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SENATE BILL 1240

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

INTRODUCED BY

MANNY M ARAGON

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH CARE ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE, PLANNING AND COST SAVINGS; CREATING A COMMISSION; PROVIDING ITS POWERS AND DUTIES; PROVIDING FOR TRANSFERS; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE. -- This act may be cited as the "Health Care Act"

Section 2. PURPOSE OF ACT. -- The purpose of the Health Care Act is to create a publicly financed statewide health program to provide coverage for health care services for all state residents and to control escalating health care costs.

Section 3. DEFINITIONS. -- As used in the Health Care Act:

A. "capital budget" means that portion of a health care facility's global budget that applies to real property and

1 tangible personal property, including buildings, machinery and
2 equipment and transportation equipment;

3 B. "capitation" means a set fee for providing
4 specified health care services for all members of an enrolled
5 group;

6 C. "commission" means the health care commission
7 created pursuant to the Health Care Act;

8 D. "director" means the director of the commission;

9 E. "eligible person" means:

10 (1) except as provided in Paragraphs (2)
11 through (7) of this subsection, a person who has resided in the
12 state for at least one year and any child of that person who
13 lives with the person and is in the legal custody of the person;

14 (2) a public employee, including an employee of
15 the state or any political subdivision of the state and an
16 employee of a public school or state educational institution;

17 (3) a medicaid or medicare recipient as
18 participation is authorized by federal statute, regulation,
19 waiver or agreement;

20 (4) a person entitled to health care services
21 through the veterans' administration as participation is
22 authorized by federal statute, regulation, waiver or agreement;

23 (5) a person, except federal retirees covered
24 by other federal health insurance plans as participation is
25 authorized by federal statute, regulation, waiver or agreement;

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1 (6) a person covered by a health insurance plan
2 pursuant to the provisions of the federal Employee Retirement
3 Income Security Act of 1974 as participation is authorized by
4 federal statute, regulation, waiver or agreement or as a
5 business covered by the provisions of that act chooses to be
6 covered under the provisions of the health care plan; or

7 (7) a person becoming eligible by payment of a
8 premium pursuant to Section 17 of the Health Care Act,

9 F. "global budget" means the prospective operating
10 budget of a health care facility, excluding the capital budget;

11 G. "group practice" means a health maintenance
12 organization or other association of health care providers that
13 provides one or more specialized health care services, such as
14 laboratory services, x-Ray services, emergency care and
15 inpatient or outpatient hospital services;

16 H. "health care facility" means a clinic, general or
17 special hospital, outpatient facility, psychiatric hospital,
18 laboratory, skilled nursing facility or nursing facility. For
19 the purpose of determining global budgets, "health care
20 facility" includes a group practice or transportation service;

21 I. "health care provider" means:

22 (1) a person licensed or certified in New
23 Mexico as a:

24 (a) physician;

25 (b) osteopathic physician;

- 1 (c) physician assistant or osteopathic
2 physician's assistant;
- 3 (d) chiropractic physician;
- 4 (e) dentist;
- 5 (f) psychologist, social worker;
6 professional clinical mental health counselor, professional
7 mental health counselor, marriage and family therapist or
8 registered mental health counselor;
- 9 (g) optometrist;
- 10 (h) podiatrist;
- 11 (I) pharmacist;
- 12 (j) pharmacist clinician;
- 13 (k) registered nurse or certified nurse
14 practitioner;
- 15 (l) visiting nurse service, private duty
16 registry or other certified home health agency;
- 17 (m) doctor of oriental medicine;
- 18 (n) physical therapist;
- 19 (o) massage therapist;
- 20 (p) occupational therapist;
- 21 (q) speech-language pathologist;
- 22 (r) audiologist;
- 23 (s) respiratory care practitioner;
- 24 (t) midwife;
- 25 (u) dietician or nutritionist;

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- (v) transportation service; or
- (w) other practitioner of the healing arts designated as a health care provider by the commission;
- (2) a person licensed or certified by a nationally recognized professional organization and designated as a health care provider by the commission as a:
 - (a) prosthetist;
 - (b) orthotist; or
 - (c) oculist; or
- (3) a group practice or transportation service for that portion of the group practice or transportation service that is paid pursuant to a fee schedule established by the commission;
- J. "health plan" means the mechanism developed by the commission for provision of health care services pursuant to the Health Care Act;
- K. "implicit price deflator" means a measure of inflation that is published in the United States department of commerce survey of current business;
- L. "major capital expenditure" means the purchase of diagnostic, treatment or transportation equipment costing fifty thousand dollars (\$50,000) or more or construction or renovation of facilities;
- M "person" means a legal entity;
- N. "primary care provider" means a licensed

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1 physician, osteopathic physician, nurse practitioner,
2 physician's assistant, osteopathic physician's assistant,
3 pharmacist clinician or other provider certified by the
4 commission as a primary care provider who provides the first
5 level of health care for an eligible person's health needs, as
6 specified by the commission;

7 0. "provider budget" means the fee schedule
8 established by the commission each year to pay for health care
9 services provided by health care providers participating in the
10 health plan; and

11 P. "transportation service" means ambulance,
12 helicopter or other transport that is equipped with emergency
13 supplies and equipment and is used to transport patients to
14 health care providers or facilities and other transportation
15 authorized by the commission.

16 Section 4. HEALTH CARE COMMISSION CREATED-- VOTING AND
17 NONVOTING MEMBERS. --

18 A. The "health care commission" is created as an
19 adjunct agency pursuant to the Executive Reorganization Act.
20 The general services department, the department of health and
21 the human services department shall cooperate with the
22 commission and assist it as needed. The commission consists of
23 fifteen voting members and nine nonvoting members. The voting
24 members, all of whom shall be appointed by the governor with the
25 advice and consent of the senate, are:

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1 (1) four persons who represent consumer
2 interests, at least one of whom represents elderly consumer
3 interests and at least one of whom represents Native American
4 interests;

5 (2) two persons who represent persons with
6 physical or mental impairments that limit one or more of their
7 major life activities;

8 (3) five persons who represent either health
9 care providers or health care facilities;

10 (4) two persons who represent business
11 ownership interests, with one person representing employers of
12 more than fifteen persons and one person representing employers
13 of fifteen persons or fewer; and

14 (5) two persons who represent organized labor.

15 B. The voting members appointed shall reflect the
16 ethnic, gender, economic and geographic diversity of the state.
17 To ensure fair geographic representation of all areas of the
18 state, members shall be appointed from each of the state board
19 of education districts established by the 1991 Educational
20 Redistricting Act as follows:

21 (1) two from state board of education district
22 1;

23 (2) one from state board of education district
24 2;

25 (3) one from state board of education district

- 1 3;
2 (4) two from state board of education district
3 4;
4 (5) two from state board of education district
5 5;
6 (6) one from state board of education district
7 6;
8 (7) two from state board of education district
9 7;
10 (8) two from state board of education district
11 8;
12 (9) one from state board of education district
13 9; and
14 (10) one from state board of education district
15 10.

16 C. The initial voting members of the commission
17 shall be appointed by the governor by August 1, 1997. The terms
18 of the initial voting members appointed shall be staggered as
19 follows: five members shall be appointed for a term of four
20 years; five members shall be appointed for a term of three
21 years; and five members shall be appointed for a term of two
22 years. Thereafter, all members shall be appointed for terms of
23 four years. After initial terms are served, no member shall
24 serve more than two consecutive four-year terms.

25 D. A voting member may be removed from the

1 commission only for incompetence, neglect of duty or malfeasance
2 in office. The governor shall initiate removal proceedings.
3 No voting member shall be removed without having first been
4 given notice of hearing and an opportunity to be heard. The
5 supreme court has exclusive original jurisdiction over
6 proceedings to remove a voting member. The supreme court's
7 decision on removal shall be final.

8 E. A majority of the commission's voting members
9 constitutes a quorum for the transaction of business. The
10 commission shall choose annually its chairman and any other
11 officers it deems necessary.

12 F. Voting members shall receive per diem and mileage
13 in accordance with the provisions of the Per Diem and Mileage
14 Act.

15 G. The commission is composed of the following nine
16 nonvoting members:

- 17 (1) the secretary of health;
18 (2) the secretary of human services;
19 (3) the secretary of children, youth and
20 families;
21 (4) the secretary of taxation and revenue;
22 (5) a person designated by the New Mexico
23 office of Indian affairs, after consultation with the federal
24 Indian health services;
25 (6) two members of the house of representatives

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1 appointed by the speaker of the house, including one member of
2 the majority party and one member of the minority party; and

3 (7) two members of the senate, including one
4 member of the majority party and one member of the minority
5 party appointed by the committees' committee of the senate, or,
6 if the senate appointments are made in the interim, by the
7 president pro tempore of the senate after consultation with and
8 agreement of a majority of the members of the committees'
9 committee.

10 H. The governor shall recommend to the legislature
11 by January 1, 1998 the need for compensation for commission
12 members.

13 Section 5. CONFLICT OF INTEREST. --

14 A. Except for nonvoting members and members
15 appointed to represent health care facilities or health care
16 providers, no commission member or a member of his immediate
17 family shall have any financial interest, direct or indirect, in
18 a person providing health care services or health care
19 insurance.

20 B. The commission shall adopt a conflict of interest
21 disclosure statement for use by all members that specifies
22 financial interests of the member or member of his immediate
23 family in a person providing the health care services or health
24 care insurance.

25 C. No member of the commission shall vote on any

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1 matter in which he or a member of his immediate family has a
2 financial interest.

3 D. If there is a question about a conflict of
4 interest of a member, the commission shall vote on whether to
5 allow the member to vote.

6 Section 6. DIRECTOR--STAFF--CONTRACTS--BUDGETS.--

7 A. To assist in carrying out its duties, the
8 commission shall appoint and set the salary of a "director".
9 The director shall serve at the pleasure of the commission.

10 B. The director may employ those persons necessary
11 to carry out the purposes of the Health Care Act. Employees are
12 subject to the provisions of the Personnel Act.

13 C. The director and his staff shall implement the
14 Health Care Act in accordance with that act and the policies and
15 regulations adopted by the commission.

16 D. If the director determines that commission staff
17 or another state agency does not have the resources or expertise
18 to perform a necessary task, the commission may contract with a
19 person that has a demonstrated capability to perform the task.
20 If claims processing is provided by contract, that contract
21 shall require that all work shall be performed entirely in New
22 Mexico. All contracts shall be reviewed at least every two
23 years to ensure that they continue to meet the criteria and
24 performance standards of the contract and the needs of the
25 commission.

1 E. The director may contract with consultants that
2 the director deems necessary to advise him or the commission in
3 carrying out the provisions of the Health Care Act.

4 F. The director shall prepare an annual budget and
5 plan of operation for the commission. He shall submit both to
6 the commission for its approval before implementation.

