a complete notice of a proposed transaction, the authority shall complete a review, confer with the office and either:

(1) approve the proposed transaction;

(2) approve the proposed transaction with conditions; or

(3) disapprove the proposed transaction.

B. The secretary shall notify the submitting party in writing of the authority's determination and the reasons for the determination.

C. The review period may be extended if the parties agree to an extension.

D. In conducting a review of a proposed transaction, the authority may consider the likely effect in New Mexico of the proposed transaction on:

(1) the potential reduction or elimination in access to essential services;

(2) the availability, accessibility and quality of health care services to the area affected by the transaction;

(3) the health care market share of a party and whether the transaction may foreclose competitors of a party from a segment of the market or otherwise increase barriers to entry in a health care market;

(4) changes in practice restrictions for health care providers who work at the hospital;

(5) patient costs, including premiums and out-of-pocket costs;

(6) health care provider networks;

(7) the potential for the proposed transaction to affect health outcomes for New Mexico residents; and

(8) current and future wages, benefits, working conditions, employment protections and restrictions and other terms and conditions of employment for employees of hospitals or health care provider organizations that are parties to or the subject of the proposed transaction.

E. The authority shall approve the proposed transaction after the review if the authority determines that:

(1) the parties to the proposed transaction have demonstrated that the transaction will benefit the public by:

(a) reducing the growth in patient costs, including premiums and out-of-pocket costs; or

(b) maintaining or increasing access to services, especially in medically underserved areas;

(2) the proposed transaction will improve health outcomes for New Mexico residents; and

(3) there is no substantial likelihood of:

(a) a significant reduction in the availability, accessibility, affordability or quality of care for patients and other consumers of health care services; or

(b) anti-competitive effects from the proposed transaction that outweigh the benefits of the transaction.

History: Laws 2024, ch. 40, § 7; 1978 Comp., § 59A-63-7, recompiled and amended as § 24A-9-7 by Laws 2025, ch. 50, § 8.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 8 recompiled and amended former 59A-63-7 NMSA 1978 as 24A-9-7 NMSA 1978, effective July 1, 2025.

Repeals. — Laws 2025, ch. 50, § 15 repealed Laws 2024, ch. 40, § 9 that provided for the repeal of 59A-63-7 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, substituted references to the "office of superintendent of insurance" with references to the "health care authority" and revised the list of criteria that the health care authority may consider in conducting a review of a proposed transaction; and in Subsection D, added Paragraph D(8).

24A-9-8. Post-transaction oversight.

A. The person that acquired control over the hospital or independent health care practice through an approved or conditionally approved transaction shall submit reports to the authority and the office in the form and manner prescribed by the authority annually for three years after approval or conditional approval. Conditions to an approval shall remain in effect for no longer than three years from the date of the conditional approval.

B. Reports shall:

(1) describe compliance with conditions placed on the transaction, if any;

(2) describe the growth, decline and other changes in services provided by the person; and

(3) provide analyses of cost trends and cost growth trends of the hospital.

History: Laws 2024, ch. 40, § 8; 1978 Comp., § 59A-63-8, recompiled and amended as § 24A-9-8 by Laws 2025, ch. 50, § 9.

ANNOTATIONS

Recompilations. — Laws 2025, ch. 50, § 9 recompiled and amended former 59A-63-8 NMSA 1978 as 24A-9-8 NMSA 1978, effective July 1, 2025.

The 2025 amendment, effective July 1, 2025, included independent health care practices within the scope of this section, provided that conditions to an approval of a transaction shall remain in effect no longer than three years, and substituted references to the "office of superintendent of insurance" with references to the "health care authority"; in Subsection A, after "hospital" added "or independent health care practice", and after "approval or conditional approval" added "Conditions to an approval shall remain in effect for no longer than three years from the date of the conditional approval".

24A-9-9. Enforcement and administrative fines.

A. The authority shall enforce the provisions of the Health Care Consolidation Oversight Act.

B. A transaction that is covered by Section 24A-9-3 NMSA 1978 shall not be effectuated in New Mexico without the secretary's written determination that no review is needed or without the written approval, with or without conditions, of the secretary following review.

