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**HOUSE BILL 746**

**47TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2005**

**INTRODUCED BY**

**Luciano "Lucky" Varela**

**AN ACT**

**RELATING TO HEALTH CARE; ENACTING THE HEALTH SECURITY ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE; PROVIDING FOR HEALTH CARE PLANNING; ESTABLISHING PROCEDURES TO CONTAIN HEALTH CARE COSTS; CREATING A COMMISSION; PROVIDING FOR ITS POWERS AND DUTIES; PROVIDING FOR HEALTH CARE DELIVERY REGIONS AND REGIONAL COUNCILS; DIRECTING AND AUTHORIZING THE DEVELOPMENT OF A STATE HEALTH CARE PLAN.**

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

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

**Section 2. PURPOSES OF ACT. --The purposes of the Health Security Act are to:**

**A. create a program that ensures health care coverage to all New Mexicans through a combination of public**

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1 and private financing;

2 B. control escalating health care costs; and

3 C. improve the health care of all New Mexicans.

4 Section 3. DEFINITIONS. -- As used in the Health Security  
5 Act:

6 A. "beneficiary" means a person eligible for health  
7 care and benefits pursuant to the health plan;

8 B. "budget" means the total of all categories of  
9 dollar amounts of expenditures for a stated period authorized  
10 for an entity or a program;

11 C. "capital budget" means that portion of a budget  
12 that establishes expenditures for:

13 (1) acquisition or addition of substantial  
14 improvements to real property; or

15 (2) acquisition of tangible personal property;

16 D. "case management" means a comprehensive program  
17 designed to meet an individual's need for care by coordinating  
18 and linking the components of health care;

19 E. "commission" means the health care commission  
20 created pursuant to the Health Security Act;

21 F. "consumer price index for medical care prices"  
22 means that index as published by the bureau of labor statistics  
23 of the federal department of labor;

24 G. "controlling interest" means:

25 (1) a five percent or greater ownership

1 interest, direct or indirect, in the person controlled; or

2 (2) a financial interest, direct or indirect,  
3 and, because of business or personal relationships, having the  
4 power to influence important decisions of the person  
5 controlled;

6 H. "financial interest" means an ownership interest  
7 of any amount, direct or indirect;

8 I. "group practice" means an association of health  
9 care providers that provides one or more specialized health  
10 care services or a tribal or urban Indian coalition in  
11 partnership or under contract with the federal Indian health  
12 service that is authorized under federal law to provide health  
13 care to Native American populations in the state;

14 J. "health care" means health care provider  
15 services and health facility services;

16 K. "health care provider" means:

17 (1) a person licensed or certified and  
18 authorized to provide health care in New Mexico;

19 (2) an individual licensed or certified by a  
20 nationally recognized professional organization and designated  
21 as a health care provider by the commission; or

22 (3) a person that is a group practice of  
23 licensed providers or a transportation service;

24 L. "health facility" means a school-based clinic,  
25 an Indian health service facility, a tribally operated health

1 care facility, a licensed general hospital, a special hospital,  
2 an outpatient facility, a psychiatric hospital, a laboratory, a  
3 skilled nursing facility or a nursing facility;

4 M "health plan" means the program that is created  
5 and administered by the commission for provision of health care  
6 pursuant to the Health Security Act;

7 N. "major capital expenditure" means construction  
8 or renovation of facilities or the acquisition of diagnostic,  
9 treatment or transportation equipment by a health care provider  
10 or health facility that costs more than an amount recommended  
11 and established by the commission;

12 O. "operating budget" means the budget of a health  
13 facility exclusive of the facility's capital budget;

14 P. "person" means an individual or any other legal  
15 entity;

16 Q. "primary care provider" means a health care  
17 provider who is a physician, osteopathic physician, nurse  
18 practitioner, physician assistant, osteopathic physician's  
19 assistant, pharmacist clinician or other health care provider  
20 certified by the commission;

21 R. "provider budget" means the authorized  
22 expenditures pursuant to payment mechanisms established by the  
23 commission to pay for health care furnished by health care  
24 providers participating in the health plan; and

25 S. "transportation service" means a person

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1 providing the services of an ambulance, helicopter or other  
2 conveyance that is equipped with health care supplies and  
3 equipment and is used to transport patients to other health  
4 care providers or health facilities.

5 Section 4. HEALTH CARE COMMISSION CREATED--GOVERNMENTAL  
6 INSTRUMENTALITY.--The "health care commission" is created as a  
7 public body, politic and corporate, constituting a governmental  
8 instrumentality. The commission consists of fifteen members.

9 Section 5. COMMISSION--APPOINTING AUTHORITY FOR  
10 MEMBERS--CREATION OF HEALTH CARE COMMISSION MEMBERSHIP  
11 NOMINATING COMMITTEE--MEMBERSHIP, TERMS AND DUTIES OF  
12 COMMITTEE.--

13 A. The members of the commission shall be appointed  
14 by the governor. The governor shall appoint those members in  
15 accordance with the procedures and provisions of this section.

16 B. The "health care commission membership  
17 nominating committee" is created consisting of twelve members,  
18 to reflect the geographic diversity of the state, as follows:

19 (1) two members appointed by the governor;

20 (2) three members appointed by the speaker of  
21 the house of representatives;

22 (3) three members appointed by the president  
23 pro tempore of the senate;

24 (4) two members appointed by the minority  
25 leader of the house of representatives; and

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1 (5) two members appointed by the minority  
2 leader of the senate.

3 C. An elected official shall not be appointed to  
4 serve on the committee. At the first meeting of the committee  
5 it shall elect a chair from its membership. The chair shall  
6 vote only in the case of a tie vote.