7 Section 7. COMMISSION--GENERAL POWERS AND DUTIES.--The
8 commission shall:

9 A. adopt a five-year program of operation to
10 implement the provisions of the Health Care Act;

11 B. provide a program to educate the public, health
12 care providers and health care facilities about the health care
13 plan and the persons eligible to receive its benefits;

14 C. study and adopt the most cost-effective methods
15 of providing health care services to all eligible persons,
16 according high priority to increased reliance on:

17 (1) preventive and primary care, including
18 immunization and screening examinations;

19 (2) providing health care services in rural or
20 underserved areas of the state;

21 (3) in-home and community-based alternatives to
22 institutional care; and

23 (4) case management services when appropriate;

24 D. establish fee schedules and other compensation
25 for health care providers and adopt standards and procedures for

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1 negotiating and entering into contracts with participating
2 health care providers;

3 E. establish global budgets for health care
4 facilities and adopt:

5 (1) standards and procedures for determining
6 base budgets and annual global budgets for health care
7 facilities; and

8 (2) a capital expenditure program that requires
9 prior approval for major capital expenditures by health care
10 facilities;

11 F. negotiate and enter into health care reciprocity
12 agreements with other states and foreign countries and negotiate
13 and enter into health care agreements with out-of-state health
14 care providers and health care facilities;

15 G. develop a payment system for health care
16 providers and health care facilities that affords continuity of
17 payments;

18 H. collect and analyze health care data and other
19 data necessary to improve the efficiency and effectiveness of
20 health care services and to control costs of health care
21 services in New Mexico, and shall include data on:

22 (1) mortality and natality, including
23 accidental causes of death;

24 (2) morbidity;

25 (3) health behavior;

- 1 (4) disability;
- 2 (5) health care services system costs,
- 3 availability, utilization and revenues;
- 4 (6) environmental factors;
- 5 (7) availability, adequacy and training of
- 6 health care services personnel;
- 7 (8) demographic factors;
- 8 (9) social and economic conditions affecting
- 9 health; and
- 10 (10) other factors determined by the
- 11 commission;

12 I. standardize data collection and specific methods
13 of measurement across databases and use scientific sampling or
14 complete enumeration for reporting health information;

15 J. establish a health care delivery system that is
16 efficient to administer and that eliminates unnecessary
17 administrative costs;

18 K. adopt rules and regulations necessary to
19 implement and monitor a state formulary to provide prescription
20 drugs, medicine, durable medical equipment and supplies,
21 eyeglasses, hearing aids, oxygen and related services;

22 L. study and evaluate the adequacy and quality of
23 health care services furnished pursuant to the Health Care Act,
24 the cost of each type of service and the effectiveness of cost-
25 containment measures in the health plan;

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1 M study and monitor the migration of persons to New
2 Mexico to determine if persons with costly health care needs are
3 moving to New Mexico to receive health care services. If
4 migration appears to threaten the financial stability of the
5 health plan, the commission shall recommend to the legislature
6 changes in eligibility requirements, premiums or other statutory
7 changes that may be necessary to maintain the financial
8 stability of the health plan;

9 N. study and evaluate the cost of medical
10 professional liability and medical professional liability
11 insurance and recommend statutory changes to the legislature as
12 necessary;

13 O. set or approve changes in benefit standards
14 covered by the health plan;

15 P. conduct necessary investigations and inquiries
16 and compel by subpoena the submission of information and
17 documents that the commission considers necessary to carry out
18 its duties;

19 Q. adopt rules and regulations necessary to
20 implement, administer and monitor the operation of the health
21 plan;

22 R. meet as needed, but no less than once every three
23 months; and

24 S. report annually to the legislature and the
25 governor on the commission's activities and the operation of

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1 the health plan and include in the annual report:

2 (1) a summary of information about health care
3 needs, health care services, health care expenditures, revenues
4 and other relevant issues relating to the health plan and the
5 five-year program; and

6 (2) recommendations on methods to control
7 health care costs and improve access to and the quality of
8 health care for state residents, as well as recommendations for
9 legislative action if any are found to be necessary.

10 Section 8. ADVISORY BOARDS. --

11 A. The commission may establish advisory boards to
12 assist it in performing its duties.

13 B. The commission shall establish a "health care
14 provider advisory board" to advise and assist the commission in
15 all decisions requiring the expertise of health care providers.
16 Each noncommission member shall represent a different licensed
17 health profession.

18 C. The commission may appoint commission members and
19 up to five additional persons to serve on each advisory board it
20 creates. Advisory board members who are not commission members
21 may be paid per diem and mileage in accordance with the
22 provisions of the Per Diem and Mileage Act.

23 D. Staff and technical assistance for the advisory
24 boards shall be provided by the commission as necessary.

25 Section 9. HEALTH CARE DELIVERY REGIONS. -- The commission

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1 shall establish health care delivery regions in the state, based
2 on geography and health care resources. The regions may have
3 differential fee schedules, global budgets, capital allocations
4 or other features to encourage the provision of health care
5 services in rural and other underserved areas.

6 Section 10. REGIONAL COUNCILS. --

7 A. The commission shall create regional councils in
8 the health care delivery regions of the state.

9 B. The regional councils shall be composed of at
10 least one of the commission members who live in the region and
11 five other members appointed by the commission. No more than
12 two council members shall have any financial interest, direct or
13 indirect, in a person providing health care services or a person
14 providing health care insurance.

15 C. Members of a regional council may be paid per
16 diem and mileage in accordance with the provisions of the Per
17 Diem and Mileage Act.

18 D. The regional councils shall hold public hearings
19 to receive comments, suggestions and recommendations from the
20 public regarding regional health care needs. The councils shall
21 report to the commission so that regional concerns are
22 considered in the development and update of the five-year
23 program, fee schedules and global budgets.

24 E. Staff and technical assistance for the regional
25 councils shall be provided by the commission as necessary.

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1 Section 11. COMMISSION, COUNCILS AND ADVISORY BOARDS--
2 MEETINGS.--All meetings of the commission, councils and advisory
3 boards shall be conducted pursuant to the provisions of the Open
4 Meetings Act.

5 Section 12. RULES AND REGULATIONS.--

6 A. The commission shall adopt reasonable regulations
7 necessary to carry out the duties of the commission and the
8 provisions of the Health Care Act.

9 B. No regulation affecting any person or agency
10 outside the commission shall be adopted, amended or repealed
11 without a public hearing on the proposed action before the
12 commission or a hearing officer designated by the commission.
13 The hearing officer may be a member of the commission's staff.
14 The hearing shall be held in Santa Fe unless the commission
15 determines that it would be in the interest of those affected to
16 hold the hearing elsewhere in the state. Notice of the subject
17 matter of the regulation, the action proposed to be taken, the
18 time and place of the hearing, the manner in which interested
19 persons may present their views and the method by which copies
20 of the proposed regulation, proposed amendment or repeal of an
21 existing regulation may be obtained shall be published once at
22 least thirty days prior to the hearing date in a newspaper of
23 general circulation and mailed at least thirty days prior to the
24 hearing date to all persons who have made a written request for
25 advance notice of hearing.

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1 C. All rules and regulations adopted by the
2 commission shall be filed in accordance with the State Rules
3 Act.

4 Section 13. HEALTH PLAN. --

5 A. After notice and public hearing, including taking
6 public comment and the reports of the regional councils, the
7 commission shall adopt a health plan.

8 B. The health plan shall be designed to provide
9 comprehensive, necessary and appropriate health care benefits,
10 including preventive health care and primary, secondary and
11 tertiary health care for acute and chronic conditions. The
12 health plan may provide for certain health care services to be
13 phased in as the health plan budget allows.

14 C. The commission shall specify the health care
15 services to be included as covered by the health plan and shall
16 include:

- 17 (1) preventive health services;
18 (2) provider services;
19 (3) inpatient and outpatient medical services;
20 (4) laboratory tests and imaging procedures;
21 (5) in-home, community-based and institutional
22 long-term care services;
23 (6) prescription drugs;
24 (7) inpatient and outpatient mental health
25 services;

1 (8) drug and substance abuse services;
2 (9) preventive and prophylactic dental
3 services, including an annual dental examination and cleaning,
4 but not including orthodontic services;

5 (10) vision appliances, including medically
6 necessary contact lenses;

7 (11) medical supplies, durable medical
8 equipment and selected assistive devices, including hearing and
9 speech assistance devices; and

10 (12) experimental treatment services as
11 specified on a case-by-case basis by the commission.

12 D. Covered services shall not include:

13 (1) surgery for cosmetic purposes other than
14 for reconstructive purposes;

15 (2) medical examinations and medical reports
16 prepared for purchasing or renewing life insurance or
17 participating as a plaintiff or defendant in a civil action for
18 the recovery or settlement of damages; and

19 (3) cosmetic dental services except for
20 reconstructive purposes.

21 E. The health plan shall specify the services to be
22 covered and the amount, scope and duration of benefits. The
23 plan shall include a maximum amount or percentage for
24 administrative costs, and this maximum may be variable in
25 relation to total costs of services provided under the health

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1 plan.

2 F. The commission shall specify the terms and
3 conditions for participation of health care providers and health
4 care facilities in the health plan.

5 G. The commission shall control health care costs so
6 that eligible persons receive comprehensive health services,
7 consistent with budget constraints, including needed health care
8 services in rural and other underserved areas.

9 H. The health plan shall phase in eligible persons
10 as their participation becomes possible through agreements,
11 waivers or federal legislation. The health plan may provide for
12 certain preventive health care services to be offered to all New
13 Mexicans regardless of eligibility.

14 I. The five-year program shall be reviewed by the
15 regional councils and the commission annually and revised as
16 necessary. Revisions shall be adopted by the commission in
17 accordance with Section 12 of the Health Care Act. In
18 projecting services under the health plan, the commission shall
19 take all reasonable steps to ensure that long-term care, mental
20 health services and dental care are provided at the earliest
21 practical times consistent with budget constraints.

22 J. Any changes in health care services offered by
23 the health plan shall be approved by the commission.

24 Section 14. LONG-TERM CARE. --

25 A. Long-term care may include:

1 (1) home- and community-based services,
2 including personal assistance and attendant care;

3 (2) hospice care; and

4 (3) institutional care.

5 B. No later than one year after appointment of the
6 director, the commission shall appoint a "long-term care
7 committee" made up of representatives of health care consumers,
8 providers and administrators to develop a plan for integrating
9 long-term care into the health plan. The committee shall report
10 its plan to the commission no later than one year from its
11 appointment. Committee members may receive per diem and mileage
12 as provided in the Per Diem and Mileage Act.

13 C. The long-term care component of the health plan
14 shall provide for service coordination, case management and
15 noninstitutional services where appropriate.

16 D. Nothing in this section affects long-term care
17 services paid through federal programs or private insurance.

18 E. Nothing in this section precludes the commission
19 from including long-term care services from the inception of the
20 health plan.

21 Section 15. MENTAL HEALTH SERVICES. --

22 A. Mental health services may include:

23 (1) services for acute and chronic conditions;

24 (2) home- and community-based services; and

25 (3) institutional care.

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1 B. No later than one year after appointment of the
2 director, the commission shall appoint a "mental health services
3 committee" made up of representatives of mental health care
4 consumers, providers and administrators to develop a plan for
5 integrating mental health services into the health plan. The
6 committee shall report its plan to the commission no later than
7 one year from its appointment. Committee members may receive
8 per diem and mileage as provided in the Per Diem and Mileage
9 Act.

10 C. The mental health services component of the
11 health plan shall provide for service coordination, case
12 management and noninstitutional services where appropriate.

13 D. Nothing in this section affects mental health
14 services paid through federal programs or private insurance.

15 E. Nothing in this section precludes the commission
16 from including mental health services from the inception of the
17 health care plan.

18 Section 16. ~~MEDICAID COVERAGE-- JOINT POWERS AGREEMENTS. --~~
19 The commission may enter into joint powers agreements with the
20 human services department in accordance with the Joint Powers
21 Agreements Act for the purpose of furthering the goals of the
22 Health Care Act. These agreements may transfer certain medicaid
23 functions to the commission to allow the commission to implement
24 the health plan.

25 Section 17. ~~HEALTH PLAN COVERAGE-- ELIGIBLE PERSONS--~~

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1 NONRESIDENT STUDENTS-- ELIGIBILITY CARD-- PENALTIES. --

2 A. An eligible person shall be covered by the health
3 plan, but a person who has not resided in New Mexico for at
4 least one year may become an eligible person upon payment of a
5 premium as determined by the commission.

6 B. State educational institutions shall purchase
7 coverage under the health plan for its out-of-state and
8 emancipated students through fees assessed to students. The
9 board of regents or other governing body of a state educational
10 institution shall set the fees at the amount determined by the
11 commission.

12 C. A student at a state educational institution who
13 has not resided in the state for one year may demonstrate proof
14 of health insurance coverage by a policy in another state that
15 is acceptable to the commission, and his fee shall be reduced as
16 provided by the commission.

17 D. The commission shall adopt regulations to
18 determine proof of a person's eligibility for the health plan or
19 a student's proof of nonresident insurance coverage. The
20 regulations shall provide a method for the purging of
21 eligibility when a person is no longer eligible for coverage.