C. A person that violates a material or substantive provision of the Health Care Consolidation Oversight Act or an order or rule of the authority issued or adopted in accordance with that act may be assessed an administrative fine by the secretary of not more than five thousand dollars ($5,000) for each instance of violation unless the violation is willful and intentional, in which case the secretary may assess a fine of not more than ten thousand dollars ($10,000) for each violation, except as provided in Paragraph (2) of Subsection D of this section. For purposes of calculating the fine, the secretary shall determine what constitutes an "instance of violation" based on:

(1) the nature of the violation, including whether it is on a per-day, per-patient, per-instance or other basis;

(2) the nature of the proposed transaction and the circumstances of the parties involved;

(3) the potential impact on the availability, accessibility, affordability or quality of care for patients of health care services in New Mexico; and

(4) any anticompetitive effects from the proposed transaction.

D. In the event of a failure to provide the required notice of proposed transaction, in addition to the imposition of administrative fines, the secretary may:

(1) require the parties to the unnoticed transaction to submit a notice of proposed transaction to allow the authority to complete a preliminary review and:

(a) determine if the transaction should be subject to a review; and

(b) if needed, conduct such review to determine if the transaction should: 1) remain effectuated; 2) remain effectuated with conditions; or 3) be disapproved; and

(2) in the event of a willful and intentional failure to provide the notice of proposed transaction, impose an administrative fine of not more than fifteen thousand dollars ($15,000) per day from the date on which the notice was required to be submitted to the authority to the date of issuance of an order approving, approving with conditions or disapproving the transaction.

E. Money collected from the imposition of an administrative fine pursuant to the Health Care Consolidation Oversight Act shall be deposited in the state treasury to the credit of the current school fund as provided by Article 12, Section 4 of the constitution of New Mexico.

History: 1978 Comp., § 24A-9-9, enacted by Laws 2025, ch. 50, § 10.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 50, § 16 made Laws 2025, ch. 50, § 10 effective July 1, 2025.

24A-9-10. Act not exclusive; attorney general.

Nothing in the Health Care Consolidation Oversight Act limits the authority of the attorney general to protect consumers in the health care market or to protect the economy of the state or any significant part of the state insofar as health care is concerned under any state or federal law. The authority of the attorney general to maintain competitive markets and prosecute state and federal antitrust and unfair competition violations shall not be narrowed, abrogated or otherwise altered by that act

History: 1978 Comp., § 24A-9-10, enacted by Laws 2025, ch. 50, § 11.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 50, § 16 made Laws 2025, ch. 50, § 11 effective July 1, 2025.

24A-9-11. Jurisdiction.

New Mexico courts shall have personal jurisdiction over the parties to a transaction subject to the provisions of the Health Care Consolidation Oversight Act, including the parties to the transaction and any person affiliated with a party.

History: 1978 Comp., § 24A-9-11, enacted by Laws 2025, ch. 50, § 12.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 50, § 16 made Laws 2025, ch. 50, § 12 effective July 1, 2025.

24A-9-12. Whistleblower protection; policy required; retaliation prohibited; penalties.

A. As used in this section:

(1) "entity" means hospitals, management services organizations and health care provider organizations that are owned or affiliated with health insurers;

(2) "good faith" means that a reasonable basis exists in fact as evidenced by the facts available;

(3) "retaliatory action" means any discriminatory or adverse action taken by an entity against a whistleblower, including termination, discharge, demotion, suspension, harassment or limitation on access to health care services;

(4) "unlawful or improper act" means a practice, procedure, action or failure to act on the part of an entity that violates the Health Care Consolidation Oversight Act or the authority's or attorney general's ability to exercise authority pursuant to that act; and

(5) "whistleblower" means a health care provider, officer, employee, contractor, subcontractor or authorized agent of an entity who reveals information about an unlawful or improper act by the entity.

B. An entity shall not take any retaliatory action against a whistleblower who:

(1) discloses to the authority, the attorney general, the office or any other state, local or federal governmental body information about an action or a failure to act that the whistleblower believes in good faith constitutes an unlawful or improper act;

(2) provides information to or testifies before a public body as part of an investigation, hearing or inquiry into an unlawful or improper act; or

(3) objects to or refuses to participate in an activity, policy or practice that the whistleblower believes in good faith constitutes an unlawful or improper act.

