HOUSE BILL 845

45TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2001

INTRODUCED BY

Patsy G. Trujillo

AN ACT

RELATING TO MEDICAID; TRANSFERRING RESPONSIBILITY FOR THE MEDICAID PROGRAM FROM THE HUMAN SERVICES DEPARTMENT TO THE DEPARTMENT OF HEALTH; TRANSFERRING THE MEDICAL ASSISTANCE DIVISION FROM THE HUMAN SERVICES DEPARTMENT TO THE DEPARTMENT OF HEALTH; ENACTING THE MEDICAL ASSISTANCE APPEALS ACT; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

Section 1. Section 9-7-3 NMSA 1978 (being Laws 1977, Chapter 253, Section 3, as amended) is amended to read:

"9-7-3. PURPOSE.--The purpose of the Department of Health Act is to establish a single, unified department to administer the laws and exercise the functions relating to health formerly administered and exercised by various organizational units of state government, including the

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medicaid program, the state health agency, the scientific laboratory system and an appropriate allocation of administrative support services of the health and social services department and the hospital and institutions department. All public health, behavioral health and scientific laboratory functions formerly performed by the health and environment department shall be performed by the department [~~of health~~]."

Section 2. Section 9-7-4 NMSA 1978 (being Laws 1991, Chapter 25, Section 16) is amended to read:

"9-7-4. DEPARTMENT ESTABLISHED.--

A. There is created in the executive branch the "department of health". The department shall be a cabinet department and shall include [~~but not be limited to~~] the programs and functions of the medicaid program, the public health division, the behavioral health services division and the scientific laboratory.

B. All references in the law to the [~~"health services division" shall be construed to be references to the "public health division"~~] medicaid program, the public health division of the health and environment department, the behavioral health services division of the health and environment department, the state department of public health, the public health department, the health services division or the state board of health shall be construed as referring to

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the department [~~of health~~].

C. The administrative services division of the department [~~of health~~] shall provide clerical, recordkeeping and administrative support to the department [~~of health~~] and to the department of environment, including, but not limited to, the areas of personnel, budget, procurement and contracting."

Section 3. A new section of the Department of Health Act is enacted to read:

"[NEW MATERIAL] CUSTODIAN OF FUNDS.--The department is designated as the custodian of all money received by the state which the department is authorized to administer, from any appropriations made by the congress of the United States to cooperate with the several states in the enforcement and administration of the provisions of the federal act and all money received from any source for the provisions in Chapter 27 NMSA 1978. The department is authorized to receive such money, provide for its proper custody and make disbursements of it under such rules and regulations as the department may prescribe."

Section 4. Section 9-8-9 NMSA 1978 (being Laws 1977, Chapter 252, Section 10, as amended) is amended to read:

"9-8-9. DIRECTORS.--The secretary shall appoint with the approval of the governor "directors" of divisions established within the department. The positions so appointed are exempt

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from the Personnel Act with the exception of the director of the child support enforcement division [~~and the director of the medical assistance division~~] who [~~each~~] shall be covered under the Personnel Act."

Section 5. Section 27-1-3 NMSA 1978 (being Laws 1937, Chapter 18, Section 4, as amended) is amended to read:

"27-1-3. ACTIVITIES OF HUMAN SERVICES DEPARTMENT.--The [~~human services~~] department shall be charged with the administration of all the welfare activities of the state as provided in Chapter 27 NMSA 1978, except for the administration of the medicaid program that is administered by the department of health and as otherwise provided for by law. The [~~human services~~] department shall, except as otherwise provided by law:

A. administer old age assistance, aid to dependent children, assistance to the needy blind and otherwise handicapped and general relief;

B. administer all aid or services to crippled children, including the extension and improvement of services for crippled children, insofar as practicable under conditions in this state; provide for locating children who are crippled or who are suffering from conditions [~~which~~] that lead to crippling; provide corrective and any other services and care and facilities for diagnosis, hospitalization and after-care for children who are crippled or who are suffering from

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conditions [~~which~~] that lead to crippling; and supervise the administration of those services [~~which~~] that are not administered directly by the department;

C. administer and supervise all child welfare activities, service to children placed for adoption, service and care of homeless, dependent and neglected children, service and care for children in foster family homes or in institutions because of dependency or delinquency and care and service to any child who because of physical or mental defect may need such service;

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

E. cooperate with the federal government in matters of mutual concern pertaining to public welfare and public assistance, including the adoption of such methods of administration as are found by the federal government to be necessary for the efficient operation of the plan for public welfare and assistance;

F. assist other departments, agencies and institutions of local, state and federal governments when so requested; cooperate with such agencies when expedient in performing services in conformity with the purposes of Chapter 27 NMSA 1978; and cooperate with medical, health, nursing and

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welfare groups, any state agency charged with the administration of laws providing for vocational rehabilitation of physically handicapped persons and organizations within the state;

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

H. establish in counties or in districts, which may include two or more counties, local units of administration to serve as agents of the department;

I. at its discretion, establish local boards of public welfare for such territory as it may see fit and by rule [~~and regulation~~] prescribe the duties of the local board;

J. administer such other public welfare functions as may be assumed by the state after the effective date of this section;

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

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L. inspect and require reports from all private institutions, boarding homes and agencies providing assistance, care or other direct services to children who are crippled, neglected, delinquent or dependent; the aged; blind; feeble-minded; and other dependent persons.

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

Section 6. Section 27-1-3.1 NMSA 1978 (being Laws 1980, Chapter 83, Section 1) is amended to read:

"27-1-3.1. ACUTE CARE BED USAGE--FUNDING AUTHORIZATION.--The [~~human services~~] department of health is authorized to accept and use federal grants or matching funds for the purpose of reimbursement to certain rural hospitals for using empty acute care beds for intermediate care and skilled nursing care, as defined in federal statutes and regulations, subject to federal approval and the availability of funds. The department of health is authorized to use funds from existing appropriations for matching federal funds for the purposes of this [~~act~~] section."

Section 7. Section 27-2-2 NMSA 1978 (being Laws 1973, Chapter 376, Section 2, as amended) is amended to read:

"27-2-2. DEFINITIONS.--As used in the Public Assistance

Act:

A. "department" means the human services department;

B. "board" means the human services department;

C. "director" means the secretary of human services;

D. "local office" means the county or district office of the human services department;

E. "public welfare" or "public assistance" means any aid or relief granted to or on behalf of an eligible person under the Public Assistance Act and [~~regulations~~] rules issued pursuant to that act, but does not mean medical assistance, which is provided by the medical assistance division of the department of health;

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

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

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

I. "secretary" means the secretary of human services; and

J. "medical assistance" means health care services or supplies furnished pursuant to Title 19 or Title 21 of the

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Social Security Act."