22 E. An eligible person shall receive a card as proof
23 of eligibility. The card shall be electronically readable and
24 shall contain a picture or electronic image, information that
25 identifies the person for treatment and electronic billing and

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1 payment and any other information the commission deems
2 necessary.

3 F. The eligibility card is not transferable. A
4 person who lends his card to another and a person who uses
5 another's card shall each be liable to the commission for the
6 full cost of the health care services provided to the user.
7 Each person shall pay the liability in full within ten days of
8 being billed. If either person does not pay his liability, the
9 other person shall be liable for that share. Liabilities
10 pursuant to this section shall be collected by the taxation and
11 revenue department in the same manner as delinquent taxes are
12 collected pursuant to the Tax Administration Act.

13 G. A person who lends his card to another or a
14 person who uses another's card a second time is guilty of a
15 misdemeanor and shall be sentenced pursuant to the provisions of
16 Section 31-19-1 NMSA 1978. A third or subsequent conviction is
17 a fourth degree felony and the offender shall be sentenced
18 pursuant to the provisions of Section 31-18-15 NMSA 1978.
19 Persons convicted pursuant to this subsection are also liable
20 for the amounts specified in Subsection F of this section.

21 Section 18. PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS
22 TO SERVICES.--

23 A. Except as provided in the Workers' Compensation
24 Act, an eligible person has the right to choose a primary care
25 provider. If an eligible person does not choose a primary care

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1 provider, one shall be assigned by procedures pursuant to
2 regulations of the commission.

3 B. The primary care provider shall be responsible
4 for providing medical treatment, other than medical emergencies.
5 If the expertise of another health care provider is needed, the
6 primary care provider shall make a referral to the appropriate
7 specialty. Except as provided in Subsections C and E of this
8 section, health care provider specialists shall be paid only if
9 the patient has been referred by the patient's primary care
10 provider.

11 C. The commission shall by regulation specify the
12 conditions under which an eligible person may select a
13 specialist as a primary care provider. The commission shall set
14 primary care provider rates for specialists when serving as
15 primary care providers.

16 D. The commission shall by regulation specify how
17 often and under what conditions an eligible person may change
18 his primary care provider.

19 E. The commission shall by regulation specify when
20 and under what circumstances an eligible person may self-refer,
21 including self-referral to chiropractors, acupuncturists, mental
22 health professionals and other health care providers who are not
23 primary care providers.

24 Section 19. DISCRIMINATION PROHIBITED. --No health care
25 provider or health care facility shall discriminate against or

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1 refuse to furnish health care services to a person covered by
2 the plan on the basis of race, color, income level, national
3 origin, religion, gender, sexual orientation, disabling
4 condition or payment status. Nothing in this section shall
5 require a health care provider or health care facility to care
6 for a patient if it is not qualified to provide the needed care
7 and it does not offer that needed care to the general public.

8 Section 20. UTILIZATION REVIEW--MONITORING--EFFICIENCY
9 OF OPERATIONS--PENALTIES.--

10 A. The commission shall implement an evaluation and
11 monitoring program that considers, at a minimum, access to care,
12 quality of care and utilization of care provided by the health
13 plan, including geographic distribution of health care
14 resources.

15 B. The commission shall set standards and review
16 benefits to ensure that effective, cost-efficient and
17 appropriate health care services are rendered.

18 C. The commission shall establish an ongoing system
19 for monitoring patterns of practice and peer review. The system
20 shall include the appointment of an advisory group consisting of
21 health care providers, health care facilities and other
22 knowledgeable persons to advise the commission and staff on
23 health care practice issues.

24 D. The commission shall establish a system of peer
25 education for health care providers or health care facilities

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1 engaging in aberrant patterns of practice. If the commission
2 determines that peer education efforts have failed, the
3 commission may refer the matter to the appropriate licensing or
4 certifying board.

5 E. The commission shall provide by regulation the
6 procedures for recouping payments or withholding payments for
7 health care services determined by the commission to be
8 medically unnecessary. In addition, the commission may provide
9 by regulation for the assessment of administrative penalties for
10 up to three times the amount of excess payments if it finds that
11 excessive billings were part of an aberrant pattern of practice.
12 Administrative penalties shall be deposited in the current
13 school fund.

14 F. After consultation with the peer review advisory
15 group, the commission may suspend or revoke a health care
16 provider's or health care facility's privilege to provide health
17 care services under the health plan for aberrant patterns of
18 practice, including overutilization, unnecessary referrals,
19 attempts to unbundle health care services or other practices
20 that the commission deems a violation of the Health Care Act or
21 regulations adopted pursuant to that act. As used in this
22 section, "unbundle" means to divide a service into components in
23 an attempt to increase or with the effect of increasing
24 compensation from the health plan.

25 G. The commission shall report a suspension or

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1 revocation to practice under the Health Care Act to the
2 appropriate licensing or certifying board.

3 H. The commission shall report cases of suspected
4 fraud by a health care provider or a health care facility to the
5 attorney general or to the district attorney of the county where
6 the health care provider or health care facility operates for
7 investigation and prosecution.

8 I. The commission shall review and adopt
9 professional practice guidelines developed by state and national
10 medical and specialty organizations, the United States agencies
11 for health care policy and research and other organizations as
12 it deems necessary to promote the quality and cost-effectiveness
13 of health care services provided through the health plan.

14 Section 21. HEALTH PLAN BUDGET. --

15 A. Each year, the commission shall develop a health
16 plan budget. The budget shall establish the total amount to be
17 spent by the plan for covered health care services in the next
18 year. The budget shall include provider budgets and global
19 budgets.

20 B. Unless otherwise provided in the general
21 appropriation act or other act of the legislature, the health
22 plan budget shall be within projected annual revenues.

23 C. In developing the health plan budget, the
24 commission shall provide that credit be taken in that budget for
25 all revenues produced for health care services and facilities in

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1 the state pursuant to any law other than the Health Care Act.

2 Section 22. PROVIDER BUDGET--PAYMENTS TO HEALTH CARE
3 PROVIDER--CO-PAYMENTS. --

4 A. Consistent with budget constraints, the health
5 plan shall provide payment for all covered health care services
6 rendered by health care providers. A variety of payment plans,
7 including fee-for-service, compensation caps and capitated
8 payments may be adopted by the commission. Payment plans shall
9 be negotiated with providers as provided by regulation.

10 B. Different or supplemental payment rates may be
11 adopted to provide incentives to help ensure the delivery of
12 needed health care services in rural and other underserved areas
13 throughout the state.

14 C. The annual percentage increase in provider
15 budgets shall be no greater than the percentage increase in the
16 implicit price deflator using one year prior to implementation
17 of the health plan as the baseline year.

18 D. Payment, or the offer of payment whether or not
19 that offer is accepted, to a health care provider for services
20 covered by the health plan shall be payment in full for those
21 services. A health care provider shall not charge a patient
22 covered under the health plan any additional amounts for
23 services covered by the plan.

24 E. The commission may set co-payments if co-payment
25 is determined to be an effective cost-control measure. No co-

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1 payment shall be required for preventive care or if it creates a
2 barrier to medically necessary care. When a co-payment is
3 required, the health care provider or health care facility shall
4 not waive the co-payment.

5 Section 23. GLOBAL BUDGET--PAYMENTS TO HEALTH CARE
6 FACILITIES.--

7 A. A health care facility shall negotiate an annual
8 global budget with the commission. The global budget shall be
9 based on a base budget of past performance and projected changes
10 upward or downward in costs and services anticipated for the
11 next year. If a negotiated agreement is not reached, the
12 commission shall set the global budget for the health care
13 facility. The initial base budget for a health care facility
14 shall be based on a twelve-month period that is no later than
15 the year the health plan is implemented, appropriately adjusted
16 by the implicit price deflator not to exceed five percent a year
17 from 1995 to the first global budget. Thereafter, increases in
18 global budgets are limited by the implicit price deflator.

19 B. Different or supplemental payment rates may be
20 adopted to provide incentives to help ensure the delivery of
21 needed health care services in rural and other underserved areas
22 throughout the state.

23 C. Each health care provider employed by a globally
24 budgeted health care facility shall be paid from the budget
25 allocation in a manner determined by the health care facility.

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1 Section 24. CAPITAL BUDGETS-- COMMISSION APPROVAL REQUIRED
2 FOR MAJOR CAPITAL EXPENDITURE. --

3 A. The commission shall adopt an annual capital
4 budget.

5 B. Allocations to geographic areas and to individual
6 health care facilities and health care providers shall be based
7 on need and shall be calculated so that the minimum access
8 standards adopted by the commission are considered for all areas
9 of the state, and shall ensure the efficient development and
10 operation of necessary facilities.

11 C. No major capital expenditure shall be made by a
12 health care provider or health care facility without prior
13 approval. The director of the commission has approval authority
14 for major capital expenditures between fifty thousand dollars
15 (\$50,000) and five hundred thousand dollars (\$500,000), based on
16 regulations adopted by the commission. The commission has
17 approval authority for major capital expenditures over five
18 hundred thousand dollars (\$500,000).

19 D. The approval of any proposed major capital
20 expenditure shall be based on efforts to do all of the
21 following:

- 22 (1) fulfill unmet needs;
- 23 (2) preclude unnecessary expansion of
24 facilities and services;
- 25 (3) ensure the efficient development of health

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1 care facilities that are appropriate to the services provided;

2 (4) ensure sufficient access to health care
3 facilities; and

4 (5) ensure access to efficacious new
5 technologies.

6 E. No health care facility or health care provider
7 shall engage in component purchasing to avoid restrictions on
8 major capital expenditures. The commission may deduct the total
9 cost of component purchases in the next year's capital budget or
10 the appropriate operating budget. As used in this subsection,
11 "component purchasing" means the purchase of component parts or
12 other purchasing practice with the effect of circumventing major
13 capital expenditure restrictions.

14 F. There is a two-year moratorium on major capital
15 expenditures beginning July 1, 1997. The commission may grant
16 waivers to the moratorium in emergencies.

17 G. No later than January 1, 1998, the commission
18 shall report to the appropriate committees of the legislature on
19 the capital needs of health care facilities, including
20 facilities of state and local governments, with a focus on
21 underserved geographic areas with substantially below-average
22 health care facilities and investment per capita as compared to
23 the state average. The report shall also describe geographic
24 areas where the distance to health care facilities imposes a
25 barrier to care. The report shall include a section on health

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1 care transportation needs, including capital, personnel and
2 training needs.

3 Section 25. ACTUARIAL REVIEW- -AUDITS. - -

4 A. The commission shall provide for an annual
5 independent actuarial review of the health plan and any funds of
6 the commission or the plan.

7 B. The commission shall provide by regulation for
8 independent financial audits of health care providers and health
9 care facilities.

10 C. The commission, through its staff or by contract,
11 shall perform announced and unannounced audits, including
12 financial, operational, management and electronic data
13 processing audits of health care providers and health care
14 facilities. The auditor shall report directly to the
15 commission. A copy of the audit report shall be given to the
16 state auditor.

17 D. Actuarial reviews, financial audits and internal
18 audits are public documents after they have been released by the
19 commission.

20 Section 26. STANDARD CLAIM FORMS FOR INSURANCE PAYMENT. - -

21 The commission shall adopt standard claim forms that shall be
22 used by all health care providers and health care facilities
23 that seek payment through the health plan or from private
24 persons, including private insurance companies, for health care
25 services rendered in the state. Each claim form may indicate

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1 whether a person is eligible for federal or other insurance
2 programs for payment. Each claim form shall include data
3 elements required by the commission.

4 Section 27. COMPUTERIZED SYSTEM --The commission shall
5 require that all health care providers and health care
6 facilities participate in the health plan's computer network
7 that provides for electronic transfer of payments to health care
8 providers and health care facilities; transmittal of reports,
9 including patient data and other statistical reports; billing
10 data, with specificity as to procedures or services provided to
11 individual patients; and any other information required or
12 requested by the commission.