C. Every entity shall adopt, promulgate and enforce a whistleblower protection policy that, at a minimum, meets the requirements of Subsection B of this section to protect whistleblowers from any form of retaliatory action by the entity. The policy shall be posted at each entity's workplace, published on the entity's website and given, by either written or electronic communication, to every officer, employee, contractor or other agent of the entity.

D. Except as otherwise provided in the Health Care Consolidation Oversight Act and in addition to any criminal charges or civil suits that may be brought against an entity for either an unlawful or improper act or retaliatory actions, the secretary may assess an administrative fine not to exceed ten thousand dollars ($10,000) on an entity that the secretary finds has engaged in retaliatory action. Each retaliatory action or each day of violation may be considered a separate violation. If the secretary finds the entity willfully or repeatedly violated or continues to violate the prohibition against retaliatory actions, the secretary may assess an administrative fine not to exceed one hundred thousand dollars ($100,000) for each violation.

E. The secretary shall give notice to the entity of the secretary's intention to assess an administrative fine and specify the findings of retaliatory action. The entity may request a hearing, which shall be conducted as provided in the Administrative Procedures Act [12-8-1 to 12-8-25 NMSA 1978]. The secretary shall make final findings and decisions, which may include the time in which the entity must correct an unlawful or improper violation, and send a copy by registered mail to the entity. The decision of the secretary is a final agency action and may be appealed to the district court as provided in Section 39-3-1.1 NMSA 1978. The entity has thirty days in which to pay the administrative fine.

F. An entity that fails to stop or correct a retaliatory action within the period allowed for its correction, which period shall not begin to run until the date of the final order or appeal, if applicable, may be assessed a separate administrative fine not to exceed fifteen thousand dollars ($15,000) for each day during which the failure to stop or correct retaliatory action continues past the deadline for stopping or correcting the action.

G. Administrative fines shall be deposited in the state treasury to the credit of the current school fund as required by Article 12, Section 4 of the constitution of New Mexico.

H. The rights and remedies provided in this section shall not be waived by an agreement, policy form or condition of employment, including by an arbitration agreement.

I. Nothing in this section shall be deemed to diminish the rights, privileges or remedies of a whistleblower or other person pursuant to any federal or state law or pursuant to any collective bargaining agreement.

History: 1978 Comp., § 24A-9-12, enacted by Laws 2025, ch. 50, § 13.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 50, § 16 made Laws 2025, ch. 50, § 13 effective July 1, 2025.

24A-9-13. Authority; hospital ownership; annual posting on website.

The authority shall post hospital ownership annually on the authority's website and at any point in which there is a change of ownership of a hospital or the real estate on which a hospital stands.

History: 1978 Comp., § 24A-9-13, enacted by Laws 2025, ch. 50, § 14.

ANNOTATIONS

Effective dates. — Laws 2025, ch. 50, § 16 made Laws 2025, ch. 50, § 14 effective July 1, 2025.

ARTICLE 10
Behavioral Health Reform and Investment

24A-10-1. Short title.

This act [24A-10-1 to 24A-10-10 NMSA 1978] may be cited as the "Behavioral Health Reform and Investment Act".

History: Laws 2025, ch. 3, § 1.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-2. Definitions.

As used in the Behavioral Health Reform and Investment Act:

A. "behavioral health region" means a geographic area of the state that is designated in accordance with Subsection B of Section 3 [24A-10-3 NMSA 1978] of the

Behavioral Health Reform and Investment Act and encompasses one or more counties or judicial districts;

B. "behavioral health services" means a comprehensive array of professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses and substance misuse, including telemedicine;

C. "behavioral health stakeholders" means representatives from the administrative office of the courts, the public defender department, the district attorney's office in the behavioral health region, behavioral health service recipients, behavioral health service providers, behavioral health care advocates, the health care authority, the department of health, the children, youth and families department, the university of New Mexico health sciences center, higher education institutions within behavioral health regions, Indian nations, tribes and pueblos, local and regional governments and other appropriate state or local agencies or nongovernmental entities, including school districts, local and regional law enforcement agencies, local jails or detention centers, behavioral health associations and local behavioral health collaboratives;