Section 8. Section 27-2-12 NMSA 1978 (being Laws 1973, Chapter 376, Section 16, as amended) is amended to read:

"27-2-12. MEDICAL ASSISTANCE PROGRAMS.--Consistent with the federal act and subject to the appropriation and availability of federal and state funds, the medical assistance division of the [~~human services~~] department of health may by [~~regulation~~] rule provide medical assistance, including the services of licensed doctors of oriental medicine and licensed chiropractors, to persons eligible for public assistance programs under the federal act."

Section 9. Section 27-2-12.3 NMSA 1978 (being Laws 1987, Chapter 269, Section 1, as amended) is amended to read:

"27-2-12.3. MEDICAID REIMBURSEMENT--EQUAL PAY FOR EQUAL PHYSICIANS', DENTISTS', OPTOMETRISTS', PODIATRISTS' AND PSYCHOLOGISTS' SERVICES.--The [~~human services~~] department of health shall establish a rate for the reimbursement of physicians, dentists, optometrists, podiatrists and psychologists for services rendered to medicaid patients that provides equal reimbursement for the same or similar services rendered without respect to the date on which such physician, dentist, optometrist, podiatrist or psychologist entered into practice in New Mexico, the date on which the physician, dentist, optometrist, podiatrist or psychologist entered into an agreement or contract to provide such services or the

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location in which such services are to be provided in the state; provided, however, that the requirements of this section shall not apply when the [~~human services~~] department of health contracts with entities pursuant to Section 27-2-12.6 NMSA 1978 to negotiate a rate for the reimbursement for services rendered to medicaid patients in the medicaid managed care system."

Section 10. Section 27-2-12.4 NMSA 1978 (being Laws 1987, Chapter 214, Section 1) is amended to read:

"27-2-12.4. LONG-TERM CARE FACILITIES--NONCOMPLIANCE WITH STANDARDS AND CONDITIONS--SANCTIONS.--

A. In addition to any other actions required or permitted by federal law or regulation, the [~~human services~~] department of health shall impose a hold on state medicaid payments to a long-term care facility thirty days after the [~~health and environment department notifies the human services department in writing~~] department of health determines pursuant to an on-site visit that the long-term care facility is not in substantial compliance with the standards or conditions of participation promulgated by the federal department of health and human services pursuant to which the facility is a party to a medicaid provider agreement, unless the substantial noncompliance has been corrected within that thirty-day period or the facility's medicaid provider agreement is terminated or not renewed based in whole or in

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part on the noncompliance. The written notice shall cite the specific deficiencies that constitute noncompliance.

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

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

D. If a long-term care facility is certified in writing to be in noncompliance pursuant to Subsection A of this section for the second time in any twelve-month period, the [~~human services~~] department of health shall cancel or refuse to execute the long-term care facility's medicaid provider agreement for a two-month period, unless it can be demonstrated that harm to the [~~patients~~] medicaid recipients would result from this action or that good cause exists to allow the facility to continue to participate in the medicaid

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program. The provisions of this subsection are subject to appeal procedures set forth in federal regulations for nonrenewal or termination of a medicaid provider agreement.

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

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

G. As used in this section:

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

(2) "long-term care facility" means any intermediate care facility or skilled nursing facility [~~which~~] that is licensed by the [~~health and environment~~] department of health and [~~which~~] that is medicaid certified;

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

(a) [~~individuals~~] persons who were in the long-term care facility before the effective date of the

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hold on medicaid payments and became eligible for medicaid after that date; and

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

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

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

(b) do not interfere with adequate patient care;

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

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

(e) are ones [~~which~~] that the long-term care facility is making reasonable plans to correct."

Section 11. Section 27-2-12.5 NMSA 1978 (being Laws 1989, Chapter 83, Section 1, as amended) is amended to read:

"27-2-12.5. MEDICAID-CERTIFIED NURSING FACILITIES--RETROACTIVE ELIGIBILITY--REFUNDS--PENALTY.--

A. Medicaid payment for a medicaid-eligible patient shall be accepted by a medicaid-certified nursing facility from the first month of medicaid eligibility,

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

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

Section 12. Section 27-2-12.6 NMSA 1978 (being Laws 1994, Chapter 62, Section 22) is amended to read:

"27-2-12.6. MEDICAID PAYMENTS--MANAGED CARE.--

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

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B. The managed care system shall ensure:

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

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

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

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

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

Section 13. Section 27-2-12.7 NMSA 1978 (being Laws 1980, Chapter 86, Section 1) is amended to read:

"27-2-12.7. MEDICAID--[~~HUMAN SERVICES~~] DEPARTMENT OF HEALTH EMPLOYEES--STANDARDS OF CONDUCT--ENFORCEMENT.--

A. As used in this section:

(1) "business" means a corporation,

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partnership, sole proprietorship, firm, organization or [~~individual~~] person carrying on a business;

(2) "department" means the [~~human services~~] department of health;

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

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

(5) "financial interest" means an interest held by [~~an individual~~] a person, his spouse or minor child [~~which~~] that is:

(a) an ownership interest in business; or

(b) [~~any~~] an employment or prospective employment for which negotiations have already begun.

B. No employee with responsibility shall, for twenty-four months following the date on which he ceases to be an employee, act as agent or attorney for [~~any other~~] another person or business in connection with a judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to the medicaid program with

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respect to which the employee made an investigation, rendered [~~any~~] a ruling or was otherwise substantially and directly involved during the last year he was an employee and which was actually pending under his responsibility within that period.

C. No [~~department~~] secretary of health, income support division director of the human services department or medical assistance [~~bureau chief~~] division director of the department of health or their deputies shall, for twelve months following the date on which he ceases to be an employee, participate [~~in any manner~~] with respect to a judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to the medicaid program and pending before the department.