7 D. The first twelve members appointed to the  
8 committee shall have terms chosen by lot: four two-year terms;  
9 four three-year terms; and four four-year terms. Thereafter,  
10 members shall serve four-year terms. A member shall serve  
11 until his successor is appointed and qualified. Successor  
12 members shall be appointed by the appointing authority that  
13 made the initial appointment to the committee.

14 E. Appointed members of the committee shall have  
15 substantial knowledge of the health care system as demonstrated  
16 by education or experience. A person shall not be appointed to  
17 the committee if, currently or within the previous thirty-six  
18 months, he or a member of his household is employed by, an  
19 officer of or has a controlling interest in a person providing  
20 health care or health insurance, directly or as an agent of a  
21 health insurer.

22 F. The committee shall take appropriate action to  
23 ensure that adequate prior notice of its meetings is advertised  
24 and reported in media outlets throughout the state in addition  
25 to publication of a legal notice in major newspapers.

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1 Publication of the legal notice shall occur once each week for  
2 the two weeks immediately preceding the date of a meeting.  
3 Meetings of the committee shall be open to the public, and  
4 public comment shall be allowed. A majority of the committee  
5 shall constitute a quorum. The committee may allow members'  
6 participation in meetings by telephone or other electronic  
7 media that allows full participation. Meetings may be closed  
8 only for discussion of candidates prior to selection. Final  
9 selection of candidates shall be by vote of the members and  
10 shall be conducted in a public meeting.

11 G. The committee shall hold its first meeting on or  
12 before June 15, 2006. The committee shall actively solicit,  
13 accept and evaluate applications from qualified persons for  
14 membership on the commission subject to the requirements for  
15 commission membership qualifications pursuant to Section 6 of  
16 the Health Security Act.

17 H. No later than September 15, 2006, the committee  
18 shall submit to the governor the names of persons recommended  
19 for appointment to the commission by a majority of the  
20 committee. Immediately after receiving committee nominations,  
21 the governor may make one request of the committee for  
22 submission of additional names. If a majority of the committee  
23 finds that additional persons would be qualified, the committee  
24 shall promptly submit additional names and recommend those  
25 persons for appointment to the commission. The committee shall

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1 submit not fewer than one or more than three names for a  
2 membership position for initial and additional appointments.

3 I. Appointed committee members shall be reimbursed  
4 pursuant to the Per Diem and Mileage Act for expenses incurred  
5 in fulfilling their duties.

6 J. Staff to assist the committee in its duties  
7 until a commission is appointed shall be furnished by the  
8 department of health. Thereafter, commission staff shall  
9 assist the committee in its duties.

10 Section 6. APPOINTMENT OF COMMISSION MEMBERS--  
11 QUALIFICATIONS--TERMS.--

12 A. From the nominees submitted by the health care  
13 commission membership nominating committee, the governor shall  
14 appoint fifteen members and the initial commission shall be in  
15 place by November 1, 2006.

16 B. The terms of the initial members appointed shall  
17 be chosen by lot: five members shall be appointed for terms of  
18 four years; five members shall be appointed for terms of three  
19 years; and five members shall be appointed for terms of two  
20 years. Thereafter, all members shall be appointed for terms of  
21 four years. After initial terms are served, no member shall  
22 serve more than three consecutive four-year terms. A member  
23 may serve until a successor is appointed.

24 C. A person who served on the health care  
25 commission membership nominating committee shall not be



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1 nominated for or serve on the commission within thirty-six  
2 months from the time served on the committee. A state employee  
3 who is exempt from the Personnel Act is not eligible to serve  
4 on the commission.

5 D. When a vacancy occurs in the membership of the  
6 commission, the health care commission membership nominating  
7 committee shall meet and act within thirty days of the  
8 occurrence of the vacancy. From the nominees submitted, the  
9 governor shall fill the vacancy within thirty days after  
10 receiving final nominations.

11 E. Members of the commission shall include five  
12 persons who represent either health care providers or health  
13 facilities and ten persons who represent consumer and employer  
14 interests, the majority of whom shall represent consumer  
15 interests.

16 F. Except for persons appointed to represent health  
17 facilities or health care providers, a person shall be  
18 disqualified for appointment to the commission if, currently or  
19 during the previous thirty-six months, he or a member of his  
20 household is employed by, an officer of or has a controlling  
21 interest in a person providing health care or health insurance,  
22 directly or as an agent of a health insurer.

23 G. Persons appointed who do not represent health  
24 care providers or health facilities must have a knowledge of  
25 the health care system as demonstrated by experience or

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1 education. To ensure fair representation of all areas of the  
2 state, members shall be appointed from each of the state board  
3 of education districts as follows:

4 (1) two from state board of education  
5 district 1;

6 (2) one from state board of education  
7 district 2;

8 (3) one from state board of education  
9 district 3;

10 (4) two from state board of education  
11 district 4;

12 (5) two from state board of education  
13 district 5;

14 (6) one from state board of education  
15 district 6;

16 (7) two from state board of education  
17 district 7;

18 (8) two from state board of education  
19 district 8;

20 (9) one from state board of education  
21 district 9; and

22 (10) one from state board of education  
23 district 10.

24 H. A member may be removed from the commission by a  
25 majority vote of the members present at a meeting where a

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1 quorum is duly constituted. The commission shall set standards  
2 for attendance and may remove a member for incompetence, lack  
3 of attendance, neglect of duty or malfeasance in office. A  
4 member shall not be removed without proceedings consisting of  
5 at least one notice of hearing and an opportunity to be heard.  
6 Removal proceedings shall be before the commission and in  
7 accordance with rules adopted by the commission.

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

12 J. A member may receive per diem and mileage in  
13 accordance with the provisions of the Per Diem and Mileage Act.  
14 Additionally, members shall be compensated at the rate of two  
15 hundred dollars (\$200) for each meeting actually attended not  
16 to exceed compensation for one hundred twenty meetings for a  
17 two-year period occurring in a term.