D. "continuity of care plan" means a plan identifying the interrelationship of available and prospective behavioral health services for recipients to ensure consistent and coordinated services over time;

E. "disproportionately impacted community" means a community or population of people for which multiple burdens, including mental, substance misuse and physical stressors, inequity, poverty, limited behavioral health services and high unemployment, may act to persistently and negatively affect the health and well-being of the community or population;

F. "generally recognized standards for behavioral health" means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance misuse care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling;

(6) family and marriage counseling;

(7) public health officials; and

(8) certified peer support workers;

G. "regional meeting" means a meeting held by behavioral health stakeholders at a government-owned or -operated facility within a behavioral health region;

H. "regional plan" means a plan that is developed collaboratively by behavioral health stakeholders to provide behavioral health services to a behavioral health region; and

I. "sequential intercept mapping" means a strategic planning tool that helps communities identify resources and gaps and develop plans to divert people with mental health disorders and substance misuse away from the criminal justice system and into treatment.

History: Laws 2025, ch. 3, § 2.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-3. Behavioral health executive committee.

A. The "behavioral health executive committee" is created and shall be composed of:

(1) the secretary of health care authority;

(2) the director of the behavioral health services division of the health care authority, who shall chair the committee;

(3) the director of the medical assistance division of the health care authority;

(4) the director of the administrative office of the courts; and

(5) three behavioral health experts designated by the director of the administrative office of the courts.

B. The behavioral health executive committee shall:

(1) designate behavioral health regions;

(2) review and approve regional plans;

(3) establish funding strategies and structure based on approved regional plans;

(4) monitor and track deliverables and expenditures and address deficiencies and implementation issues of regional plans; and

(5) establish a project management strategy that shall be led by a project manager at the health care authority.

C. The behavioral health executive committee shall convene at least quarterly. Meetings of the committee shall be subject to the Open Meetings Act [Chapter 10, Article 15 NMSA 1978]; provided that executive sessions are permitted when considering confidential or sensitive information.

D. The behavioral health executive committee shall report on a quarterly basis to the legislative finance committee on the implementation status of the regional plans.

History: Laws 2025, ch. 3, § 3.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-4. Regional plan; sequential intercept mapping; reporting requirements.

A. The administrative office of the courts shall coordinate regional meetings, complete sequential intercept mapping and coordinate the development of regional plans. If behavioral health stakeholders request to participate in the development of a regional plan, the administrative office of the courts shall include those stakeholders in the development of the plan. If requested by the administrative office of the courts, behavioral health stakeholders shall provide support in coordinating regional meetings. The health care authority shall verify that nothing in a proposed regional plan jeopardizes the state medicaid program, and if something in the regional plan does jeopardize the state medicaid program, that section of the regional plan is void.

B. A behavioral health stakeholder receiving appropriations pursuant to the Behavioral Health Reform and Investment Act shall participate in regional meetings, provide substantive expertise, develop relevant portions of the regional plans, submit annual reports based on those plans and share relevant data as requested by a legislative interim committee, the administrative office of the courts or the health care authority.

C. For fiscal years 2025, 2026, 2027 and 2028, the administrative office of the courts and the health care authority shall collaborate to utilize current data to identify gaps in any existing sequential intercept mapping and supplement the mapping to ensure complete behavioral health coverage prior to regional plan finalization. Nothing in this subsection shall prevent the development of regional plans prior to the finalization of the sequential intercept mapping. Any grant or funding awards are contingent on finalized regional plans; provided that those regional plans shall be updated upon the completion of sequential intercept mapping.

D. A regional plan shall:

(1) include a phased implementation addressing behavioral health service gaps, including the continuation and expansion of behavioral health services;

(2) identify no more than five grants or state-funded priorities per phase; provided that additional priorities can be identified if the health care authority determines that the service gaps in a behavioral health region are large enough to warrant more priorities;

(3) identify local resources that may help offset part of the costs associated with each funding priority;

(4) provide a time line and performance measures for each funding priority that include a plan for developing data collection and infrastructure, performance measures, feasibility analysis and a sustainability plan;

(5) provide a continuity of care plan for the region;

(6) consider the need for language access for behavioral health services in the region;

(7) when appropriate, establish a plan to obtain federal, local or private resources to advance a regional priority;

(8) identify a capable and accountable entity to execute regional plans; provided that different entities may be accountable for each identified regional funding priority;

(9) include an appendix with a list of all behavioral service providers in the behavioral health region; and

(10) identify how regional plans will optimize, leverage or reinforce coordination with the state medicaid program as the primary payor of behavioral health services.