13 Section 28. REPORTS REQUIRED-- CONFIDENTIAL INFORMATION. --

14 A. The commission, through the state health
15 information system, shall require reports by all health care
16 providers and health care facilities of information needed to
17 allow the commission to evaluate the health plan, cost-
18 containment measures, utilization review, health care facility
19 global budgets, health care provider fees and any other
20 information the commission deems necessary to carry out its
21 duties under the Health Care Act.

22 B. The commission shall establish uniform reporting
23 requirements for health care providers and health care
24 facilities.

25 C. Information confidential pursuant to other

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1 provisions of law shall be confidential under the Health Care
2 Act. Within the constraints of confidentiality, reports of the
3 commission are public documents.

4 Section 29. OMBUDSMAN PROGRAM --

5 A. The commission shall establish an ombudsman
6 program to take complaints and to provide timely and
7 knowledgeable assistance to:

8 (1) eligible persons and applicants about their
9 rights and responsibilities and the coverages provided in
10 accordance with the Health Care Act; and

11 (2) health care providers and health care
12 facilities about status of claims, payments and other pertinent
13 information relevant to the claims payment process.

14 B. The commission shall establish a toll-free
15 telephone line for the ombudsman programs and shall have
16 ombudsmen available throughout the state to assist eligible
17 persons, applicants, health care providers and health care
18 facilities in person.

19 Section 30. APPEALS--MEDIATION--FAIR HEARING. --

20 A. An applicant for or recipient of a health care
21 service may appeal a decision related to eligibility, covered
22 services or a primary care provider's referral decision.

23 B. A health care provider or health care facility
24 may appeal a decision related to claims, budgets or right to
25 practice.

1 C. An appeal of a decision may be summarily settled
2 by the director if the person filing for an appeal presents
3 evidence satisfactory to the director that an erroneous decision
4 had been made. If the summary appeal is unsuccessful, the
5 person may request mediation or a hearing.

6 D. The commission shall by regulation establish
7 procedures for a mediation process. The regulations shall
8 provide for the selection of a mediator that is acceptable to
9 all parties.

10 E. The commission shall by regulation establish
11 procedures for the filing of a request for hearing and the time
12 limits within which a request may be filed. The commission may
13 grant reasonable extensions of the time limits. If the request
14 for hearing is not filed within the specified time or within
15 whatever extension the commission may grant, the initial
16 decision shall be final. Upon receipt of a timely request, the
17 commission shall give the appellant reasonable notice of an
18 opportunity for a fair hearing in accordance with the
19 regulations of the commission.

20 F. The hearing shall be conducted by a hearing
21 officer designated by the director. The hearing officer may be
22 an employee of the commission if there is no conflict of
23 interest in the appointment of the employee.

24 G. The powers of the hearing officer include
25 administering oaths or affirmations to witnesses called to

1 testify, taking testimony, examining witnesses, admitting or
2 excluding evidence and reopening any hearing to receive
3 additional evidence. The technical rules of evidence and rules
4 of civil procedure shall not apply. The hearing shall be
5 conducted so that the contentions or defenses of each party to
6 the hearing are amply and fairly presented. Either party may be
7 represented by counsel or other representative of his
8 designation, and he or his representative may conduct cross-
9 examinations. Any oral or documentary evidence may be received,
10 but the hearing officer may exclude irrelevant, immaterial or
11 unduly repetitious evidence. A verbatim record by audio
12 recording or other means shall be made.

13 H. The commission shall review the verbatim record
14 of the proceedings and shall make a decision based on the
15 record. A written notice of decision shall be sent by certified
16 mail to the person requesting the hearing.

17 Section 31. REVIEW AND APPEAL. --

18 A. Within thirty days after the date written notice
19 of the decision of the commission is mailed, an applicant,
20 recipient, health care provider or health care facility may file
21 a notice of appeal with the court of appeals, together with a
22 copy of the notice of the decision. The clerk of the court
23 shall transmit a copy of the notice of appeal to the director.

24 B. The filing of a notice of appeal shall not stay
25 the enforcement of the decision of the commission, but the

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1 commission may grant, or the court upon motion and good cause
2 shown may order, a stay.

3 C. Appeals shall be taken as provided in the Rules
4 of Appellate Procedure.

5 D. The review of the court shall be made upon the
6 decision and the record of the proceedings.

7 E. The court shall set aside a decision and order of
8 the commission only if found to be:

9 (1) arbitrary, capricious or an abuse of
10 discretion;

11 (2) not supported by substantial evidence in
12 the record as a whole; or

13 (3) otherwise not in accordance with law or the
14 rules and regulations of the commission.

15 Section 32. REIMBURSEMENT FOR OUT-OF-STATE SERVICES--
16 HEALTH PLAN'S RIGHT TO SUBROGATION AND PAYMENT FROM OTHER
17 INSURANCE PLANS--CHARGES FOR NON-COVERED PERSONS. --

18 A. If an eligible person needs health care services
19 out of state, those services shall be covered at the same rate
20 that would apply if the services were received in New Mexico.
21 Additional charges for those services shall not be paid by the
22 health care plan unless the commission has negotiated a
23 reciprocity or other agreement with the other state or foreign
24 country or with the out-of-state health care provider or health
25 care facility.

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1 B. If an otherwise eligible person has a separate
2 health insurance plan that covers the same services, the health
3 plan has the right of subrogation to receive payment from the
4 separate health insurance plan for all covered services paid by
5 the health plan. In those circumstances, the health plan shall
6 be the payer of last resort. Any services provided by a
7 separate health insurance plan not covered in the health plan
8 shall not be affected.

9 C. Nothing in this section affects an ineligible
10 person's responsibility for payment of health care services.

11 Section 33. PRIVATE HEALTH INSURANCE COVERAGE LIMITED--
12 COMMUNITY RATING REQUIRED.--

13 A. Except as provided in Subsection B of Section 32
14 of the Health Care Act, no person shall provide private health
15 insurance to an eligible person for a health care service that
16 is covered by the health plan.

17 B. Health insurance for a health care service that
18 is not covered by the health plan shall be based on a system of
19 community rating in which an insurer shall charge the same
20 premium for the same coverage to each New Mexico resident,
21 regardless of a person's individual circumstances for pre-
22 existing condition, medical risk, job risk, age or gender.

23 C. Nothing in this section shall be construed to
24 affect insurance coverage pursuant to the federal Employee
25 Retirement Income Security Act of 1974 unless the state obtains

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1 a congressional exemption or a waiver from the federal
2 government. Businesses that are covered by the provisions of
3 that act may elect to participate in the health plan.

4 Section 34. FEDERAL HEALTH INSURANCE PROGRAM WAIVERS--
5 REIMBURSEMENT TO PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE
6 PROGRAMS. --

7 A. The commission, in conjunction with the human
8 services department, shall:

9 (1) apply to the United States department of
10 health and human services for all waivers of requirements under
11 health care programs established pursuant to the federal Social
12 Security Act, as amended, that are necessary to enable the state
13 to deposit federal payments for services covered by the health
14 plan into the plan's fund and to be the supplemental payer of
15 benefits for persons receiving medicare benefits;

16 (2) identify other federal programs that
17 provide federal funds for payment of health care services to
18 individuals and apply for any waivers or enter into any
19 agreements that are necessary to enable the state to deposit
20 federal payments for health care services covered by the health
21 plan into the plan's fund; provided, however, agreements
22 negotiated with Indian health services shall not impair treaty
23 obligations of the United States government and other agreements
24 negotiated shall not impair portability or other aspects of the
25 health care coverage; and

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1 (3) seek an amendment to the federal Employee
2 Retirement Income Security Act of 1974 to exempt New Mexico from
3 the provisions of that act that relate to health care services
4 or health insurance, or the commission shall apply to the
5 appropriate federal agency for waivers of any requirements of
6 that act if congress provides for waivers to enable the
7 commission to extend coverage through the Health Care Act to as
8 many New Mexicans as possible.

9 B. The commission shall seek payment to the health
10 plan from medicaid, medicare or any other federal or other
11 insurance program for any reimbursable payment provided under
12 the plan.

13 C. The commission shall seek to maximize federal
14 contributions and payments for health care services provided in
15 New Mexico and shall ensure that the contributions of the
16 federal government for health care services in New Mexico will
17 not decrease in relation to other states as a result of any
18 waivers, exemptions or agreements.

19 Section 35. INSURANCE--COMMISSION APPROVAL.--No person
20 shall insure himself or his employees after July 1, 1997 unless
21 the coverage terminates on the date that the insureds are
22 eligible for coverage under the health plan. Nothing in this
23 section prohibits insurance coverage for health care services
24 not covered by the health plan or for people not eligible for
25 coverage under the health plan.

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1 Section 36. [NEW MATERIAL] INSURANCE RATES-- COMMISSION
2 AND SUPERINTENDENT OF INSURANCE DUTIES. --

3 A. The commission shall work closely with the
4 superintendent of insurance to identify health care cost savings
5 that have been achieved as a result of implementation of the
6 health plan. The commission and the superintendent shall
7 identify savings by insurance companies on payments made for
8 medical services through motor vehicle liability insurance,
9 homeowners' insurance, workers' compensation insurance or other
10 insurance policies that have a medical payment component. The
11 commission and the superintendent shall report their findings to
12 the legislature.

13 B. The superintendent shall lower insurance premiums
14 associated with medical benefits on all types of insurance
15 policies written in New Mexico that have a medical payment
16 component as soon as data indicate health care savings have been
17 achieved as a result of operation of the health plan.

18 Section 37. TEMPORARY PROVISION-- TRANSITION PERIOD
19 ARRANGEMENTS-- PUBLICLY FUNDED HEALTH CARE SERVICE PLANS. --

20 A. A person who, on the date benefits are available
21 under the Health Care Act health plan, receives health care
22 benefits under private contract or collective bargaining
23 agreement entered into prior to July 1, 1997 shall continue to
24 receive those benefits until the contract or agreement expires
25 or unless the contract or agreement is renegotiated to provide

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1 participation in the health plan.

2 B. A person covered by a health care services plan
3 that has its premiums paid for in any part by public money,
4 including money from the state, a political subdivision, state
5 educational institution, public school or other entity that
6 receives public money to pay health insurance premiums, shall be
7 covered by the Health Care Act health plan on the effective date
8 that benefits are available under the plan.

9 Section 38. EFFECTIVE DATE. --The effective date of the
10 provisions of this act is July 1, 1997.

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1 FORTY-THIRD LEGISLATURE
2 FIRST SESSION, 1997
3
4

5 March 10, 1997
6

7 Mr. President:
8

9 Your PUBLIC AFFAIRS COMMITTEE, to whom has been
10 referred

11
12 SENATE BILL 1240
13

14 has had it under consideration and reports same with
15 recommendation that it DO NOT PASS, but that

16
17 SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
18 SENATE BILL 1240
19

20 is reported WITHOUT RECOMMENDATION, and thence referred to the
21 CORPORATIONS & TRANSPORTATION COMMITTEE.
22

23 Respectfully submitted,
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25

Shannon Robinson, Chairman

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Adopted _____ Not Adopted _____
(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 4 For 3 Against

Yes: 4
No: Adair, Boitano, Ingle
Excused: Vernon
Absent: None

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SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 1240

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH CARE ACT TO PROVIDE
FOR COMPREHENSIVE STATEWIDE HEALTH CARE; PROVIDING FOR HEALTH
CARE PLANNING; ESTABLISHING PROCEDURES TO CONTAIN HEALTH CARE
COSTS; CREATING A COMMISSION; PROVIDING ITS POWERS AND DUTIES;
PROVIDING FOR HEALTH CARE DELIVERY REGIONS AND REGIONAL
COUNCILS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE. -- This act may be cited as the
"Health Care Act"

Section 2. PURPOSE OF ACT. -- The purposes of the Health Care
Act are to create a publicly financed statewide health program
to provide coverage for health care services for all state
residents and to control escalating health care costs.