D. No employee with responsibility shall participate [~~in any manner~~] with respect to a judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to the medicaid program and involving his spouse, minor child or [~~any~~] a business in which he has a financial interest unless prior to [~~such~~] the participation:

(1) full disclosure of his relationship or financial interest is made in writing to the secretary of [~~the department~~] health; and

(2) a written determination is made by the secretary of health that the disclosed relationship or

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financial interest is too remote or inconsequential to affect the integrity of the services of the employee.

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

Section 14. Section 27-2-16 NMSA 1978 (being Laws 1974, Chapter 31, Section 1, as amended) is amended to read:

"27-2-16. COMPLIANCE WITH FEDERAL LAW.--

A. Subject to the availability of state funds, the [~~human services~~] department of health may provide assistance to aged, blind or disabled [~~individuals~~] persons in the amounts consistent with federal law to enable the state to be eligible for medicaid funding. [~~Individuals~~] A person shall be determined to be aged, blind or disabled according to [~~regulations~~] rules of the [~~human services~~] department of health.

B. If drug product selection is permitted by Section 26-3-3 NMSA 1978, reimbursement by the medicaid program shall be limited to the wholesale cost of the [~~lesser~~]

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less expensive therapeutic equivalent drug generally available in New Mexico plus a reasonable dispensing fee of at least three dollars sixty-five cents ($3.65)."

Section 15. Section 27-2-23 NMSA 1978 (being Laws 1969, Chapter 232, Section 1) is amended to read:

"27-2-23. THIRD PARTY LIABILITY.--

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

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

Section 16. Section 27-2A-3 NMSA 1978 (being Laws 1994, Chapter 87, Section 3) is amended to read:

"27-2A-3. DEFINITIONS.--As used in the Medicaid Estate Recovery Act:

A. "department" means the [~~human services~~] department of health;

B. "estate" means real and personal property and other assets of the [~~individual~~] person subject to probate or

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administration pursuant to the provisions of the Uniform Probate Code; and

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

Section 17. Section 27-3-2 NMSA 1978 (being Laws 1973, Chapter 256, Section 2, as amended) is amended to read:

"27-3-2. DEFINITIONS.--As used in the Public Assistance Appeals Act:

A. "department" means the income support division [~~the medical assistance division~~] or the social services division of the human services department;

B. "board" means the income support division [~~the medical assistance division~~] or the social services division of the human services department; and

C. "director" means the director of the income support division [~~the medical assistance division~~] or the social services division of the human services department."

Section 18. [NEW MATERIAL] SHORT TITLE.--Sections 18 through 22 of this act may be cited as the "Medical Assistance Appeals Act".

Section 19. [NEW MATERIAL] DEFINITIONS.--As used in the Medical Assistance Appeals Act:

A. "department" means the department of health;

B. "director" means the director of the medical

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assistance division of the department of health; and

C. "division" means the medical assistance division of the department of health.

Section 20. [NEW MATERIAL] FAIR HEARING.--

A. An applicant for or a recipient of medical assistance under any provisions of the Social Security Act or rules of the department adopted pursuant to that act may request a hearing in accordance with rules of the department if:

(1) an application is not acted upon within a reasonable time after the filing of the application;

(2) an application is denied in whole or in part; or

(3) the assistance or services are modified, terminated or not provided.

The division shall notify the recipient or applicant of his rights under this section.

B. The division shall by rule establish procedures for the filing of a request for a hearing and the time limits within which a request may be filed; provided, however, that the department may grant reasonable extensions of the time limits. If the request is not filed within the specified time for appeal or within whatever extension the department may grant, the department's actions shall be final. Upon receipt of a timely request, the department shall give the applicant

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or recipient reasonable notice of an opportunity for a fair hearing in accordance with the rules of the division.

C. The hearing shall be conducted by a hearing officer designated by the director. The powers of the hearing officer shall include administering oaths or affirmations to witnesses called to testify, taking testimony, examining witnesses, admitting or excluding evidence and reopening any hearing to receive additional evidence. The technical rules of evidence and the rules of civil procedure shall not apply. The hearing shall be conducted so that the contentions or defenses of each party to the hearing are amply and fairly presented. Either party may be represented by counsel or other representative of his designation, and he or his representative may conduct cross-examination. Any oral or documentary evidence may be received, but the hearing officer may exclude irrelevant, immaterial or unduly repetitious evidence.

D. The director shall review the record of the proceedings and shall make a decision thereon. The applicant or recipient or his representative shall be notified in writing of the director's decision and the reasons for the decision. The written notice shall inform the applicant or recipient of his right to judicial review. The department shall be responsible for assuring that the decision is enforced.

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Section 21. [NEW MATERIAL] APPEAL.--Within thirty days after receiving written notice of the decision of the director pursuant to the Medical Assistance Appeals Act, an applicant or recipient may file a notice of appeal with the district court pursuant to the provisions of Chapter 39, Article 3 NMSA 1978.

Section 22. [NEW MATERIAL] EXPENDITURES.--Nothing in the Medical Assistance Appeals Act shall be construed as authorizing or allowing expenditures for the affected programs in excess of the amounts previously appropriated by the legislature for medical assistance.

Section 23. Section 27-5-3 NMSA 1978 (being Laws 1965, Chapter 234, Section 3, as amended) is amended to read:

"27-5-3. PUBLIC ASSISTANCE PROVISIONS.--

A. A hospital shall not be paid from the [~~county indigent hospital claims~~] fund under the Indigent Hospital and County Health Care Act for any costs of an indigent patient for services that have been determined by the [~~human services~~] department of health to be eligible for medicaid reimbursement [~~from that department~~]. However, nothing in the Indigent Hospital and County Health Care Act shall be construed to prevent the board from transferring money from the [~~county indigent hospital claims~~] fund to the sole community provider fund or the county-supported medicaid fund for support of the state medicaid program.

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B. No action for collection of claims under the Indigent Hospital and County Health Care Act shall be allowed against an indigent patient who is medicaid eligible for [~~medicaid covered~~] medicaid-covered services, nor shall action be allowed against the person who is legally responsible for the care of the indigent patient during the time that person is medicaid eligible."

Section 24. Section 27-5-6.1 NMSA 1978 (being Laws 1993, Chapter 321, Section 18) is amended to read:

"27-5-6.1. SOLE COMMUNITY PROVIDER FUND CREATED.--

A. The "sole community provider fund" is created in the state treasury. The sole community provider fund, which shall be administered by the [~~human services~~] department of health, shall consist of funds provided by counties to match federal funds for medicaid sole community provider hospital payments. Money in the fund shall be invested by the state treasurer as other state funds are invested. Any unexpended or unencumbered balance remaining in the fund at the end of any fiscal year shall not revert.