18 Section 7. CONFLICT OF INTEREST--DISCLOSURE BY MEMBERS  
19 AND DISQUALIFICATION FROM VOTING ON CERTAIN MATTERS.--

20 A. The commission shall adopt a conflict-of-  
21 interest disclosure statement for use by all members that  
22 requires disclosure of a financial interest, whether or not a  
23 controlling interest, of the member or a member of his  
24 household in a person providing health care or health  
25 insurance.

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1           B. A member representing health facilities or  
2 health care providers may vote on matters that pertain  
3 generally to health facilities or health care providers.

4           C. If there is a question about a conflict of  
5 interest of a commission member, the other members shall vote  
6 on whether to allow the member to vote.

7           Section 8. CODE OF CONDUCT TO BE ADOPTED BY COMMISSION. --

8           A. The commission shall adopt a general code of  
9 conduct for commission members and employees subject to the  
10 commission's control. The code of conduct shall include at  
11 least those matters and activities proscribed by the  
12 Governmental Conduct Act.

13           B. Violation of a provision of the adopted code of  
14 conduct is grounds for removal of a commission member and  
15 grounds for suspension, termination or other disciplinary  
16 action of an employee.

17           Section 9. APPLICATION OF CERTAIN STATE LAWS TO  
18 COMMISSION. --The commission and regional councils created  
19 pursuant to the Health Security Act shall be subject to and  
20 shall comply with the provisions of the:

- 21           A. Open Meetings Act;
- 22           B. State Rules Act;
- 23           C. Inspection of Public Records Act; and
- 24           D. Public Records Act.

25           Section 10. CHIEF EXECUTIVE OFFICER-- STAFF-- CONTRACTS--

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1 BUDGETS. --

2 A. The commission shall appoint and set the salary  
3 of a "chief executive officer". The chief executive officer  
4 shall serve at the pleasure of the commission and has authority  
5 to carry on the day-to-day operations of the commission and the  
6 health plan.

7 B. The chief executive officer shall employ those  
8 persons necessary to administer and implement the provisions of  
9 the Health Security Act.

10 C. The chief executive officer and the chief  
11 executive officer's staff shall implement the Health Security  
12 Act in accordance with that act and the rules adopted by the  
13 commission. The chief executive officer may delegate authority  
14 to employees and may organize the staff into units to  
15 facilitate its work.

16 D. If the chief executive officer determines that  
17 the commission staff or a state agency does not have the  
18 resources or expertise to perform a necessary task, the chief  
19 executive officer may contract for performance from a person  
20 who has a demonstrated capability to perform the task. The  
21 commission shall establish the standards and requirements by  
22 which a contract is executed by the commission or the chief  
23 executive officer. A contract shall be reviewed by the  
24 commission or the chief executive officer to ensure that it  
25 meets the criteria, performance standards, expectations and

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1 needs of the commission.

2 E. The chief executive officer shall prepare and  
3 submit an annual budget request and plan of operation to the  
4 commission for its approval. The chief executive officer shall  
5 provide at least quarterly status reports on the budget and  
6 advise of a potential shortfall as soon as practically  
7 possible.

8 F. A contract for claims processing functions shall  
9 require that all work for claims processing, customer service,  
10 medical and utilization review, financial audit and  
11 reimbursement and related claims adjudication functions be  
12 performed entirely in New Mexico. To the extent practicable,  
13 all other work shall be performed in New Mexico.

14 Section 11. COMMISSION--GENERAL DUTIES.--The commission  
15 shall:

16 A. adopt a five-year plan for the initial  
17 implementation of the provisions of the Health Security Act,  
18 update that plan and adopt other long- and short-range plans to  
19 provide continuity and development of the state's health care  
20 system;

21 B. design the health plan to fulfill the purposes  
22 of and conform with the provisions of the Health Security Act;

23 C. provide a program to educate the public, health  
24 care providers and health facilities about the health plan and  
25 the persons eligible to receive its benefits;

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1           D. study and adopt as provisions of the health plan  
2 cost-effective methods of providing quality health care to all  
3 beneficiaries, according high priority to increased reliance  
4 on:

5                   (1) preventive and primary care that includes  
6 immunization and screening examinations;

7                   (2) providing health care in rural or  
8 underserved areas of the state;

9                   (3) in-home and community-based alternatives  
10 to institutional health care; and

11                   (4) case management services when appropriate;

12           E. establish compensation methods for health care  
13 providers and health facilities and adopt standards and  
14 procedures for negotiating and entering into contracts with  
15 participating health care providers and health facilities;

16           F. annually, and for those projected future periods  
17 the commission believes appropriate, establish health plan  
18 budgets;

19           G. establish capital budgets for health facilities,  
20 limited to capital expenditures subject to the Health Security  
21 Act, and include and adopt in establishing those budgets:

22                   (1) standards and procedures for determining  
23 the budgets; and

24                   (2) a requirement for prior approval by the  
25 commission for major capital expenditures by a health facility;

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1           H. negotiate and enter into health care reciprocity  
2 agreements with other states and negotiate and enter into  
3 health care agreements with out-of-state health care providers  
4 and health facilities;

5           I. develop claims and payment procedures for health  
6 care providers, health facilities and claims administrators and  
7 include provisions to ensure timely payments and provide for  
8 payment of interest when reimbursable claims are not paid  
9 within a reasonable time;

10           J. establish, in conjunction with other state  
11 agencies similarly charged, a system to collect and analyze  
12 health care data and other data necessary to improve the  
13 quality, efficiency and effectiveness of health care and to  
14 control costs of health care in New Mexico, which system shall  
15 include data on:

16                   (1) mortality, including accidental causes of  
17 death, and natality;

18                   (2) morbidity;