Section 3. DEFINITIONS. -- As used in the Health Care Act:

SPAC/SB 1240

1 A. "beneficiary" means a person eligible for coverage
2 and benefits pursuant to the health plan;

3 B. "capital budget" means that portion of a budget
4 that establishes dollar amounts for expenditures for:

5 (1) acquisition or addition of substantial
6 improvements to real property; and

7 (2) acquisition of tangible personal property;

8 C. "capitation" means allocation of health plan funds
9 to a health care provider based on the number of individuals
10 whose health care must be covered by the provider, with respect
11 to all benefits available under the health plan, for a calendar
12 year or part of a calendar year;

13 D. "commission" means the health care commission
14 created pursuant to the Health Care Act;

15 E. "director" means the director of the commission;

16 F. "global budget" means the prospective operating
17 budget of a health facility, excluding the capital budget;

18 G. "group practice" means a health maintenance
19 organization, an association of health care providers that
20 provides one or more specialized health care services, such as
21 laboratory services, x-ray services, emergency care and
22 inpatient or outpatient hospital services, a tribally operated
23 health care center or tribal coalitions in partnership or under
24 contract with the Indian health service that is authorized under
25 federal law to provide health care to Native American

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1 populations in the state;

2 H. "health care provider" means:

3 (1) a person licensed or certified in New Mexico as
4 a:

5 (a) physician;

6 (b) osteopathic physician;

7 (c) physician assistant or osteopathic
8 physician's assistant;

9 (d) chiropractic physician;

10 (e) dentist;

11 (f) psychologist, social worker; professional
12 clinical mental health counselor, professional mental health
13 counselor, marriage and family therapist or registered mental
14 health counselor;

15 (g) optometrist;

16 (h) podiatrist;

17 (i) pharmacist;

18 (j) pharmacist clinician;

19 (k) registered nurse or certified nurse
20 practitioner;

21 (l) visiting nurse service, private duty
22 registry or other certified home health agency;

23 (m) doctor of oriental medicine;

24 (n) physical therapist;

25 (o) massage therapist;

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- 1 (p) occupational therapist;
 - 2 (q) speech-language pathologist;
 - 3 (r) audiologist;
 - 4 (s) respiratory care practitioner;
 - 5 (t) midwife;
 - 6 (u) dietitian or nutritionist;
 - 7 (v) transportation service; or
 - 8 (w) other practitioner of the healing arts
- 9 designated as a health care provider by the commission;

10 (2) a person licensed or certified by a nationally
11 recognized professional organization and designated as a health
12 care provider by the commission as a:

- 13 (a) prosthetist;
- 14 (b) orthotist; or
- 15 (c) oculist; or

16 (3) a group practice or transportation service for
17 that portion of the group practice or transportation service that
18 is paid pursuant to a fee schedule established by the commission;

19 I. "health facility" means a clinic, general or special
20 hospital, outpatient facility, psychiatric hospital, laboratory,
21 skilled nursing facility or nursing facility. For the purpose of
22 determining global budgets, "health facility" includes a group
23 practice or transportation service;

24 J. "health plan" means the mechanism developed by the
25 commission for provision of health care services pursuant to the

1 Health Care Act;

2 K. "health plan budget" means all expenditures for the
 3 health plan, including the costs of services and benefits provided,
 4 administration, data gathering and other activities;

5 L. "implicit price deflator" means a measure of inflation
 6 that is published in the United States department of commerce
 7 survey of current business;

8 M "major capital expenditure" means construction or
 9 renovation of facilities or the purchase of diagnostic, treatment
 10 or transportation equipment costing more than an amount established
 11 by the legislature after the commission completes a study and makes
 12 recommendations on this matter;

13 N. "person" means a legal entity;

14 O. "primary care provider" means a licensed physician,
 15 osteopathic physician, nurse practitioner, physician assistant,
 16 osteopathic physician's assistant, pharmacist clinician or other
 17 provider certified by the commission as a primary care provider
 18 after the commission's determination that the provider provides the
 19 first level of health care for a beneficiary's health needs;

20 P. "provider budget" means the fee schedule established
 21 by the commission each year to pay for health care services
 22 provided by health care providers participating in the health plan;
 23 and

24 Q. "transportation service" means the services of an
 25 ambulance, helicopter or other conveyance that is equipped with

1 emergency supplies and equipment and is used to transport patients
2 to health care providers or health facilities.

3 Section 4. HEALTH CARE COMMISSION CREATED--VOTING AND
4 NONVOTING MEMBERS.--

5 A. The "health care commission" is created as an adjunct
6 agency pursuant to the Executive Reorganization Act. The general
7 services department, the department of health and the human
8 services department shall cooperate with the commission and assist
9 it as needed. The commission consists of fifteen voting members
10 and nine nonvoting members. The voting members, all of whom shall
11 be appointed by the governor with the advice and consent of the
12 senate, are:

13 (1) four persons who represent consumer interests,
14 at least one of whom represents elderly consumer interests;

15 (2) two persons who represent persons with physical
16 or mental impairments that limit one or more of their major life
17 activities;

18 (3) five persons who represent either health care
19 providers or health facilities;

20 (4) two persons who represent business ownership
21 interests, with one person representing employers of more than
22 fifteen persons and one person representing employers of fifteen
23 persons or fewer; and

24 (5) two persons who represent organized labor.

25 B. The voting members appointed shall reflect the ethnic,

1 gender, economic and geographic diversity of the state. To ensure
2 fair geographic representation of all areas of the state, members
3 shall be appointed from each of the state board of education
4 districts established by the 1991 Educational Redistricting Act as
5 follows:

- 6 (1) two from state board of education district 1;
- 7 (2) one from state board of education district 2;
- 8 (3) one from state board of education district 3;
- 9 (4) two from state board of education district 4;
- 10 (5) two from state board of education district 5;
- 11 (6) one from state board of education district 6;
- 12 (7) two from state board of education district 7;
- 13 (8) two from state board of education district 8;
- 14 (9) one from state board of education district 9;

15 and

- 16 (10) one from state board of education district 10.

17 C. The initial voting members of the commission shall be
18 appointed by the governor by July 1, 1998. The terms of the
19 initial voting members appointed shall be staggered as follows:
20 five members shall be appointed for a term of four years; five
21 members shall be appointed for a term of three years; and five
22 members shall be appointed for a term of two years. Thereafter,
23 all members shall be appointed for terms of four years. After
24 initial terms are served, no member shall serve more than three
25 consecutive four-year terms.

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1 D. A voting member may be removed from the commission
2 only for incompetence, neglect of duty or malfeasance in office.
3 No voting member shall be removed without having first been given
4 notice of hearing and an opportunity to be heard. The supreme
5 court has exclusive original jurisdiction over proceedings to
6 remove a voting member. The supreme court's decision on removal
7 shall be final.

8 E. A majority of the commission's voting members
9 constitutes a quorum for the transaction of business. Annually the
10 commission shall elect its chairman and any other officers it deems
11 necessary.

12 F. Voting members shall receive per diem and mileage in
13 accordance with the provisions of the Per Diem and Mileage Act.

14 G. The commission is composed of the following nine
15 nonvoting members:

16 (1) the secretary of health;
17 (2) the secretary of human services;
18 (3) the secretary of children, youth and families;
19 (4) the secretary of taxation and revenue;
20 (5) a person designated by the New Mexico office of
21 Indian affairs, after consultation with the federal Indian health
22 service;

23 (6) two members of the house of representatives,
24 including one member of the majority party and one member of the
25 minority party, appointed by the speaker of the house; and

1 (7) two members of the senate, including one member
2 of the majority party and one member of the minority party,
3 appointed by the committees' committee of the senate, or, if the
4 senate appointments are made in the interim, by the president pro
5 tempore of the senate after consultation with and agreement of a
6 majority of the members of the committees' committee.

7 H. The governor shall recommend to the legislature by
8 January 1, 1998 whether or not the members of the commission should
9 be compensated.

10 Section 5. CONFLICT OF INTEREST. --

11 A. Except for nonvoting members and members appointed to
12 represent health facilities or health care providers, no commission
13 member or a member of his immediate family shall have any financial
14 interest, direct or indirect, in a person providing health care
15 services or health insurance.

16 B. The commission shall adopt a conflict of interest
17 disclosure statement for use by all members that requires
18 disclosure of financial interests of the member or a member of his
19 immediate family in a person providing the health care services or
20 health insurance.

21 C. No member of the commission shall vote on any matter
22 in which he or a member of his immediate family has a financial
23 interest, except that members representing health facilities or
24 health care providers may vote on matters that pertain generally to
25 health facilities or health care providers.

1 D. If there is a question about a conflict of interest of
2 a member, the commission shall vote on whether to allow the member
3 to vote.

4 Section 6. DIRECTOR--STAFF--CONTRACTS--BUDGETS.--

5 A. To assist in carrying out its duties, the commission
6 shall appoint and set the salary of a "director", subject to the
7 provisions of Section 10-9-5 NMSA 1978. The director shall serve
8 at the pleasure of the commission.

9 B. The director may employ those persons necessary to
10 administer and implement the provisions of the Health Care Act.
11 Employees are subject to the provisions of the Personnel Act.

12 C. The director and his staff shall implement the Health
13 Care Act in accordance with that act and the policies and
14 regulations adopted by the commission. The director may delegate
15 authority to employees and may organize the staff into units to
16 facilitate its work.

17 D. If the director determines that commission staff or
18 another state agency does not have the resources or expertise to
19 perform a necessary task, the commission may contract with a person
20 that has a demonstrated capability to perform the task. If claims
21 processing is provided by contract, that contract shall require
22 that all work shall be performed entirely in New Mexico. All
23 contracts shall be reviewed at least every two years to ensure that
24 they continue to meet the criteria and performance standards of the
25 contract and the needs of the commission.

1 E. The director may contract with consultants that the
2 director deems necessary to advise him or the commission in
3 carrying out the provisions of the Health Care Act.

4 F. The director shall prepare an annual budget and plan
5 of operation for the commission. He shall submit both to the
6 commission for its approval before implementation.

7 Section 7. COMMISSION--GENERAL POWERS AND DUTIES.--The
8 commission shall:

9 A. adopt a five-year program of operation to implement
10 the provisions of the Health Care Act;

11 B. provide a program to educate the public, health care
12 providers and health facilities about the health plan and the
13 persons eligible to receive its benefits;

14 C. study and adopt the most cost-effective methods of
15 providing health care services to all beneficiaries, according high
16 priority to increased reliance on:

17 (1) preventive and primary care that shall include
18 immunization and screening examinations;

19 (2) providing health care services in rural or
20 undeserved areas of the state;

21 (3) in-home and community-based alternatives to
22 institutional care; and

23 (4) case management services when appropriate;

24 D. establish compensation mechanisms for health care
25 providers and adopt standards and procedures for negotiating and

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1 entering into contracts with participating health care providers;

2 E. establish a health plan budget;

3 F. establish global budgets for health facilities and
4 adopt:

5 (1) standards and procedures for determining base
6 budgets and annual global budgets for health facilities; and

7 (2) a capital expenditure program that requires
8 prior approval for major capital expenditures by health facilities;

9 G. negotiate and enter into health care reciprocity
10 agreements with other states and foreign countries and negotiate
11 and enter into health care agreements with out-of-state health care
12 providers and health facilities;

13 H. develop a payment system for health care providers and
14 health facilities that ensures continuity of payments to enable the
15 providers and facilities to meet their financial obligations as
16 they become due;

17 I. establish a system to collect and analyze health care
18 data and other data necessary to improve the quality, efficiency
19 and effectiveness of health care services and to control costs of
20 health care services in New Mexico, and at a minimum the system
21 shall include data on:

22 (1) mortality, including accidental causes of death,
23 and natality;

24 (2) morbidity;

25 (3) health behavior;

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- 1 (4) physical and psychological impairment and
- 2 disability;
- 3 (5) health care services system costs and health
- 4 care services availability, utilization and revenues;
- 5 (6) environmental factors;
- 6 (7) availability, adequacy and training of health
- 7 care services personnel;
- 8 (8) demographic factors;
- 9 (9) social and economic conditions affecting health;
- 10 and
- 11 (10) other factors determined by the commission;

12 J. standardize data collection and specific methods of
13 measurement across databases and use scientific sampling or
14 complete enumeration for reporting health information;