B. Money in the sole community provider fund is appropriated to the [~~human services~~] department of health to make sole community provider hospital payments pursuant to the state medicaid program. No sole community provider hospital payments or money in the sole community provider fund shall be used to supplant any general fund support for the state

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medicaid program.

C. Money in the sole community provider fund shall be remitted back to the individual counties from which it came if federal medicaid matching funds are not received for medicaid sole community provider hospital payments."

Section 25. Section 27-5-7.1 NMSA 1978 (being Laws 1993, Chapter 321, Section 16) is amended to read:

"27-5-7.1. COUNTY INDIGENT HOSPITAL CLAIMS FUND--AUTHORIZED USES OF THE FUND.--

A. The fund shall be used:

(1) to meet the county's contribution for support of sole community provider payments as calculated by the department of health for that county; and

(2) to pay all claims that have been approved by the board that are not matched with federal funds under the state medicaid program.

B. The fund may be used to meet the county's obligation under Section 27-10-4 NMSA 1978.

C. Until June 30, 1996, the cash reserves from the fund may be used to meet the county's obligation under Section 27-10-4 NMSA 1978."

Section 26. Section 27-5-11 NMSA 1978 (being Laws 1965, Chapter 234, Section 12, as amended) is amended to read:

"27-5-11. HOSPITALS AND AMBULANCE SERVICES--HEALTH CARE PROVIDERS--REQUIRED TO FILE DATA--SOLE COMMUNITY PROVIDER

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HOSPITAL DUTIES.--

A. Any ambulance service, hospital or health care provider in New Mexico or licensed out-of-state hospital, prior to the filing of a claim with the board, shall have placed on file with the board:

(1) current data, statistics, schedules and information deemed necessary by the board to determine the cost for all patients in that hospital or cared for by that health care provider or tariff rates or charges of an ambulance service;

(2) proof that the hospital, ambulance service or health care provider is licensed, where required, under the laws of this state or the state in which the hospital operates; and

(3) any other information or data deemed necessary by the board.

B. Every sole community provider hospital requesting or receiving medicaid sole community provider hospital payments shall:

(1) accept indigent patients and request reimbursement for those patients through the appropriate county indigent fund. The responsible county shall approve requests meeting its eligibility standards and notify the hospital of such approval;

(2) confirm the amount of payment authorized

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by each county for indigent patients, to that county for the previous fiscal year, by September 30 of each calendar year;

(3) negotiate with each county the amount of indigent hospital payments anticipated for the following fiscal year by December 31 of each year; and

(4) provide to the department of health prior to January 15 of each year the amount of the authorized indigent hospital payments anticipated for the following fiscal year after an agreement has been reached on the amount with each responsible county and such other related information as the department of health may request."

Section 27. Section 27-5-12.2 NMSA 1978 (being Laws 1993, Chapter 321, Section 15) is amended to read:

"27-5-12.2. DUTIES OF THE COUNTY--SOLE COMMUNITY PROVIDER HOSPITAL PAYMENTS.--Every county in New Mexico that authorizes payment for services to a sole community provider hospital shall:

A. determine eligibility for benefits and determine an amount payable on each claim for services to indigent patients from sole community provider hospitals;

B. notify the sole community provider hospital of its decision on each request for payment while not actually reimbursing the hospital for the services that are reimbursed with federal funds under the state medicaid program;

C. confirm the amount of the sole community

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provider hospital payments authorized for each hospital for the past fiscal year by September 30 of the current fiscal year;

D. negotiate agreements with each sole community provider hospital providing services for county residents on the anticipated amount of the payments for the following fiscal year; and

E. provide the [~~human services~~] department of health by January 15 of each year with the budgeted amount of sole community provider hospital payments, by hospital, for the following fiscal year."

Section 28. Section 27-5-16 NMSA 1978 (being Laws 1965, Chapter 234, Section 16, as amended) is amended to read:

"27-5-16. DEPARTMENT--PAYMENTS--COOPERATION.--

A. The department of health shall not decrease the amount of any medical assistance payments made to the hospitals or health care providers of this state pursuant to law because of any financial reimbursement made to ambulance services, hospitals or health care providers for indigent or [~~medicaid eligible~~] medicaid-eligible patients as provided in the Indigent Hospital and County Health Care Act.

B. The department of health shall cooperate with each board in furnishing information or assisting in the investigation of any person to determine whether he meets the qualifications of an indigent patient as defined in the

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Indigent Hospital and County Health Care Act.

C. The department of health shall ensure that the sole community provider payment and the reimbursement to hospitals made under the state medicaid program do not exceed what would have been paid for under medicare payment principles. In the event the sole community provider payment and medicaid reimbursement to hospitals would exceed medicare payment principles, the department of health shall reduce the sole community provider payment prior to making any reduction in reimbursement to hospitals made under the state medicaid program."

Section 29. Section 27-10-3 NMSA 1978 (being Laws 1991, Chapter 212, Section 3, as amended) is amended to read:

"27-10-3. COUNTY-SUPPORTED MEDICAID FUND CREATED--USE--APPROPRIATION BY THE LEGISLATURE.--

A. There is created in the state treasury the "county-supported medicaid fund". The fund shall be invested by the state treasurer as other state funds are invested. Income earned from investment of the fund shall be credited to the county-supported medicaid fund. The fund shall not revert in any fiscal year.

B. Money in the county-supported medicaid fund is subject to appropriation by the legislature to support the state medicaid program and to institute or support primary care health care services pursuant to Subsections D and E of

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Section 24-1A-3.1 NMSA 1978. Of the amount appropriated each year, nine percent shall be appropriated to the department of health to institute or support primary care health care services pursuant to Subsections D and E of Section 24-1A-3.1 NMSA 1978.

C. Up to three percent of the county-supported medicaid fund each year may be expended for administrative costs related to medicaid or developing new primary care health care centers or facilities.

D. In the event federal funds for medicaid are not received by New Mexico for any eighteen-month period, the unencumbered balance remaining in the county-supported medicaid fund and the sole community provider fund at the end of the fiscal year following the end of any eighteen-month period shall be paid within a reasonable time to each county for deposit in the county indigent hospital claims fund in proportion to the payments made by each county through tax revenues or transfers in the previous fiscal year as certified by the local government division of the department of finance and administration. The department of health will provide for budgeting and accounting of payments to the fund."