E. The administrative office of the courts shall distribute each regional plan to the legislature and the appropriate state agencies.

F. The health care authority, in consultation with the legislative finance committee and the legislative health and human services committee, shall determine baseline data collection points to be collected and reported in all reports subject to Subsection G of this section.

G. Beginning no later than June 30, 2027 and by every June 30 thereafter, the behavioral health executive committee shall designate a government entity within each behavioral health region to provide a written report to the legislature and the judicial and executive branches of government that includes:

(1) the status of the implementation of each regional plan and sequential intercept mapping;

(2) available data on performance measures included in each regional plan;

(3) public feedback on the implementation of each regional plan;

(4) uniform responses to data requests made by a legislative committee, the administrative office of the courts or an executive agency;

(5) a list of qualified and certified behavioral health service providers in each region that provide services described in the Behavioral Health Reform and Investment Act; and

(6) recommendations on successes, gaps and needs to better provide behavioral health care services.

H. Starting May 1, 2025, and continuing through December 31, 2025, the administrative office of the courts shall provide the appropriate interim legislative committees and the health care authority a monthly update on the status of sequential intercept mapping and regional planning. After January 1, 2026, the administrative office of the courts shall provide quarterly updates on the status of sequential intercept mapping and regional planning to the legislature and the health care authority. The behavioral health executive committee shall provide the legislature quarterly updates on the implementation of regional plans starting when the regional plans begin to be implemented.

I. Higher education institutions within behavioral health regions shall coordinate with the health care authority, the workforce solutions department and other behavioral health stakeholders to create a behavioral health workforce pipeline for the behavioral health services identified within regional plans. A behavioral health workforce pipeline may include:

(1) pathways for people with lived experience to enter the behavioral health workforce;

(2) in-state and national recruitment of behavioral health professionals;

(3) increased awareness of behavioral health careers within middle and high schools in the region;

(4) optimization of state funding to enhance or create behavioral health educational opportunities within the behavioral health region; and

(5) making recommendations to the legislature to better address the behavioral health workforce needs of the region.

J. As New Mexico's single state authority, the behavioral health services division of the health care authority shall continue to oversee the adult behavioral health system, including programming and rulemaking. Nothing in the Behavioral Health Reform and Investment Act shall be interpreted to imply anything to the contrary. The health care authority remains the primary designated federal entity for the state medicaid program.

History: Laws 2025, ch. 3, § 4.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-5. Behavioral health service standards.

A. By June 1, 2025, the health care authority, in consultation with other state agencies that have behavioral health programs, shall provide the administrative office of the courts with an initial set of generally recognized standards for behavioral health services for adoption and implementation in regional plans and any behavioral health service access priorities or gaps in the regions. The standards may be amended or updated to ensure that best practices of behavioral health services are delivered. The health care authority shall confirm whether or not each regional plan meets the behavioral health standards as set forth in the Behavioral Health Reform and Investment Act.

B. By June 1, 2025, the legislative finance committee and the health care authority shall provide the administrative office of the courts an initial set of evaluation guidelines for behavioral health services for adoption and implementation of regional plans. The evaluation guidelines shall include methods for evaluating the effectiveness of promising practices and behavioral health services not identified in Subsection A of this section. A promising practice is a program that has shown potential to improve outcomes or increase efficiency and is worthy of further study through a pilot implementation. The guidelines may be amended or updated at the request of the legislative finance committee or the legislative health and human services committee.

The health care authority, in consultation with the legislative finance committee, shall confirm whether or not each behavioral health service in a regional plan meets the evaluation guidelines as set forth in the Behavioral Health Reform and Investment Act.

History: Laws 2025, ch. 3, § 5.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-6. Behavioral health investments.