19                   (3) health behavior;

20                   (4) physical and psychological impairment and  
21 disability;

22                   (5) health care system costs and health care  
23 availability, utilization and revenues;

24                   (6) environmental factors;

25                   (7) availability, adequacy and training of



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1 health care personnel;

2 (8) demographic factors;

3 (9) social and economic conditions affecting  
4 health; and

5 (10) other factors determined by the  
6 commission;

7 K. standardize data collection and specific methods  
8 of measurement across databases and use scientific sampling or  
9 complete enumeration for reporting health information;

10 L. establish a health care delivery system that is  
11 efficient to administer and that eliminates unnecessary  
12 administrative costs;

13 M adopt rules necessary to implement and monitor a  
14 preferred drug list, bulk purchasing or other mechanism to  
15 provide prescription drugs and a pricing procedure for  
16 nonprescription drugs, durable medical equipment and supplies,  
17 eyeglasses, hearing aids and oxygen;

18 N. establish a pharmacy and therapeutics committee  
19 to:

20 (1) conduct concurrent, prospective and  
21 retrospective drug utilization review;

22 (2) conduct pharmacoeconomic research and  
23 analysis of clinical safety, efficacy and effectiveness of  
24 drugs;

25 (3) consult with specialists in appropriate

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1 fields of medicine for therapeutic classes of drugs;

2 (4) recommend therapeutic classes of drugs,  
3 including specific drugs within each class to be included in  
4 the preferred drug list;

5 (5) identify appropriate exclusions from the  
6 preferred drug list; and

7 (6) conduct periodic clinical reviews of  
8 preferred, non-preferred and new drugs;

9 0. study and evaluate the adequacy and quality of  
10 health care furnished pursuant to the Health Security Act, the  
11 cost of each type of service and the effectiveness of cost-  
12 containment measures in the health plan;

13 P. study and monitor the migration of persons to  
14 New Mexico to determine if persons with costly health care  
15 needs are moving to New Mexico to receive health care, and if  
16 migration appears to threaten the financial stability of the  
17 health plan, recommend to the legislature changes in  
18 eligibility requirements, premiums or other changes that may be  
19 necessary to maintain the financial integrity of the health  
20 plan;

21 Q. study and evaluate the cost of health care  
22 provider professional liability insurance and its impact on the  
23 price of health care services and recommend changes to the  
24 legislature as necessary;

25 R. establish and approve changes in coverage

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1 benefits and benefit standards in the health plan;

2 S. conduct necessary investigations and inquiries;

3 T. adopt rules necessary to implement, administer  
4 and monitor the operation of the health plan;

5 U. adopt rules to establish a procurement process  
6 for services and property;

7 V. meet as needed, but no less often than once  
8 every month; and

9 W. report annually to the legislature and the  
10 governor on the commission's activities and the operation of  
11 the health plan and include in the annual report:

12 (1) a summary of information about health care  
13 needs, health care services, health care expenditures, revenues  
14 received and projected revenues and other relevant issues  
15 relating to the health plan, the initial five-year plan and  
16 future updates of that plan and other long- and short-range  
17 plans; and

18 (2) recommendations on methods to control  
19 health care costs and improve access to and the quality of  
20 health care for state residents, as well as recommendations for  
21 legislative action.

22 Section 12. COMMISSION--AUTHORITY.--The commission has  
23 the authority necessary to carry out the powers and duties  
24 pursuant to the Health Security Act. The commission retains  
25 responsibility for its duties but may delegate authority to the

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1 chief executive officer. However, the authority to take the  
2 following actions is expressly reserved to the commission:

3 A. approve the commission's budget and plan of  
4 operation;

5 B. approve the health plan and make changes in the  
6 health plan, but only after legislative approval of those  
7 changes specified in Section 30 of the Health Security Act;

8 C. make rules and conduct both rulemaking and  
9 adjudicatory hearings in person or by use of a hearing officer;

10 D. issue subpoenas to persons to appear and testify  
11 before the commission and to produce documents and other  
12 information relevant to the commission's inquiry and enforce  
13 this subpoena power through an action in a state district  
14 court;

15 E. make reports and recommendations to the  
16 legislature;

17 F. subject to the prohibitions and restrictions of  
18 Section 21 of the Health Security Act, apply for program  
19 waivers from any governmental entity if the commission  
20 determines that the waivers are necessary to ensure the  
21 participation by the greatest possible number of beneficiaries;

22 G. apply for and accept grants, loans and  
23 donations;

24 H. acquire or lease real property and make  
25 improvements on it and acquire by lease or by purchase tangible

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1 and intangible personal property;

2 I. dispose of and transfer personal property, but  
3 only at public sale after adequate notice;

4 J. appoint and prescribe the duties of employees,  
5 fix their compensation, pay their expenses and provide an  
6 employee benefit program;

7 K. establish and maintain banking relationships,  
8 including establishment of checking and savings accounts;

9 L. participate as an eligible entity in the  
10 programs of the New Mexico finance authority; and

11 M. enter into agreements with an employer to  
12 provide health care services for the employer's employees or  
13 retirees; provided, however, that nothing in the Health  
14 Security Act shall be construed to reduce or eliminate benefits  
15 to which the employee or retiree is entitled.

16 Section 13. ADVISORY BOARDS. --

17 A. The commission shall establish a "health care  
18 provider advisory board" and a "health facility advisory  
19 board". It may establish additional advisory boards to assist  
20 it in performing its duties. Advisory boards shall assist the  
21 commission in matters requiring the expertise and knowledge of  
22 the advisory boards' members.

23 B. The commission may appoint not more than two  
24 commission members and up to five additional persons to serve  
25 on an advisory board it creates. Advisory board members shall

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1 be paid per diem and mileage in accordance with the provisions  
2 of the Per Diem and Mileage Act.