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

"27-11-2. DEFINITIONS.--As used in the Medicaid Provider Act:

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A. "department" means the [~~human services~~] department <u>of health</u>;

B. "managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements with the department to provide health care and related services;

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

D. "medicaid provider" means a person, including a managed care organization, operating under contract with the department to provide medicaid-related services to recipients;

E. "person" means an individual or other legal entity;

F. "recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;

G. "secretary" means the secretary of [~~human services~~] <u>health</u>; and

H. "subcontractor" means a person who contracts with a medicaid provider to provide medicaid-related services to recipients."

Section 31. Section 27-11-3 NMSA 1978 (being Laws 1998, Chapter 30, Section 3, as amended) is amended to read:

"27-11-3. REVIEW OF MEDICAID PROVIDERS--CONTRACT

REMEDIES--PENALTIES.--

A. Consistent with the terms of any contract between the department and a medicaid provider, the secretary shall have the right to be afforded access to such of the medicaid provider's records and personnel, as well as its subcontracts and that subcontractor's records and personnel, as may be necessary to ensure that the medicaid provider is complying with the terms of its contract with the department.

B. Upon not less than two days' written notice to a medicaid provider the secretary may, consistent with the provisions of the Medicaid Provider Act and rules issued pursuant to that act, carry out an administrative investigation or conduct administrative proceedings to determine whether a medicaid provider has:

(1) materially breached its obligation to furnish medicaid-related services to recipients, or any other duty specified in its contract with the department;

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

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

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

(5) hindered or prevented the secretary from performing any duty imposed by the Public Assistance Act, the Human Services Department Act, the Department of Health Act, or the Medicaid Provider Act or any rules issued pursuant to those acts; or

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

C. Subject to the provisions of Subsection D of this section, after affording a medicaid provider written notice of hearing not less than ten days before the hearing date and an opportunity to be heard, and upon making appropriate administrative findings, the secretary may take any or any combination of the following actions against the provider:

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

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(2) issue an administrative order requiring the provider to:

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

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

(c) provide any service that has been denied;

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

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

(3) suspend or revoke the contract between the provider and the department pursuant to the terms of that contract.

D. If a contract between the department and a medicaid provider explicitly specifies a dispute resolution mechanism for use in resolving disputes over performance of that contract, the dispute resolution mechanism specified in the contract shall be used to resolve such disputes in lieu of the mechanism set forth in Subsection C of this section.

E. If a medicaid provider's contract so specifies,

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the medicaid provider shall have the right to seek de novo review in district court of any decision by the secretary regarding a contractual dispute."

Section 32. Section 27-12-3 NMSA 1978 (being Laws 1998, Chapter 52, Section 3) is amended to read:

"27-12-3. DEFINITIONS.--As used in the Child Health Act:

A. "child" means a natural person who has not reached his nineteenth birthday;

B. "department" means the [~~human services~~] department of health;

C. "low-income children and their families" means a family with a dependent child with income at or below the level specified in Section [~~6 of the Child Health Act~~] 27-12-6 NMSA 1978; and

D. "secretary" means the secretary of [~~human services~~] health."

Section 33. Section 27-12-4 NMSA 1978 (being Laws 1998, Chapter 52, Section 4) is amended to read:

"27-12-4. PROGRAM CREATED.--After consultation with the secretary of [~~health~~] human services and the secretary of children, youth and families, the secretary is directed to design and implement a program to provide health services to low-income children and their families in accordance with the provisions of the Child Health Act. The program shall meet the requirements for obtaining allotted federal funds pursuant

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to the provisions of Title 21 of the federal Social Security Act. In accordance with those requirements and the requirements of the Child Health Act, the secretary shall prepare and submit a child health plan to the federal secretary of health and human services. The department is the designated state agency to administer the program and cooperate with the federal government in its administration."

Section 34. Section 30-40-1 NMSA 1978 (being Laws 1979, Chapter 170, Section 1, as amended) is amended to read:

"30-40-1. FAILING TO DISCLOSE FACTS OR CHANGE OF CIRCUMSTANCES TO OBTAIN PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE.--

A. Failing to disclose facts or change of circumstances to obtain public assistance or medical assistance consists of any person knowingly failing to disclose any material facts known to be necessary to determine eligibility for public assistance or medical assistance or knowingly failing to disclose a change in circumstances for the purpose of obtaining or continuing to receive public assistance or medical assistance to which he is not entitled or in amounts greater than that to which he is entitled.

B. Whoever commits failing to disclose facts or change of circumstances to obtain public assistance or medical assistance when the value of the assistance wrongfully received is one hundred dollars ($100) or less in any twelve

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consecutive months is guilty of a petty misdemeanor.

C. Whoever commits failing to disclose facts or change of circumstances to obtain public assistance or medical assistance when the value of the assistance wrongfully received is more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) in any twelve consecutive months is guilty of a misdemeanor.

D. Whoever commits failing to disclose facts or change of circumstances to obtain public assistance or medical assistance when the value of the assistance wrongfully received is more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) in any twelve consecutive months is guilty of a fourth degree felony.

E. Whoever commits failing to disclose facts or change of circumstances to obtain public assistance or medical assistance when the value of the assistance wrongfully received is more than two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is guilty of a third degree felony.

F. Whoever commits failing to disclose facts or change of circumstances to obtain public assistance or medical assistance when the value of the assistance wrongfully received exceeds twenty thousand dollars ($20,000) is guilty of a second degree felony."

Section 35. Section 30-40-2 NMSA 1978 (being Laws 1979,

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Chapter 170, Section 2, as amended) is amended to read:

"30-40-2. UNLAWFUL USE OF FOOD STAMP IDENTIFICATION CARD OR MEDICAL IDENTIFICATION CARD.--

A. Unlawful use of food stamp identification card or medical identification card consists of the use of a food stamp or medical identification card by any person to whom it has not been issued, or who is not an authorized representative of such a person, for a food stamp allotment.

B. Whoever commits unlawful use of food stamp identification card or medical identification card when the value of the food stamps or medical [~~services~~] assistance wrongfully received is one hundred dollars ($100) or less is guilty of a petty misdemeanor.

C. Whoever commits unlawful use of food stamp identification card or medical identification card when the value of the food stamps or medical [~~services~~] assistance wrongfully received is more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) is guilty of a misdemeanor.