A. Money appropriated to carry out the provisions of the Behavioral Health Reform and Investment Act:

(1) shall be used to address priorities and funding gaps identified in the regional plans;

(2) shall be equitably distributed for all eligible priorities identified in each regional plan and shall prioritize funding behavioral health services for disproportionately impacted communities;

(3) may be used to fund grants not more than four years in length that require annual reports to evaluate the effectiveness of behavioral health services delivered;

(4) may be used to fund grants to cover costs of providing non-acute care behavioral health services to indigent and uninsured persons; and

(5) may be used to provide advance disbursement of up to five percent for emergencies or unforeseen circumstances that could adversely impact the contracted behavioral health services within the regional plan should funding not be made available or accessible.

B. A behavioral health region may request to repurpose any unexpended balance of a grant subject to the Behavioral Health Reform and Investment Act to another identified funding priority within that region, and the health care authority shall approve that request if:

(1) no report is provided by the grant recipient as required by Section 4 of that act;

(2) the grant purpose is not meeting performance measures identified in the regional plan; or

(3) the audit or evaluation required by Section 10 [24A-9-10 NMSA 1978] of that act finds the initial grant purpose to have been implemented ineffectively.

History: Laws 2025, ch. 3, § 6.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-7. Universal behavioral health credentialing process.

No later than June 30, 2027, the health care authority shall establish a universal behavioral health service provider enrollment and credentialing process for medicaid to reduce the administrative burden on behavioral health service providers. No later than December 31, 2025, the health care authority, in consultation with the legislative finance committee and the legislative health and human services committee, shall establish a working group of health care licensing boards to streamline the process to verify behavioral health licensing and improve the overall behavioral health licensing process. The working group shall provide the legislature with statutory recommendations if needed.

History: Laws 2025, ch. 3, § 7.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-8. Behavioral health services; limitations.

The health care authority shall promulgate rules outlining the benefits and structure related to behavioral health services. Any limitation on the number of new behavioral health recipients that a behavioral health service provider serves and is paid for shall be consistent with standards of care for the behavioral health services provided to patients.

History: Laws 2025, ch. 3, § 8.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-9. 988 and 911 coordination.

The state agencies that manage the 988 behavioral health emergency system and the 911 emergency system shall ensure the interoperability and bidirectionality of those systems to improve crisis and emergency response.

History: Laws 2025, ch. 3, § 9.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.

24A-10-10. Behavioral health audit and evaluation requirements.

A. The health care authority shall regularly monitor and audit contracts and grantees subject to the Behavioral Health Reform and Investment Act to ensure that behavioral health service quality standards are met and to ensure financial and programmatic compliance during the duration of an active regional plan. The health care authority shall complete a statewide gap analysis of adult behavioral health services every two fiscal years, beginning on July 1, 2027, that shall be used to inform regional plans and sequential intercept mapping. Any data requests made by the health care authority to a local government body related to the local government body's behavioral health programs, including financial information, shall be provided within thirty days of the written request and shall be shared with the administrative office of the courts and the legislative finance committee. The health care authority shall review regional plans for reasonableness of budget and service delivery to optimize infrastructure and behavioral health services throughout the state.

B. The legislative finance committee, in consultation with the health care authority, shall conduct or contract for program evaluations and reviews of the sufficiency of regional plans' program design and implementation plans to ensure that they can meet the stated objectives, including:

(1) review and assessment of the sufficiency of the regional plan, time lines and resources;

(2) review of the adequacy of functional, technical and operational requirements, capabilities and resources;

(3) identification of gaps and deficiencies in the regional plan; and

(4) review of the sufficiency of staff, other resources and partnerships.

C. During implementation of the Behavioral Health Reform and Investment Act, the legislative finance committee or a contractor retained by the legislative finance committee shall report on the following services and progress to the appropriate interim legislative committees, administrative office of the courts and the health care authority:

(1) ongoing, real-time review of project progress and deliverables;

(2) ongoing, real-time review of gaps, resources and deficiencies; and

(3) ongoing verification of critical features, operations and program viability of grantees subject to that act.

History: Laws 2025, ch. 3, § 10.

ANNOTATIONS

Effective dates. — Pursuant to N.M. Const., art. IV, § 23, Laws 2025, ch. 3 did not pass with the required two-thirds vote of each house. Therefore, the effective date of Laws 2025, ch. 3 was June 20, 2025.