3 C. Except for the health care provider advisory  
4 board and the health facility advisory board, no more than two  
5 advisory board members shall have a controlling interest,  
6 direct or indirect, in a person providing health care or a  
7 person providing health insurance.

8 D. Staff and technical assistance for an advisory  
9 board shall be provided by the commission as necessary.

10 Section 14. HEALTH CARE DELIVERY REGIONS. -- The commission  
11 shall establish health care delivery regions in the state,  
12 based on geography and health care resources. The regions may  
13 have differential fee schedules, budgets, capital expenditure  
14 allocations or other features to encourage the provision of  
15 health care in rural and other underserved areas or to  
16 otherwise tailor the delivery of health care to fit the needs  
17 of a region or a part of a region.

18 Section 15. REGIONAL COUNCILS. --

19 A. The commission shall designate regional councils  
20 in the designated health care delivery regions. In selecting  
21 persons to serve as members of regional councils, the  
22 commission shall consider the comments and recommendations of  
23 persons in the region who are knowledgeable about health care  
24 and the economic and social factors affecting the region.

25 B. The regional councils shall be composed of the

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1 commission members who live in the region and five other  
2 members who live in the region and are appointed by the  
3 commission. No more than two noncommission council members  
4 shall have a controlling interest, direct or indirect, in a  
5 person providing health care or a person providing health  
6 insurance.

7 C. Members of a regional council shall be paid per  
8 diem and mileage in accordance with the provisions of the Per  
9 Diem and Mileage Act.

10 D. The regional councils shall hold public hearings  
11 to receive comments, suggestions and recommendations from the  
12 public regarding regional health care needs. The councils  
13 shall report to the commission at times specified by the  
14 commission to ensure that regional concerns are considered in  
15 the development and update of the five-year plan, other short-  
16 and long-range plans and projections, fee schedules, budgets  
17 and capital expenditure allocations.

18 E. Staff technical assistance for the regional  
19 councils shall be provided by the commission.

20 Section 16. RULEMAKING. --

21 A. The commission shall adopt rules necessary to  
22 carry out the duties of the commission and the provisions of  
23 the Health Security Act.

24 B. The commission shall not adopt, amend or repeal  
25 any rule affecting a person outside the commission without a

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1 public hearing on the proposed action before the commission or  
2 a hearing officer designated by the commission. The hearing  
3 officer may be a member of the commission's staff. The hearing  
4 shall be held in a county that the commission determines would  
5 be in the interest of those affected. Notice of the subject  
6 matter of the rule, the action proposed to be taken, the time  
7 and place of the hearing, the manner in which interested  
8 persons may present their views and the method by which copies  
9 of the proposed rule or an amendment or repeal of an existing  
10 rule may be obtained shall be published once at least thirty  
11 days prior to the hearing date in a newspaper of general  
12 circulation in the state and shall also be published in an  
13 informative non-legal format in one newspaper published in each  
14 health care delivery region and mailed at least thirty days  
15 prior to the hearing date to all persons who have made a  
16 written request for advance notice of hearing.

17 C. All rules adopted by the commission shall be  
18 filed in accordance with the State Rules Act.

19 Section 17. HEALTH PLAN. --

20 A. After notice and public hearing, including  
21 taking public comment and the reports of the regional councils,  
22 the commission, in conjunction with other state agencies, shall  
23 adopt a five-year health plan and review it at regular  
24 intervals for possible revision.

25 B. The health plan shall be designed to provide



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1 comprehensive, necessary and appropriate health care benefits,  
2 including preventive health care and primary, secondary and  
3 tertiary health care for acute and chronic conditions. The  
4 health plan may provide for certain health care services to be  
5 phased in as the health plan budget allows.

6 C. Pursuant to the phase-in provisions of  
7 Subsection B of this section, the commission shall provide for  
8 coverage of the following health care services:

- 9 (1) preventive health services;
- 10 (2) health care provider services;
- 11 (3) health facility inpatient and outpatient  
12 services;
- 13 (4) laboratory tests and radiology procedures;
- 14 (5) hospice care;
- 15 (6) in-home, community-based and institutional  
16 long-term care services;
- 17 (7) prescription drugs;
- 18 (8) inpatient and outpatient mental and  
19 behavioral health services;
- 20 (9) drug and other substance abuse services;
- 21 (10) preventive and prophylactic dental  
22 services, including an annual dental examination and cleaning;
- 23 (11) vision appliances, including medically  
24 necessary contact lenses;
- 25 (12) medical supplies, durable medical

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1 equipment and selected assistive devices, including hearing and  
2 speech assistive devices; and

3 (13) experimental or investigational  
4 procedures or treatments as specified by the commission.

5 D. Covered health care shall not include:

6 (1) surgery for cosmetic purposes other than  
7 for reconstructive purposes;

8 (2) medical examinations and medical reports  
9 prepared for purchasing or renewing life insurance or  
10 participating as a plaintiff or defendant in a civil action for  
11 the recovery or settlement of damages; and

12 (3) orthodontic services and cosmetic dental  
13 services except those cosmetic dental services necessary for  
14 reconstructive purposes.

15 E. The health plan shall specify the health care to  
16 be covered and the amount, scope and duration of benefits.

17 F. The health plan shall contain provisions to  
18 control health care costs so that beneficiaries receive  
19 comprehensive, high-quality health care consistent with  
20 available revenue and budget constraints.

21 G. The health plan shall phase in beneficiaries as  
22 their participation becomes possible through contracts, waivers  
23 or federal legislation. The health plan may provide for  
24 certain preventive health care to be offered to all New  
25 Mexicans regardless of a person's eligibility to participate as

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1 a beneficiary.