D. Whoever commits unlawful use of food stamp identification card or medical identification card when the value of the food stamps or medical [~~services~~] assistance wrongfully received is more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) is guilty of a fourth degree felony.

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E. Whoever commits unlawful use of food stamp identification card or medical identification card when the value of the food stamps or medical [~~services~~] assistance wrongfully received is more than two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is guilty of a third degree felony.

F. Whoever commits unlawful use of food stamp identification card or medical identification card when the value of the food stamps or medical [~~services~~] assistance wrongfully received exceeds twenty thousand dollars ($20,000) is guilty of a second degree felony.

G. For the purpose of this section, the value of the medical assistance received is the amount paid by the [~~human services~~] department of health for medical [~~services~~] assistance received through use of the card."

Section 36. Section 30-40-3 NMSA 1978 (being Laws 1979, Chapter 170, Section 3, as amended) is amended to read:

"30-40-3. MISAPPROPRIATING PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE.--

A. Misappropriating public assistance or medical assistance consists of any public officer or public employee fraudulently misappropriating, attempting to misappropriate or aiding and abetting in the misappropriation of food stamp coupons, WIC checks pertaining to the special supplemental food program for women, infants and children administered by

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the department of health [~~and environment department~~], food stamp or medical identification cards, public assistance benefits, medical assistance benefits or funds received in exchange for food stamp coupons.

B. Whoever commits misappropriating public assistance or medical assistance when the value of the thing misappropriated is one hundred dollars ($100) or less is guilty of a petty misdemeanor.

C. Whoever commits misappropriating public assistance or medical assistance when the value of the thing misappropriated is more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) is guilty of a misdemeanor.

D. Whoever commits misappropriating public assistance or medical assistance when the value of the thing misappropriated is more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) is guilty of a fourth degree felony.

E. Whoever commits misappropriating public assistance or medical assistance when the value of the thing misappropriated is more than two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is guilty of a third degree felony.

F. Whoever commits misappropriating public assistance or medical assistance when the value of the thing

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misappropriated exceeds twenty thousand dollars ($20,000) is guilty of a second degree felony.

G. Whoever commits misappropriating public assistance or medical assistance when the item misappropriated is a food stamp or medical identification card is guilty of a fourth degree felony."

Section 37. Section 30-40-4 NMSA 1978 (being Laws 1979, Chapter 170, Section 4) is amended to read:

"30-40-4. MAKING OR PERMITTING A FALSE CLAIM FOR REIMBURSEMENT FOR PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE SERVICES.--

A. Making or permitting a false claim for reimbursement of public assistance or medical assistance services consists of knowingly making, causing to be made or permitting to be made a claim for reimbursement for services provided to a recipient of public assistance or medical assistance for services not rendered or making a false material statement or forged signature upon any claim for services, with intent that the claim shall be relied upon for the expenditure of public money.

B. Whoever commits making or permitting a false claim for reimbursement for public assistance or medical assistance services is guilty of a fourth degree felony."

Section 38. Section 30-40-5 NMSA 1978 (being Laws 1979, Chapter 170, Section 5) is amended to read:

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"30-40-5. UNLAWFUL SEEKING OF PAYMENT FROM PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE RECIPIENTS.--

A. Unlawful seeking of payment from public assistance or medical assistance recipients consists of knowingly seeking payment from recipients or their families for any unpaid portion of a bill for which reimbursement has been or will be received from the human services department or the department of health or for claims or services denied by the human services department or the department of health because of [~~provider~~] the provider's administrative error.

B. Whoever commits unlawful seeking of payment from a public assistance or medical assistance recipient is guilty of a misdemeanor."

Section 39. Section 30-40-6 NMSA 1978 (being Laws 1979, Chapter 170, Section 6, as amended) is amended to read:

"30-40-6. FAILURE TO REIMBURSE THE DEPARTMENT UPON RECEIPT OF [~~THIRD PARTY~~] THIRD-PARTY PAYMENT.--

A. Failure to reimburse the [~~human services~~] department of health upon receipt of [~~third party~~] third-party payment consists of [~~knowingly~~] knowing failure by a medicaid provider to reimburse the [~~human services~~] department of health or the [~~department's~~] department of health fiscal agent the amount of payment received from the department of health for services when the provider receives payment for the same services from any third party.

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B. A medicaid provider who commits failure to reimburse the department of health upon receipt of [~~third party~~] third-party payment when the value of the payment made by the department of health is one hundred dollars ($100) or less is guilty of a petty misdemeanor.

C. A medicaid provider who commits failure to reimburse the department of health upon receipt of [~~third party~~] third-party payment when the value of the payment made by the department of health is more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) is guilty of a misdemeanor.

D. A medicaid provider who commits failure to reimburse the department of health upon receipt of [~~third party~~] third-party payment when the value of the payment made by the department of health is more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) is guilty of a fourth degree felony.

E. A medicaid provider who commits failure to reimburse the department of health upon receipt of [~~third party~~] third-party payment when the value of the payment made by the department of health is more than two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is guilty of a third degree felony.

F. A medicaid provider who commits failure to reimburse the department of health upon receipt of [~~third~~

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~~party~~] third-party payment when the value of the payment made by the department of health exceeds twenty thousand dollars ($20,000) is guilty of a second degree felony."

Section 40. Section 30-40-7 NMSA 1978 (being Laws 1979, Chapter 170, Section 7) is amended to read:

"30-40-7. FAILURE TO NOTIFY THE [~~DEPARTMENT~~] DEPARTMENTS OF RECEIPT OF ANYTHING OF VALUE FROM PUBLIC ASSISTANCE OR MEDICAL ASSISTANCE RECIPIENT.--Any employee of the human services department or the department of health who knowingly receives anything of value, other than as provided by law, from either a recipient of public assistance or medical assistance or from the family of a public assistance or medical assistance recipient shall notify the human services department or the department of health within ten days after such receipt on a form provided by the respective department. Whoever fails to so notify the respective department within ten days is guilty of a petty misdemeanor."