15 K. establish a health care services delivery system that
16 is efficient to administer and that eliminates unnecessary
17 administrative costs;

18 L. adopt rules and regulations necessary to implement and
19 monitor a state formulary to provide prescription drugs, medicine,
20 durable medical equipment and supplies, eyeglasses, hearing aids,
21 oxygen and related services;

22 M study and evaluate the adequacy and quality of health
23 care services furnished pursuant to the Health Care Act, the cost
24 of each type of service and the effectiveness of cost-containment
25 measures in the health plan;

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1 N. study and monitor the migration of persons to New
2 Mexico to determine if persons with costly health care needs are
3 moving to New Mexico to receive health care services, and if
4 migration appears to threaten the financial stability of the health
5 plan, recommend to the legislature changes in eligibility
6 requirements, premiums or other statutory changes that may be
7 necessary to maintain the financial integrity of the health plan;

8 O. study and evaluate the cost of health care provider
9 professional liability and health care provider professional
10 liability insurance and recommend statutory changes to the
11 legislature as necessary;

12 P. establish and approve changes in coverage benefits and
13 benefit standards in the health plan;

14 Q. conduct necessary investigations and inquiries and
15 compel by subpoena the submission of testimony, information and
16 documents that the commission considers necessary to carry out its
17 duties;

18 R. adopt rules and regulations necessary to implement,
19 administer and monitor the operation of the health plan;

20 S. meet as needed, but no less than once every three
21 months; and

22 T. report annually to the legislature and the governor on
23 the commission's activities and the operation of the health plan
24 and include in the annual report:

25 (1) a summary of information about health care

1 needs, health care services, health care expenditures, revenues
 2 received and projected revenues and other relevant issues relating
 3 to the health plan and the five-year program; and

4 (2) recommendations on methods to control health
 5 care costs and improve access to and the quality of health care for
 6 state residents, as well as recommendations for legislative action
 7 if any are found to be necessary.

8 Section 8. COMMISSION--AUTHORITY.--The commission has the
 9 authority necessary to carry out all duties and responsibilities
 10 required of it pursuant to the Health Care Act, whether that
 11 authority is expressly provided in that act or is necessarily
 12 implied. The commission may delegate its general authority to the
 13 director except for specific authority or direction that is granted
 14 to the commission by a provision of the Health Care Act and
 15 authority, which is expressly reserved in the commission, to take
 16 the following actions:

- 17 A. sue and defend suits brought against it, subject to
 18 the provisions of the Tort Claims Act;
- 19 B. enter into contracts;
- 20 C. approve its budget and plan of operation;
- 21 D. approve the health plan and make changes in the health
 22 plan;
- 23 E. adopt regulations, written policies and procedures to
 24 implement the health plan and the provisions of the Health Care
 25 Act;

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1 F. issue subpoenas to persons to appear and testify
2 before the commission and to produce documents and other
3 information, and enforce this subpoena power through an action in
4 the district court of Santa Fe county;

5 G. make reports and recommendations to the legislature;

6 H. apply for program waivers from any governmental
7 entity; and

8 I. accept grants, apply for and receive loans and accept
9 donations.

10 Section 9. ADVISORY BOARDS. --

11 A. The commission may establish advisory boards to assist
12 it in performing its duties.

13 B. The commission shall establish a "health care provider
14 advisory board" to advise and assist the commission in all
15 decisions requiring the expertise of health care providers. Each
16 noncommission member shall represent a different licensed health
17 profession.

18 C. No more than two advisory board members shall have any
19 financial interest, direct or indirect, in a person providing
20 health care services or a person providing health insurance.

21 D. The commission may appoint commission members and up
22 to five additional persons to serve on an advisory board it
23 creates. Advisory board members who are not commission members may
24 be paid per diem and mileage in accordance with the provisions of
25 the Per Diem and Mileage Act.

1 E. Staff and technical assistance for an advisory board
2 shall be provided by the commission as necessary.

3 Section 10. HEALTH CARE DELIVERY REGIONS. -- The commission
4 shall establish health care delivery regions in the state, based on
5 geography and health care resources. The regions may have
6 differential fee schedules, global budgets, capital expenditure
7 allocations or other features to encourage the provision of health
8 care services in rural and other underserved areas.

9 Section 11. REGIONAL COUNCILS. --

10 A. The commission shall create regional councils in the
11 health care delivery regions of the state.

12 B. The regional councils shall be composed of at least
13 one of the commission members who lives in the region and five
14 other members appointed by the commission. No more than two
15 council members shall have any financial interest, direct or
16 indirect, in a person providing health care services or a person
17 providing health insurance.

18 C. Members of a regional council may be paid per diem and
19 mileage in accordance with the provisions of the Per Diem and
20 Mileage Act.

21 D. The regional councils shall hold public hearings to
22 receive comments, suggestions and recommendations from the public
23 regarding regional health care needs. The councils shall report to
24 the commission at times specified by the commission to ensure that
25 regional concerns are considered in the development and update of

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1 the five-year program, fee schedules, global budgets and capital
2 expenditure allocations.

3 E. Staff and technical assistance for the regional
4 councils shall be provided by the commission.

5 Section 12. COMMISSION, COUNCILS AND ADVISORY BOARDS--
6 MEETINGS.--All meetings of the commission, councils and advisory
7 boards shall be conducted pursuant to the provisions of the Open
8 Meetings Act.

9 Section 13. RULES AND REGULATIONS.--

10 A. The commission shall adopt regulations necessary to
11 carry out the duties of the commission and the provisions of the
12 Health Care Act.

13 B. No regulation affecting any person outside the
14 commission shall be adopted, amended or repealed without a public
15 hearing on the proposed action before the commission or a hearing
16 officer designated by the commission. The hearing officer may be a
17 member of the commission's staff. The hearing shall be held in
18 Santa Fe unless the commission determines that it would be in the
19 interest of those affected to hold the hearing elsewhere in the
20 state. Notice of the subject matter of the regulation, the action
21 proposed to be taken, the time and place of the hearing, the manner
22 in which interested persons may present their views and the method
23 by which copies of the proposed regulation or an amendment or
24 repeal of an existing regulation may be obtained shall be published
25 once at least thirty days prior to the hearing date in a newspaper

1 of general circulation and mailed at least thirty days prior to the
 2 hearing date to all persons who have made a written request for
 3 advance notice of hearing.

4 C. All rules and regulations adopted by the commission
 5 shall be filed in accordance with the State Rules Act.

6 Section 14. HEALTH PLAN. --

7 A. After notice and public hearing, including taking
 8 public comment and the reports of the regional councils, the
 9 commission shall adopt a health plan.

10 B. The health plan shall be designed to provide
 11 comprehensive, necessary and appropriate health care benefits,
 12 including preventive health care and primary, secondary and
 13 tertiary health care for acute and chronic conditions. The health
 14 plan may provide for certain health care services to be phased in
 15 as the health plan budget allows.

16 C. The commission shall specify the health care services
 17 to be included as covered by the health plan but shall include:

- 18 (1) preventive health services;
- 19 (2) health care provider services;
- 20 (3) health facility inpatient and outpatient
 21 services;
- 22 (4) laboratory tests and imaging procedures;
- 23 (5) in-home, community-based and institutional long-
 24 term care services;
- 25 (6) prescription drugs;

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- 1 (7) inpatient and outpatient mental health services;
2 (8) drug and substance abuse services;
3 (9) preventive and prophylactic dental services,
4 including an annual dental examination and cleaning;
5 (10) vision appliances, including medically
6 necessary contact lenses;
7 (11) medical supplies, durable medical equipment and
8 selected assistive devices, including hearing and speech assistance
9 devices; and
10 (12) experimental or investigational procedures or
11 treatments as specified by the commission.

12 D. Covered services shall not include:

- 13 (1) surgery for cosmetic purposes other than for
14 reconstructive purposes;
15 (2) medical examinations and medical reports
16 prepared for purchasing or renewing life insurance or participating
17 as a plaintiff or defendant in a civil action for the recovery or
18 settlement of damages; and
19 (3) orthodontic services and cosmetic dental
20 services except those cosmetic dental services necessary for
21 reconstructive purposes.

22 E. The health plan shall specify the services to be
23 covered and the amount, scope and duration of benefits. The plan
24 shall include a maximum amount or percentage for administrative
25 costs, and this maximum, if a percentage, may change in relation to

1 the total costs of services provided under the health plan.

2 F. The commission shall specify the terms and conditions
3 for participation of health care providers and health facilities in
4 the health plan.

5 G. The health plan shall contain provisions to control
6 health care costs so that beneficiaries receive comprehensive
7 health services, consistent with budget constraints, including
8 needed health care services in rural and other underserved areas.

9 H. The health plan shall phase in beneficiaries as their
10 participation becomes possible through contracts, waivers or
11 federal legislation. The health plan may provide for certain
12 preventive health care services to be offered to all New Mexicans
13 regardless of eligibility.

14 I. The five-year program shall be reviewed by the
15 regional councils and the commission annually and revised as
16 necessary. Revisions shall be adopted by the commission in
17 accordance with Section 13 of the Health Care Act. In projecting
18 services under the health plan, the commission shall take all
19 reasonable steps to ensure that long-term care, mental health
20 services and dental care are provided at the earliest practical
21 times consistent with budget constraints.

22 Section 15. LONG-TERM CARE. --

23 A. Long-term care may include:

24 (1) home- and community-based services, including
25 personal assistance and attendant care;

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- 1 (2) hospice care; and
- 2 (3) institutional care.

3 B. No later than one year after appointment of the
4 director, the commission shall appoint an advisory "long-term care
5 committee" made up of representatives of health care consumers,
6 providers and administrators to develop a plan for integrating
7 long-term care into the health plan. The committee shall report
8 its plan to the commission no later than one year from its
9 appointment. Committee members may receive per diem and mileage as
10 provided in the Per Diem and Mileage Act.

11 C. The long-term care component of the health plan shall
12 provide for service coordination, case management and
13 noninstitutional services where appropriate.

14 D. Nothing in this section affects long-term care
15 services paid through federal programs or private insurance subject
16 to the provisions of Sections 34 and 35 of the Health Care Act.

17 E. Nothing in this section precludes the commission from
18 including long-term care services from the inception of the health
19 plan.

20 Section 16. MENTAL HEALTH SERVICES. --

21 A. Mental health services may include:

- 22 (1) services for acute and chronic conditions;
- 23 (2) home- and community-based services; and
- 24 (3) institutional care.

25 B. No later than one year after appointment of the

1 director, the commission shall appoint an advisory "mental health
2 services committee" made up of representatives of mental health
3 care consumers, providers and administrators to develop a plan for
4 integrating mental health services into the health plan. The
5 committee shall report its plan to the commission no later than one
6 year from its appointment. Committee members may receive per diem
7 and mileage as provided in the Per Diem and Mileage Act.

8 C. The mental health services component of the health
9 plan shall provide for service coordination, case management and
10 noninstitutional services where appropriate.

11 D. Nothing in this section affects mental health services
12 paid through federal programs or private insurance subject to the
13 provisions of Sections 34 and 35 of the Health Care Act.

14 E. Nothing in this section precludes the commission from
15 including mental health services from the inception of the health
16 plan.

17 Section 17. MEDICAID COVERAGE-- JOINT POWERS AGREEMENTS. -- The
18 commission may enter into joint powers agreements with the human
19 services department in accordance with the Joint Powers Agreements
20 Act for the purpose of furthering the goals of the Health Care Act.
21 These agreements may provide for certain medicaid functions to be
22 administered by the commission to allow the commission to implement
23 the health plan.