2 H. The five-year plan as well as other long- and  
3 short-range plans adopted by the commission shall be reviewed  
4 by the regional councils and the commission annually and  
5 revised as necessary. Revisions shall be adopted by the  
6 commission in accordance with Section 11 of the Health Security  
7 Act. In projecting services under the health plan, the  
8 commission shall take all reasonable steps to ensure that long-  
9 term care and dental care are provided at the earliest  
10 practical times consistent with budget constraints.

11 Section 18. LONG-TERM CARE. --

12 A. Long-term care may include:

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

15 (2) institutional care.

16 B. No later than one year after the effective date  
17 of the operation of the health plan, the commission shall  
18 appoint an advisory "long-term care committee" made up of  
19 representatives of health care consumers, providers and  
20 administrators to develop a plan for integrating long-term care  
21 into the health plan. The committee shall report its plan to  
22 the commission no later than one year from its appointment.  
23 Committee members shall receive per diem and mileage as  
24 provided in the Per Diem and Mileage Act.

25 C. The long-term care component of the health plan

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1 shall provide for case management and noninstitutional services  
2 when appropriate.

3 D. Nothing in this section affects long-term care  
4 services paid through private insurance or state or federal  
5 programs subject to the provisions of Sections 40 and 41 of the  
6 Health Security Act.

7 E. Nothing in this section precludes the commission  
8 from including long-term care services from the inception of  
9 the health plan.

10 Section 19. MENTAL AND BEHAVIORAL HEALTH SERVICES. --

11 A. No later than one year after appointment of the  
12 chief executive officer, the commission shall appoint an  
13 advisory "mental and behavioral health services committee" made  
14 up of representatives of mental and behavioral health care  
15 consumers, providers and administrators to develop a plan for  
16 coordinating mental and behavioral health services within the  
17 health plan. The committee shall report its plan to the  
18 commission no later than one year from its appointment.  
19 Committee members may receive per diem and mileage as provided  
20 in the Per Diem and Mileage Act.

21 B. The mental and behavioral health services  
22 component of the health plan shall provide for case management  
23 and noninstitutional services where appropriate.

24 C. The health plan shall not impose treatment  
25 limitations or financial requirements on the provision of

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1 mental and behavioral health benefits if identical limitations  
2 or requirements are not imposed on coverage of benefits for  
3 other conditions.

4 D. Nothing in this section limits mental and  
5 behavioral health services paid through private insurance or  
6 state or federal programs subject to the provisions of Sections  
7 40 and 41 of the Health Security Act.

8 Section 20. ~~MEDICAID COVERAGE--AGREEMENTS.~~ -- The  
9 commission may enter into appropriate agreements with the human  
10 services department or other state agency for the purpose of  
11 furthering the goals of the Health Security Act. These  
12 agreements may provide for certain services provided pursuant  
13 to the medicaid program under Title 19 and Title 21 of the  
14 Social Security Act to be administered by the commission to  
15 implement the health plan.

16 Section 21. ~~HEALTH PLAN COVERAGE--CONDITIONS OF~~  
17 ~~ELIGIBILITY FOR BENEFICIARIES--EXCLUSIONS.~~ --

18 A. An individual is eligible as a beneficiary of  
19 the health plan if the individual has been physically present  
20 in New Mexico for one year prior to the date of application for  
21 enrollment in the health plan and if the individual has a  
22 current intention to remain in New Mexico and not to reside  
23 elsewhere. A dependent of an eligible individual is included  
24 as a beneficiary.

25 B. Individuals covered under the following

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1 governmental programs shall not be brought into coverage:

- 2 (1) federal retiree health plan beneficiaries;
- 3 (2) active duty and retired military
- 4 personnel; and
- 5 (3) individuals covered by the federal active
- 6 and retired military health programs.

7 C. Federal Indian health service or tribally  
8 operated health care program beneficiaries shall not be brought  
9 into coverage except through agreements with:

- 10 (1) Indian nations, tribes or pueblos;
- 11 (2) consortia of tribes or pueblos; or
- 12 (3) a federal Indian health service agency
- 13 subject to the approval of the tribes or pueblos located in
- 14 that agency.

15 D. If an individual is ineligible due to the  
16 residence requirement, the individual may become eligible by  
17 paying the premium required by the health plan for coverage for  
18 the period of time up to the date he fulfills that requirement  
19 if he is an employee who physically resides and intends to  
20 reside in the state because of employment offered to him in New  
21 Mexico while he was residing elsewhere as demonstrated by  
22 furnishing that evidence of those facts required by rule  
23 adopted by the commission.

24 E. An employer that provides health care benefits  
25 for its employees after retirement, including coverage for

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1 payment of health care supplementary coverage if the retiree is  
2 eligible for medicare, may agree to participate in the health  
3 plan; provided, however, that there is no loss of benefits  
4 under the retiree health benefit coverage. An employer that  
5 participates in the health plan shall contribute to the health  
6 plan for the benefit of the retiree and the agreement shall  
7 ensure that the health benefit coverage for the retiree shall  
8 be restored in the event of the retiree's ineligibility for  
9 health plan coverage.

10 F. The commission shall prescribe by rule  
11 conditions under which other persons in the state may be  
12 eligible for coverage pursuant to the health plan.

13 Section 22. HEALTH PLAN COVERAGE OF NONRESIDENT  
14 STUDENTS. --

15 A. Except as provided in Subsection B of this  
16 section, an educational institution shall purchase coverage  
17 under the health plan for its nonresident students through fees  
18 assessed to those students. The governing body of an  
19 educational institution shall set the fees at the amount  
20 determined by the commission.

21 B. A nonresident student at an educational  
22 institution may satisfy the requirement for health care  
23 coverage by proof of coverage under a policy or plan in another  
24 state that is acceptable to the commission. The student shall  
25 not be assessed a fee in that case.