Section 41. Section 59A-18-31 NMSA 1978 (being Laws 1989, Chapter 183, Section 1, as amended) is amended to read:

"59A-18-31. ACCIDENT AND HEALTH POLICY OR CERTIFICATE PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each individual or group policy or certificate of accident or health insurance that is delivered, issued for delivery or renewed in this state shall include provisions

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that require benefits paid on behalf of a child or other insured person under the policy or certificate to be paid to the [~~human services~~] department of health when:

(1) the [~~human services~~] department of health has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the services in question has been made by the [~~human services~~] department of health to the medicaid provider; and

(3) the insurer is notified that the insured individual receives benefits under the medicaid program and that benefits [~~must~~] shall be paid directly to the [~~human services~~] department of health.

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of health for insurance benefits when the claim is first submitted by the [~~human services~~] department of health to the insurer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual or group policy or certificate of accident or health insurance for health care services provided to insured individuals who

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are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy or certificate shall be made payable to the provider. The insurer may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the insurer.

D. No individual or group accident or health policy or certificate delivered, issued for delivery or renewed in this state on or after [~~the effective date of this section~~] June 16, 1989 shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where an insurer has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the insurer for those health care items or services."

Section 42. Section 59A-22-38 NMSA 1978 (being Laws 1989, Chapter 183, Section 2, as amended) is amended to read:

"59A-22-38. INDIVIDUAL HEALTH INSURANCE--POLICY

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PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each individual health insurance policy that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy to be paid to the [~~human services~~] department of health when:

(1) the [~~human services~~] department of health has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the services in question has been made by the [~~human services~~] department of health to the medicaid provider; and

(3) the insurer is notified that the insured individual receives benefits under the medicaid program and that benefits [~~must~~] shall be paid directly to the ~~[human services~~] department of health.

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of health for insurance benefits when the claim is first submitted by the [~~human services~~] department of health to the insurer.

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C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual health insurance policy for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy shall be made payable to the provider. The insurer may be notified that the insured [~~individual~~] person is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the insurer.

D. No individual health insurance policy delivered, issued for delivery or renewed in this state on or after [~~the effective date of this section~~] June 16, 1989 shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where an insurer has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the insurer for those health care items or services."

Section 43. Section 59A-23-7 NMSA 1978 (being Laws 1989,

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Chapter 183, Section 3, as amended) is amended to read:

"59A-23-7. BLANKET OR GROUP HEALTH POLICY OR CERTIFICATE--PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each blanket or group health policy or certificate of insurance that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy or certificate to be paid to the [~~human services~~] department of health when:

(1) the [~~human services~~] department of health has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the services in question has been made by the [~~human services~~] department of health to the medicaid provider; and

(3) the insurer is notified that the insured individual receives benefits under the medicaid program and that benefits [~~must~~] shall be paid directly to the [~~human services~~] department of health.

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of

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health for insurance benefits when the claim is first submitted by the [~~human services~~] department of health to the insurer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any blanket or group health insurance policy or certificate for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy or certificate shall be made payable to the provider. The insurer may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the insurer.

D. No blanket or group health insurance policy or certificate delivered, issued for delivery or renewed in this state on or after [~~the effective date of this section~~] June 16, 1989 shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where the insurer has a legal liability to make

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payments, the state is considered to have acquired the rights of the individual to payment by an insurer for those health care items or services."

Section 44. Section 59A-24A-15 NMSA 1978 (being Laws 1989, Chapter 183, Section 4, as amended) is amended to read:

"59A-24A-15. MEDICARE SUPPLEMENT POLICY--PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each medicare supplement policy that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy to be paid to the [~~human services~~] department of health when:

(1) the [~~human services~~] department of health has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the services in question has been made by the [~~human services~~] department of health to the medicaid provider; and

(3) the issuer is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the [~~human services~~ department of health.

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B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of health for insurance benefits when the claim is first submitted by the [~~human services~~] department of health to the issuer.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any medicare supplement policy for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy shall be made payable to the provider. The issuer may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the issuer.

D. No medicare supplement policy delivered, issued for delivery or renewed in this state on or after [~~the effective date of this section~~] June 16, 1989 shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state, unless:

(1) the medicare supplement policy or certificate has been suspended at the request of a policy or

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certificate holder for a period not to exceed twenty-four months; and

(2) during the period of suspension, the policy or certificate holder is entitled to medical assistance pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~]."

Section 45. Section 59A-44-46 NMSA 1978 (being Laws 1989, Chapter 183, Section 5) is amended to read:

"59A-44-46. FRATERNAL BENEFIT SOCIETIES--CERTIFICATE PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each individual or group policy or certificate of accident or health insurance issued by a society that is delivered, issued for delivery or renewed in this state shall include provisions that require benefits paid on behalf of a child or other insured person under the policy or certificate to be paid to the [~~human services~~] department of health when:

(1) the [~~human services~~] department of health has paid or is paying benefits on behalf of the child or other insured person under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the services in question has been made by the [~~human services~~] department of health to the medicaid provider; and

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(3) the society is notified that the insured individual receives benefits under the medicaid program and that benefits must be paid directly to the [~~human services~~] department of health.

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of health for insurance benefits when the claim is first submitted by the [~~human services~~] department of health to the society.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual or group policy or certificate of accident or health insurance for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under the policy or certificate shall be made payable to the provider. The society may be notified that the insured individual is eligible for medicaid benefits through an attachment to the claim by the provider for insurance benefits when the claim is first submitted by the provider to the society.

D. No individual or group policy or certificate of accident or health insurance issued by a society that is delivered, issued for delivery or renewed in this state on or after the effective date of this section shall contain any

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provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who has received medical assistance under the medicaid program of this state."

Section 46. Section 59A-46-29 NMSA 1978 (being Laws 1989, Chapter 183, Section 6, as amended) is amended to read:

"59A-46-29. HEALTH MAINTENANCE ORGANIZATIONS--CONTRACT OR CERTIFICATE PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each individual or group contract or certificate that is delivered, issued for delivery or renewed in this state shall include provisions that require any indemnity benefits payable by a health maintenance organization on behalf of an enrollee under the contract or certificate to be paid to the [~~human services~~] department of health when:

(1) the [~~human services~~] department of health has paid or is paying benefits on behalf of the enrollee under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the services in question has been made by the [~~human services~~] department of health to the medicaid provider; and

(3) the health maintenance organization is notified that the enrollee receives benefits under the

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medicaid program and that any indemnity benefits payable by the health maintenance organization must be paid directly to the [~~human services~~] department of health.

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of health for any indemnity benefits payable by the health maintenance organization when the claim is first submitted by the [~~human services~~] department of health to the health maintenance organization.