24 Section 18. HEALTH PLAN COVERAGE-- CONDITIONS OF ELIGIBILITY
25 FOR BENEFICIARIES-- NONRESIDENT STUDENTS-- ELIGIBILITY CARD--

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1 PENALTIES. --

2 A. An individual is eligible as a beneficiary of the
3 health plan if the individual has been physically present in New
4 Mexico for one year prior to the date of application for enrollment
5 in the health plan and if the individual has a present intention to
6 remain in New Mexico and not to reside elsewhere. A dependent of
7 an eligible individual is included as a beneficiary. An individual
8 is not eligible for coverage if he is covered for the same or
9 similar benefits pursuant to a private or governmental health
10 insurance policy or plan, but he becomes eligible when that
11 coverage terminates or agreements or waivers are accomplished under
12 which coverage under the health plan is available. Individuals
13 covered under the following governmental programs shall not be
14 brought into coverage through agreements or waivers:

15 (1) federal retiree health plan beneficiaries;

16 (2) Indian health service beneficiaries, but
17 individuals who are covered by tribal providers that are in
18 partnership with or have contracts with the Indian health service
19 may be brought under coverage through agreement between the tribal
20 providers and the commission;

21 (3) active duty military personnel; and

22 (4) individuals covered by the federal civilian
23 health and medical plan for the uniformed services.

24 B. An educational institution shall purchase coverage
25 under the health plan for its nonresident students through fees

1 assessed to these students. The governing body of an educational
2 institution shall set the fees at the amount determined by the
3 commission.

4 C. A nonresident student at an educational institution
5 may demonstrate health insurance or plan coverage by proof of
6 coverage under a policy or plan in another state that is acceptable
7 to the commission. The fee that students shall be assessed shall
8 be specified by the commission.

9 D. The commission shall adopt regulations to determine
10 proof of an individual's eligibility for the health plan or a
11 student's proof of nonresident health insurance or plan coverage.

12 E. The commission shall adopt regulations to provide a
13 method for the purging of eligibility when a beneficiary is no
14 longer eligible for coverage.

15 F. A beneficiary shall receive a card as proof of
16 eligibility. The card shall be electronically readable and shall
17 contain a picture or electronic image, information that identifies
18 the beneficiary for treatment and electronic billing and payment
19 and any other information the commission deems necessary.

20 G. The eligibility card is not transferable. A
21 beneficiary who lends his card to another and an individual who
22 uses another's card shall be jointly and severally be liable to the
23 commission for the full cost of the health care services provided
24 to the user. The liability shall be paid in full within ten days
25 of billing. Liabilities created pursuant to this section shall be

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1 collected by the taxation and revenue department in the same manner
2 as delinquent taxes are collected pursuant to the Tax
3 Administration Act.

4 H. A beneficiary who lends his card to another or an
5 individual who uses another's card a second time is guilty of a
6 misdemeanor and shall be sentenced pursuant to the provisions of
7 Section 31-19-1 NMSA 1978. A third or subsequent conviction is a
8 fourth degree felony and the offender shall be sentenced pursuant
9 to the provisions of Section 31-18-15 NMSA 1978.

10 Section 19. PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS TO
11 SERVICES.--

12 A. Except as provided in the Workers' Compensation Act, a
13 beneficiary has the right to choose a primary care provider. If he
14 does not choose a primary care provider, one shall be assigned to
15 him under procedures in regulations adopted by the commission.

16 B. The primary care provider shall be responsible for
17 providing health care services other than services in medical
18 emergencies. If the expertise of another health care provider is
19 needed, the primary care provider shall make a referral to the
20 appropriate specialty. Except as provided in Subsections C and E
21 of this section, health care provider specialists shall be paid
22 pursuant to the health plan only if the patient has been referred
23 by the patient's primary care provider. Nothing in this subsection
24 prevents a beneficiary from obtaining the services of a health care
25 provider specialist and paying the specialist for services

1 provided.

2 C. The commission shall by regulation specify the
3 conditions under which a beneficiary may select a specialist as a
4 primary care provider. The commission shall set primary care
5 provider rates for specialists when serving as primary care
6 providers.

7 D. The commission shall by regulation specify how often
8 and under what conditions a beneficiary may change his primary care
9 provider.

10 E. The commission shall by regulation specify when and
11 under what circumstances a beneficiary may self-refer, including
12 self-referral to chiropractors, acupuncturists, mental health
13 professionals and other health care providers who are not primary
14 care providers.

15 Section 20. DISCRIMINATION PROHIBITED. --No health care
16 provider or health facility shall discriminate against or refuse to
17 furnish health care services to a beneficiary on the basis of race,
18 color, income level, national origin, religion, gender, sexual
19 orientation, disabling condition or payment status. Nothing in
20 this section shall require a health care provider or health
21 facility to provide services to a beneficiary if the provider or
22 facility is not qualified to provide the needed services and does
23 not offer them to the general public.

24 Section 21. GRIEVANCE PROCEDURES. --The commission shall adopt
25 regulations to cover and shall implement a prompt and fair

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1 grievance procedure to respond to complaints of applicants,
2 beneficiaries, health care providers and health facilities.

3 Section 22. UTILIZATION REVIEW. --

4 A. The commission shall adopt regulations to cover and
5 shall implement a comprehensive utilization review program. The
6 procedures and standards used in the program shall be disclosed in
7 writing to applicants, beneficiaries, health care providers and
8 health facilities at the time of application to or participation in
9 the health plan.

10 B. The decision of the health plan to approve or deny
11 health care services for payment shall be made in a timely manner.
12 A final decision to deny payment for services shall be made by a
13 health care professional having appropriate and adequate
14 qualifications to make the decision. The utilization review
15 program shall be designed to ensure that beneficiaries have proper
16 access to health care services, including referrals to necessary
17 specialists. A decision made in the utilization review program
18 shall be subject to the grievance procedures under regulations
19 adopted pursuant to Section 21 of the Health Care Act.

20 Section 23. MONITORING HEALTH CARE PROVIDER PRACTICES. --

21 A. The commission shall adopt regulations to establish
22 and implement a continuous quality improvement program that
23 monitors the quality and appropriateness of health care services
24 provided by the health plan. The commission shall set standards
25 and review benefits to ensure that effective, cost-efficient and

1 appropriate health care services are rendered.

2 B. The commission shall review and adopt professional
3 practice guidelines developed by state and national medical and
4 specialty organizations, the United States agencies for health care
5 policy and research and other organizations as it deems necessary
6 to promote the quality and cost-effectiveness of health care
7 services provided through the health plan.

8 C. The quality improvement program shall include an
9 ongoing system for monitoring patterns of practice. The commission
10 shall appoint an advisory group consisting of health care
11 providers, representatives of health facilities and other
12 knowledgeable persons to advise the commission and staff on health
13 care practice issues. The advisory group shall provide to the
14 commission recommended standards and guidelines to be followed in
15 making determinations on practice issues.

16 D. The commission shall establish a system of peer
17 education for health care providers or health facilities determined
18 to be engaging in aberrant patterns of practice. If the commission
19 determines that peer education efforts have failed, the commission
20 may refer the matter to the appropriate licensing or certifying
21 board.

22 E. The commission shall provide by regulation the
23 procedures for recouping payments or withholding payments for
24 health care services determined by the commission to be medically
25 unnecessary. In addition, the commission may provide by regulation

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1 for the assessment of administrative penalties for up to three
2 times the amount of excess payments if it finds that excessive
3 billings were part of an aberrant pattern of practice.

4 Administrative penalties shall be deposited in the current school
5 fund.

6 F. After consultation with the peer review advisory
7 group, the commission may suspend or revoke a health care
8 provider's or health facility's privilege to provide health care
9 services under the health plan for aberrant patterns of practice,
10 including overutilization, unnecessary referrals, attempts to
11 unbundle health care services or other practices that the
12 commission deems a violation of the Health Care Act or regulations
13 adopted pursuant to that act. As used in this section, "unbundle"
14 means to divide a service into components in an attempt to increase
15 or with the effect of increasing compensation from the health plan.

16 G. The commission shall report a suspension or revocation
17 to practice under the Health Care Act to the appropriate licensing
18 or certifying board.

19 H. The commission shall report cases of suspected fraud
20 by a health care provider or a health facility to the attorney
21 general or to the district attorney of the county where the health
22 care provider or health facility operates for investigation and
23 prosecution.

24 Section 24. HEALTH PLAN BUDGET. --

25 A. Each year, the commission shall develop a health plan

1 budget. The budget shall establish the total amount to be spent by
 2 the plan for covered health care services in the next year. The
 3 budget shall include administrative budgets, provider budgets and
 4 global budgets.

5 B. Unless otherwise provided in the general appropriation
 6 act or other act of the legislature, the health plan budget shall
 7 be within projected annual revenues.

8 C. In developing the health plan budget, the commission
 9 shall provide that credit be taken in that budget for all revenues
 10 produced for health care services and facilities in the state
 11 pursuant to any law other than the Health Care Act.

12 Section 25. PROVIDER BUDGET--PAYMENTS TO HEALTH CARE
 13 PROVIDER--CO-PAYMENTS. --

14 A. Consistent with budget constraints, the health plan
 15 shall provide payment for all covered health care services rendered
 16 by health care providers. A variety of payment plans, including
 17 fee-for-service, compensation caps and capitated payments may be
 18 adopted by the commission. Payment plans shall be negotiated with
 19 providers as provided by regulation. In the event that negotiation
 20 fails to develop an acceptable payment plan, the disputing parties
 21 shall submit the payment plan to mediation. The commission shall
 22 adopt regulations governing the procedures for mediation. If the
 23 disputed payment plan is not resolved in mediation, the disputing
 24 parties shall submit the payment plan to binding arbitration
 25 pursuant to the Uniform Arbitration Act and regulations to be

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1 adopted by the commission.

2 B. Different or supplemental payment rates may be adopted
3 to provide incentives to help ensure the delivery of needed health
4 care services in rural and other underserved areas throughout the
5 state.

6 C. The annual percentage increase in provider budgets
7 shall be no greater than the percentage increase in the implicit
8 price deflator using one year prior to implementation of the health
9 plan as the baseline year.

10 D. Payment, or the offer of payment whether or not that
11 offer is accepted, to a health care provider for services covered
12 by the health plan shall be payment in full for those services. A
13 health care provider shall not charge a beneficiary any additional
14 amounts for services covered by the plan.

15 E. The commission may set co-payments if co-payment is
16 determined to be an effective cost-control measure. No co-payment
17 shall be required for preventive care or if it creates a barrier to
18 medically necessary care. When a co-payment is required, the
19 health care provider shall not waive the co-payment.

20 Section 26. GLOBAL BUDGET--PAYMENTS TO HEALTH FACILITIES--CO-
21 PAYMENTS. --

22 A. A health facility shall negotiate an annual global
23 budget with the commission. The global budget shall be based on a
24 base budget of past performance and projected changes upward or
25 downward in costs and services anticipated for the next year. If a

1 negotiated annual global budget is not reached, a health facility
 2 shall submit the budget to mediation. The commission shall adopt
 3 regulations governing the procedures for mediation. If the
 4 disputed budget is not resolved in mediation, the health facility
 5 shall submit the budget to binding arbitration pursuant to the
 6 Uniform Arbitration Act and regulations adopted by the commission.
 7 The initial base budget for a health facility shall be based on a
 8 twelve-month period that is no later than the year the health plan
 9 is implemented, appropriately adjusted by the implicit price
 10 deflator not to exceed five percent a year from 1996 to the first
 11 global budget. Thereafter, increases in global budgets are limited
 12 by the implicit price deflator.

13 B. Different or supplemental payment rates may be adopted
 14 to provide incentives to help ensure the delivery of needed health
 15 care services in rural and other underserved areas throughout the
 16 state.

17 C. Each health care provider employed by a globally
 18 budgeted health facility shall be paid from the budget allocation
 19 in a manner determined by the health facility.

20
 21 D. The commission may set co-payments if co-payment is
 22 determined to be an effective cost-control measure. No co-payment
 23 shall be required for preventive care or if it creates a barrier to
 24 medically necessary care. When a co-payment is required, the
 25 health facility shall not waive the co-payment.

1 Section 27. HEALTH RESOURCE CERTIFICATE- - COMMISSION
2 REGULATIONS- - REQUIREMENT FOR REVIEW. - -

3 A. The commission shall adopt regulations pertaining to
4 when a health facility or health care provider must apply for a
5 health resource certificate, how the application will be reviewed,
6 how the certificate will be granted, how an expedited review is
7 conducted and other matters relating to health resource projects.