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1 C. The commission shall adopt rules to determine  
2 proof of an individual's eligibility for the health plan or a  
3 student's proof of nonresident health care coverage.

4 Section 23. REMOVING INELIGIBLE PERSONS. -- The commission  
5 shall adopt rules to provide procedures for removing persons no  
6 longer eligible for coverage.

7 Section 24. ELIGIBILITY CARD--USE--PENALTIES FOR  
8 MISUSE. --

9 A. A beneficiary shall receive a card as proof of  
10 eligibility. The card shall be electronically readable and  
11 shall contain a picture or electronic image, information that  
12 identifies the beneficiary for treatment, billing, payment and  
13 other information the commission deems necessary. The use of a  
14 beneficiary's social security number as an identification  
15 number is not permitted.

16 B. The eligibility card is not transferable. A  
17 beneficiary who lends his card to another and an individual who  
18 uses another's card shall be jointly and severally liable to  
19 the commission for the full cost of the health care provided to  
20 the user. The liability shall be paid in full within one year  
21 of final determination of liability. Liabilities created  
22 pursuant to this section shall be collected in a manner similar  
23 to that used for collection of delinquent taxes.

24 C. A beneficiary who lends his card to another or  
25 an individual who uses another's card after being determined



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1 liable pursuant to Subsection B of this section of a previous  
2 misuse is guilty of a misdemeanor and shall be sentenced  
3 pursuant to the provisions of Section 31-19-1 NMSA 1978. A  
4 third or subsequent conviction is a fourth degree felony, and  
5 the offender shall be sentenced pursuant to the provisions of  
6 Section 31-18-15 NMSA 1978.

7 Section 25. PRIMARY CARE PROVIDER-- RIGHT TO CHOOSE--  
8 ACCESS TO SERVICES. --

9 A. Except as provided in the Workers' Compensation  
10 Act, a beneficiary has the right to choose a primary care  
11 provider.

12 B. The primary care provider is responsible for  
13 providing health care provider services to the patient except  
14 for:

15 (1) services in medical emergencies; and

16 (2) services for which a primary care provider  
17 determines that specialist services are required, in which case  
18 the primary care provider shall advise the patient of the need  
19 for and the type of specialist services.

20 C. Except as otherwise provided in this section,  
21 health care provider specialists shall be paid pursuant to the  
22 health plan only if the patient has been referred by a primary  
23 care provider. Nothing in this subsection prevents a  
24 beneficiary from obtaining the services of a health care  
25 provider specialist and paying the specialist for services

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1 provided.

2 D. The commission shall by rule specify when and  
3 under what circumstances a beneficiary may self-refer,  
4 including self-referral to a chiropractic physician, a doctor  
5 of oriental medicine, mental and behavioral health service  
6 providers and other health care providers who are not primary  
7 care providers.

8 E. The commission shall by rule specify the  
9 conditions under which a beneficiary may select a specialist as  
10 a primary care provider.

11 Section 26. DISCRIMINATION PROHIBITED. --A health care  
12 provider or health facility shall not discriminate against or  
13 refuse to furnish health care to a beneficiary on the basis of  
14 age, race, color, income level, national origin, religion,  
15 gender, sexual orientation, disabling condition or payment  
16 status. Nothing in this section shall require a health care  
17 provider or health facility to provide services to a  
18 beneficiary if the provider or facility is not qualified to  
19 provide the needed services or does not offer them to the  
20 general public.

21 Section 27. CLAIMS REVIEW. --

22 A. The commission shall adopt rules to provide a  
23 comprehensive claims review program. The procedures and  
24 standards used in the program shall be disclosed in writing to  
25 applicants, beneficiaries, health care providers and health

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1 facilities at the time of application to or participation in  
2 the health plan.

3 B. The decision to approve or deny a claim based on  
4 a technicality shall be made in a timely manner and shall not  
5 exceed time limits established by rule of the commission. A  
6 final decision to deny payment for services based on medical  
7 necessity or utilization shall be based on a recommendation  
8 made by a health care professional having appropriate and  
9 adequate qualifications to make the recommendation. A denial  
10 of a claim for payment of a medical specialty service based on  
11 medical necessity or utilization shall be made only after a  
12 written recommendation for denial is made by a member of that  
13 medical specialty with credentials equivalent to those of the  
14 provider.

15 C. The fact of and the specific reasons for a  
16 denial of a health care claim shall be communicated promptly in  
17 writing to both the provider and the beneficiary involved.

18 Section 28. QUALITY OF CARE--HEALTH CARE PROVIDER AND  
19 HEALTH FACILITIES--PRACTICE STANDARDS. --

20 A. The commission shall adopt rules to establish  
21 and implement a quality improvement program that monitors the  
22 quality and appropriateness of health care provided by the  
23 health plan, including evidence-based medicine, best practices,  
24 outcome measurements, consumer education and patient safety.

25 The commission shall set standards and review benefits to

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1 ensure that effective, cost-efficient, high quality and  
2 appropriate health care is provided under the health plan.

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

9 C. The quality improvement program shall include an  
10 ongoing system for monitoring patterns of practice. The  
11 commission shall appoint a "health care practice advisory  
12 committee" consisting of health care providers, health  
13 facilities and other knowledgeable persons to advise the  
14 commission and staff on health care practice issues. The  
15 committee may appoint subcommittees and task forces to address  
16 practice issues of a specific health care provider discipline  
17 or a specific kind of health facility; provided, however, that  
18 the subcommittee or task force includes providers of  
19 substantially similar specialties or types of facilities. The  
20 advisory committee shall provide to the commission recommended  
21 standards and guidelines to be followed in making  
22 determinations on practice issues.