C. Notwithstanding any other provisions of law, checks in payment for claims for any indemnity benefits payable by a health maintenance organization pursuant to any individual or group contract or certificate for health care services provided to persons who are also eligible for benefits under the medicaid program and provided by medical providers not contracting with the health maintenance organization shall be made payable to the provider. The health maintenance organization may be notified that the enrollee is eligible for medicaid benefits through an attachment to the claim by the provider for health maintenance organization benefits when the claim is first submitted by the provider to the health maintenance organization.

D. No health maintenance organization group or individual contract or certificate delivered, issued for

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delivery or renewed in this state on or after [~~the effective date of this section~~] June 16, 1989 shall contain any provision denying or limiting health maintenance organization benefits because services are rendered to an enrollee who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where a health maintenance organization has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the health maintenance organization for those health care items or services."

Section 47. Section 59A-47-36 NMSA 1978 (being Laws 1989, Chapter 183, Section 7, as amended) is amended to read:

"59A-47-36. NONPROFIT HEALTH CARE PLANS--CONTRACT OR CERTIFICATE PROVISIONS RELATING TO INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAL BENEFITS UNDER THE MEDICAID PROGRAM.--

A. Each individual or group contract for health care expense payments or certificate therefor that is delivered, issued for delivery or renewed in this state by a health care plan shall include provisions that require benefits paid on behalf of a subscriber under the contract or certificate to be paid to the [~~human services~~] department of

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health when:

(1) the [~~human services~~] department of health has paid or is paying health care expenses on behalf of the subscriber under the state's medicaid program pursuant to Title [~~XIX~~] 19 or Title 21 of the federal Social Security Act [~~42 U.S.C. 1396, et seq.~~];

(2) payment for the expenses in question has been made by the [~~human services~~] department of health to the medicaid provider; and

(3) the health care plan is notified that the subscriber receives benefits under the medicaid program and that benefits must be paid directly to the [~~human services~~] department of health.

B. The notice required under Paragraph (3) of Subsection A of this section may be accomplished through an attachment to the claim by the [~~human services~~] department of health for health care expense payments when the claim is first submitted by the [~~human services~~] department of health to the health care plan.

C. Notwithstanding any other provisions of law, checks in payment for claims pursuant to any individual or group contract for health care expense payments or certificate therefor for health care services provided to subscribers who are also eligible for benefits under the medicaid program and provided by medical providers qualified to participate under

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the contract or certificate shall be made payable to the provider. The health care plan may be notified that the subscriber is eligible for medicaid benefits through an attachment to the claim by the provider for health care expense payments when the claim is first submitted by the provider to the health care plan.

D. No individual or group contract for health care expense payments or certificate therefor delivered, issued for delivery or renewed in this state on or after [~~the effective date of this section~~] June 16, 1989 shall contain any provision denying or limiting contract benefits because services are rendered to a subscriber who is eligible for or who has received medical assistance under the medicaid program of this state.

E. To the extent that payment for covered expenses has been made pursuant to the state medicaid program for health care items or services furnished to an individual, in any case where a health care plan has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by the health care plan for those health care items or services."

Section 48. Section 59A-57-7 NMSA 1978 (being Laws 1998, Chapter 107, Section 7) is amended to read:

"59A-57-7. POINT-OF-SERVICE OPTION PLAN.--

A. Except as otherwise provided in this section,

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the department may require a plan that offers a point-of-service plan or open plan to include in any managed health care plan it offers an option for a point-of-service plan or open plan to the extent that the department determines that the open plan option is financially sound.

B. No health care insurer may be required to offer a point-of-service plan or open plan as an option under a medicaid-funded managed health care plan unless the [~~human services~~] department of health has established such a requirement as part of a procurement for managed health care under the medicaid program."

Section 49. Section 59A-57-10 NMSA 1978 (being Laws 1998, Chapter 107, Section 10) is amended to read:

"59A-57-10. APPLICATION OF ACT TO MEDICAID PROGRAM.--

A. Except as otherwise provided in this section, the provisions of the Patient Protection Act apply to the medicaid program operation in the state. A managed health care plan offered through the medicaid program shall grant enrollees and providers the same rights and protections as are granted to enrollees and providers in any other managed health care plan subject to the provisions of the Patient Protection Act.

B. Nothing in the Patient Protection Act shall be construed to limit the authority of the [~~human services~~] department of health to administer the medicaid program, as

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required by law. Consistent with applicable state and federal law, the [~~human services~~] department of health shall have sole authority to determine, establish and enforce medicaid eligibility criteria, the scope, definitions and limitations of medicaid benefits and the minimum qualifications or standards for medicaid service providers.

C. Medicaid recipients and applicants retain their right to appeal decisions adversely affecting their medicaid benefits to the [~~human services~~] department of health, pursuant to the [~~Public~~] Medical Assistance Appeals Act. Notwithstanding other provisions of the Patient Protection Act, a medicaid recipient or applicant who files an appeal to the [~~human services~~] department of health pursuant to the [~~Public~~] Medical Assistance Appeals Act may not file an appeal on the same issue to the superintendent pursuant to the Patient Protection Act, unless the [~~human services~~] department of health refuses to hear the appeal. The superintendent may refer to the [~~human services~~] department of health any appeal filed with the superintendent pursuant to the Patient Protection Act if the complainant is a medicaid beneficiary and the matter in dispute is subject to the provisions of the [~~Public~~] Medical Assistance Appeals Act.

D. Any managed health care plan participating in the medicaid managed care program as of [~~the effective date of the Patient Protection Act~~] July 1, 1998 and that is in

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compliance with contractual and regulatory requirements applicable to that program shall be deemed to comply with any requirements established in accordance with [~~that~~] the Patient Protection Act until July 1, 1999; provided that, from [~~the effective date of that act~~] July 1, 1998, any rights established under that act beyond those under requirements of the [~~human services~~] department of health shall apply to enrollees in medicaid managed health care plans."

Section 50. TEMPORARY PROVISION--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On July 1, 2002:

A. all personnel, appropriations, money records, equipment, supplies and other property of the medical assistance division of the human services department shall be transferred to the department of health;

B. all contracts of the medical assistance division shall be binding and effective on the department of health; and

C. all references in law to the medical assistance division, medicaid, or Title 19 or Title 21 of the Social Security Act shall be deemed to be references to the department of health.

Section 51. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2002.

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