8 B. No health facility or health care provider shall
9 undertake a capital project or obligate a health facility or health
10 care provider to undertake a project without first obtaining a
11 health resource certificate, except as provided in Subsection F of
12 this section.

13 C. No health facility or health care provider shall
14 acquire through rental, lease or comparable arrangement or through
15 donation all or a part of a capital project that would have
16 required review if the acquisition had been by purchase unless the
17 project is granted a health resource certificate.

18 D. No health facility or health care provider shall
19 engage in component purchasing in order to avoid the provisions of
20 this section.

21 E. The commission shall grant a health resource
22 certificate for a capital project only when the project is
23 determined to be needed.

24 F. This section does not apply to:

- 25 (1) the purchase, construction or renovation of

1 office space for health care providers;

2 (2) a capital project for which a binding
3 contractual obligation was incurred prior to the effective date of
4 this section;

5 (3) expenditures incurred solely in preparation for
6 a capital project, including architectural design, surveys, plans,
7 working drawings and specifications and other related activities,
8 but those expenditures shall be included in the cost of a project
9 for the purpose of determining whether a health resource
10 certificate is required;

11 (4) acquisition of an existing health facility,
12 equipment or practice of a health care provider that does not
13 result in a new service being provided or in increased bed
14 capacity;

15 (5) capital expenditures for nonclinical services
16 when the nonclinical services are the primary purpose of the
17 expenditure; and

18 (6) the replacement of equipment with equipment that
19 has the same function and that does not result in the offering of
20 new services.

21 G. No later than January 1, 1999, the commission shall
22 report to the appropriate committees of the legislature on the
23 capital needs of health facilities, including facilities of state
24 and local governments, with a focus on underserved geographic areas
25 with substantially below-average health facilities and investment

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1 per capita as compared to the state average. The report shall also
2 describe geographic areas where the distance to health facilities
3 imposes a barrier to care. The report shall include a section on
4 health care transportation needs, including capital, personnel and
5 training needs. The report shall make recommendations for
6 legislation to amend the Health Care Act by adding to that act
7 dollar limitations to apply in denying or approving capital
8 expenditures.

9 Section 28. ACTUARIAL REVIEW--AUDITS.--

10 A. The commission shall provide for an annual independent
11 actuarial review of the health plan and any funds of the commission
12 or the plan.

13 B. The commission shall provide by regulation for
14 independent financial audits of health care providers and health
15 facilities.

16 C. The commission, through its staff or by contract,
17 shall perform announced and unannounced audits, including
18 financial, operational, management and electronic data processing
19 audits of health care providers and health facilities. The auditor
20 shall report directly to the commission. A copy of the audit
21 report shall be given to the state auditor.

22 D. Actuarial reviews, financial audits and internal
23 audits are public documents after they have been released by the
24 commission.

25 Section 29. STANDARD CLAIM FORMS FOR INSURANCE PAYMENT.--The

1 commission shall adopt standard claim forms that shall be used by
 2 all health care providers and health facilities that seek payment
 3 through the health plan or from private persons, including private
 4 insurance companies, for health care services rendered in the
 5 state. Each claim form may indicate whether a person is eligible
 6 for federal or other insurance programs for payment. Each claim
 7 form shall include data elements required by the commission.

8 Section 30. COMPUTERIZED SYSTEM -- The commission shall
 9 require that all health care providers and health facilities
 10 participate in the health plan's computer network that provides for
 11 electronic transfer of payments to health care providers and health
 12 facilities; transmittal of reports, including patient data and
 13 other statistical reports; billing data, with specificity as to
 14 procedures or services provided to individual patients; and any
 15 other information required or requested by the commission.

16 Section 31. REPORTS REQUIRED-- CONFIDENTIAL INFORMATION. --

17 A. The commission, through the state health information
 18 system, shall require reports by all health care providers and
 19 health facilities of information needed to allow the commission to
 20 evaluate the health plan, cost-containment measures, utilization
 21 review, health facility global budgets, health care provider fees
 22 and any other information the commission deems necessary to carry
 23 out its duties under the Health Care Act.

24 B. The commission shall establish uniform reporting
 25 requirements for health care providers and health facilities.

1 C. Information confidential pursuant to other provisions
2 of law shall be confidential under the Health Care Act. Within the
3 constraints of confidentiality, reports of the commission are
4 public documents.

5 Section 32. OMBUDSMAN PROGRAM --

6 A. The commission shall establish an ombudsman program to
7 take complaints and to provide timely and knowledgeable assistance
8 to:

9 (1) eligible persons and applicants about their
10 rights and responsibilities and the coverages provided in
11 accordance with the Health Care Act; and

12 (2) health care providers and health facilities
13 about status of claims, payments and other pertinent information
14 relevant to the claims payment process.

15 B. The commission shall establish a toll-free telephone
16 line for the ombudsman programs and shall have ombudsmen available
17 throughout the state to assist beneficiaries, applicants, health
18 care providers and health facilities in person.

19 Section 33. REIMBURSEMENT FOR OUT-OF-STATE SERVICES--HEALTH
20 PLAN'S RIGHT TO SUBROGATION AND PAYMENT FROM OTHER INSURANCE
21 PLANS--CHARGES FOR NON-COVERED PERSONS. --

22 A. If a beneficiary needs health care services out of
23 state, those services shall be covered at the same rate that would
24 apply if the services were received in New Mexico. Additional
25 charges for those services shall not be paid by the health plan

1 unless the commission has negotiated a reciprocity or other
 2 agreement with the other state or foreign country or with the out-
 3 of-state health care provider or health facility.

4 B. The health plan shall make reasonable efforts to
 5 ascertain any legal liability of third parties who are or may be
 6 liable to pay all or part of the health care services costs of
 7 injury, disease or disability of a beneficiary.

8 C. When the health plan makes payments on behalf of a
 9 beneficiary, the health plan is subrogated to any right of the
 10 beneficiary against a third party for recovery of amounts paid by
 11 the health plan.

12 D. By operation of law, an assignment to the health plan
 13 of the rights of a beneficiary:

14 (1) is conclusively presumed to be made of:

15 (a) a payment for health care services from any
 16 person, firm or corporation, including an insurance carrier; and

17 (b) a monetary recovery for damages for bodily
 18 injury, whether by judgment, contract for compromise or settlement;

19 (2) shall be effective to the extent of the amount
 20 of payments by the health plan; and

21 (3) shall be effective as to the rights of any other
 22 beneficiaries whose rights can legally be assigned by the
 23 beneficiary.

24 Section 34. PRIVATE HEALTH INSURANCE COVERAGE LIMITED. --

25 A. After the health plan is effective, no person shall

1 provide private health insurance to a beneficiary for a health care
2 service that is covered by the health plan except for retiree
3 health insurance plans that do not enter into contracts with the
4 health plan.

5 B. Nothing in this section shall be construed to affect
6 insurance coverage pursuant to the federal Employee Retirement
7 Income Security Act of 1974 unless the state obtains a
8 congressional exemption or a waiver from the federal government.
9 Businesses that are covered by the provisions of that act may elect
10 to participate in the health plan.

11 Section 35. FEDERAL HEALTH INSURANCE PROGRAM WAIVERS--
12 REIMBURSEMENT TO HEALTH PLAN FROM FEDERAL AND OTHER HEALTH
13 INSURANCE PROGRAMS. --

14 A. The commission, in conjunction with the human services
15 department, shall:

16 (1) apply to the United States department of health
17 and human services for all waivers of requirements under health
18 care programs established pursuant to the federal Social Security
19 Act, as amended, that are necessary to enable the state to deposit
20 federal payments for services covered by the health plan into the
21 plan's fund and to be the supplemental payer of benefits for
22 persons receiving medicare benefits;

23 (2) identify other federal programs that provide
24 federal funds for payment of health care services to individuals
25 and apply for any waivers or enter into any agreements that are

1 necessary to enable the state to deposit federal payments for
 2 health care services covered by the health plan into the plan's
 3 fund; provided, however, agreements negotiated with the Indian
 4 health service shall not impair treaty obligations of the United
 5 States government and other agreements negotiated shall not impair
 6 portability or other aspects of the health care coverage; and

7 (3) seek an amendment to the federal Employee
 8 Retirement Income Security Act of 1974 to exempt New Mexico from
 9 the provisions of that act that relate to health care services or
 10 health insurance, or the commission shall apply to the appropriate
 11 federal agency for waivers of any requirements of that act if
 12 congress provides for waivers to enable the commission to extend
 13 coverage through the Health Care Act to as many New Mexicans as
 14 possible.

15 B. The commission shall seek payment to the health plan
 16 from medicaid, medicare or any other federal or other insurance
 17 program for any reimbursable payment provided under the plan.

18 C. The commission shall seek to maximize federal
 19 contributions and payments for health care services provided in New
 20 Mexico and shall ensure that the contributions of the federal
 21 government for health care services in New Mexico will not decrease
 22 in relation to other states as a result of any waivers, exemptions
 23 or agreements.

24 Section 36. INSURANCE-- COMMISSION APPROVAL. -- No person shall
 25 insure himself or his employees after July 1, 1999 unless the

1 coverage terminates on the date that the insureds are eligible for
2 coverage under the health plan. Nothing in this section prohibits
3 insurance coverage for health care services not covered by the
4 health plan or for individuals not eligible for coverage under the
5 health plan.

6 Section 37. INSURANCE RATES--COMMISSION AND SUPERINTENDENT OF
7 INSURANCE DUTIES.--

8 A. The commission shall work closely with the
9 superintendent of insurance to identify health care cost savings
10 that have been achieved as a result of implementation of the health
11 plan. The commission and the superintendent shall identify savings
12 by insurance companies on payments made for medical services
13 through motor vehicle liability insurance, homeowners' insurance,
14 workers' compensation insurance or other insurance policies that
15 have a medical payment component. The commission and the
16 superintendent shall report their findings to the legislature.

17 B. The superintendent shall lower insurance premiums
18 associated with medical benefits on all types of insurance policies
19 written in New Mexico that have a medical payment component as soon
20 as data indicate health care savings have been achieved as a result
21 of operation of the health plan.

22 Section 38. FINANCING THE HEALTH PLAN.--

23 A. The legislative finance committee, in cooperation with
24 the New Mexico health policy commission, shall determine financing
25 options for the health plan. In making its determinations the

1 committee shall be guided by the following requirements and
2 assumptions:

3 (1) the health plan budget shall be no greater than
4 the health care expenditures projected for the 1998 calendar year
5 would have been had the health plan been in effect;

6 (2) benefits to be costed in determining the
7 financing options shall be equivalent to basic health care coverage
8 afforded state employees; and

9 (3) options shall set minimum and maximum levels of
10 premium payments and employer contributions and include a system
11 for reasonable co-payments except for preventive care and for those
12 beneficiaries at or below one hundred percent of the poverty level.

13 B. The legislative finance committee shall prepare a
14 report of its determinations with the specific options and
15 recommendations no later than December 15, 1997. The report shall
16 be submitted for consideration for legislative implementation to
17 the second session of the forty-third legislature.

18 Section 39. TEMPORARY PROVISION--TRANSITION PERIOD
19 ARRANGEMENTS--PUBLICLY FUNDED HEALTH CARE SERVICE PLANS.--

20 A. A person who, on the date benefits are available under
21 the Health Care Act health plan, receives health care benefits
22 under private contract or collective bargaining agreement entered
23 into prior to July 1, 1999 shall continue to receive those benefits
24 until the contract or agreement expires or unless the contract or
25 agreement is renegotiated to provide participation in the health

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1 plan.

2 B. A person covered by a health care services plan that
3 has its premiums paid for in any part by public money, including
4 money from the state, a political subdivision, state educational
5 institution, public school or other entity that receives public
6 money to pay health insurance premiums, shall be covered by the
7 Health Care Act health plan on the effective date that benefits are
8 available under the plan.

9 Section 40. EFFECTIVE DATE. --The effective date of the
10 provisions of this act is July 1, 1997.

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Underscored material = new
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