23 D. With the advice of the health care practice  
24 advisory committee, the commission shall establish a system of  
25 peer education for health care providers or health facilities

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1 determined to be engaging in aberrant patterns of practice  
2 pursuant to Subsection B of this section. If the commission  
3 determines that peer education efforts have failed, the  
4 commission may refer the matter to the appropriate licensing or  
5 certifying board.

6 E. The commission shall provide by rule the  
7 procedures for recouping payments or withholding payments for  
8 health care determined by the commission with the advice of the  
9 health care practice advisory committee or subcommittee to be  
10 medically unnecessary.

11 F. The commission may provide by rule for the  
12 assessment of administrative penalties for up to three times  
13 the amount of excess payments if it finds that excessive  
14 billings were part of an aberrant pattern of practice.  
15 Administrative penalties shall be deposited in the current  
16 school fund.

17 G. After consultation with the health care practice  
18 advisory committee, the commission may suspend or revoke a  
19 health care provider's or health facility's privilege to be  
20 paid for health care provided under the health plan based upon  
21 evidence clearly supporting a determination by the commission  
22 that the provider or facility engages in aberrant patterns of  
23 practice, including inappropriate utilization, attempts to  
24 unbundle health care services or other practices that the  
25 commission deems a violation of the Health Security Act or

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1 rules adopted pursuant to that act. As used in this  
2 subsection, "unbundle" means to divide a service into  
3 components in an attempt to increase or with the effect of  
4 increasing compensation from the health plan.

5 H. The commission shall report a suspension or  
6 revocation of the privilege to be paid for health care pursuant  
7 to the Health Security Act to the appropriate licensing or  
8 certifying board.

9 I. The commission shall report cases of suspected  
10 fraud by a health care provider or a health facility to the  
11 attorney general or to the district attorney of the county  
12 where the health care provider or health facility operates for  
13 investigation and prosecution.

14 Section 29. DISPUTE RESOLUTION. --A person specifically  
15 and directly aggrieved by a decision of the commission has the  
16 right to judicial review of the decision by a state district  
17 court. As a prerequisite to judicial review the person  
18 aggrieved must exhaust administrative remedies available  
19 through procedures for dispute resolution established by rule  
20 of the commission, including mandatory participation in  
21 mediation in a good-faith effort to resolve a dispute. The  
22 commission shall include in its rules for dispute resolution  
23 provisions for adequate notice to the disputants, opportunities  
24 to be heard in informal conferences prior to mediation and all  
25 procedural due process safeguards.

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1           Section 30.   HEALTH PLAN BUDGET. --

2           A.   Annually, the commission shall develop and  
3 submit to the legislature a health plan budget.   The budget  
4 shall be the commission's recommendation for the total amount  
5 to be spent by the plan for covered health care services in the  
6 next fiscal year.

7           B.   Unless otherwise provided in the general  
8 appropriation act or other act of the legislature, the health  
9 plan budget shall be within projected annual revenues.   After  
10 the legislative review and approval, the commission shall  
11 implement the health plan budget.   Without specific legislative  
12 approval, the commission shall not change the level of premium  
13 charged and used to project revenue or change the employer  
14 contributions under the health plan.

15           C.   In developing the health plan budget, the  
16 commission shall provide that credit be taken in the budget for  
17 all revenues produced for health care in the state pursuant to  
18 any law other than the Health Security Act.

19           D.   The health plan shall include a maximum amount  
20 or percentage for administrative costs, and this maximum, if a  
21 percentage, may change in relation to the total costs of  
22 services provided under the health plan.   For the sixth and  
23 subsequent calendar years of operation of the health plan,  
24 administrative costs shall not exceed five percent of the  
25 health plan budget.

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1           Section 31.   PAYMENTS TO HEALTH CARE PROVIDERS--

2   CO-PAYMENTS. --

3           A.   The commission shall prepare a provider budget.  
4   Consistent with the provider budget, the health plan shall  
5   provide payment for all covered health care rendered by health  
6   care providers.  A variety of payment plans, including fee-for-  
7   service, may be adopted by the commission.  Payment plans shall  
8   be negotiated with providers as provided by rule.  In the event  
9   that negotiation fails to develop an acceptable payment plan,  
10  the disputing parties shall submit the dispute for resolution  
11  pursuant to Section 29 of the Health Security Act.

12           B.   Supplemental payment rates may be adopted to  
13  provide incentives to help ensure the delivery of needed health  
14  care in rural and other underserved areas throughout the state.

15           C.   An annual percentage increase in the amount  
16  allocated for provider payments in the budget shall be no  
17  greater than the annual percentage increase in the consumer  
18  price index for medical care prices published by the bureau of  
19  labor statistics of the federal department of labor using the  
20  year prior to the year in which the health plan is implemented  
21  as the baseline year.  The annual limitation in this subsection  
22  may be adjusted up or down by the commission based on a showing  
23  of special and unusual circumstances in a hearing before the  
24  commission.

25           D.   Payment, or the offer of payment whether or not



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1 that offer is accepted, to a health care provider for services  
2 covered by the health plan shall be payment in full for those  
3 services. A health care provider shall not charge a  
4 beneficiary an additional amount for services covered by the  
5 plan.

6 E. The commission may establish a co-payment  
7 schedule if a required co-payment is determined to be an  
8 effective cost-control measure. A co-payment shall not be  
9 required for preventive health care. When a co-payment is  
10 required, the health care provider shall not waive it and if it  
11 remains uncollected, the health care provider shall demonstrate  
12 a good-faith effort to have collected the co-payment.

13 Section 32. PAYMENTS TO HEALTH FACILITIES--CO-PAYMENTS.--

14 A. A health facility shall negotiate an annual  
15 operating budget with the commission. The operating budget  
16 shall be based on a base operating budget of past performance  
17 and projected changes upward or downward in costs and services  
18 anticipated for the next year. If a negotiated annual operating  
19 budget is not agreed upon, a health facility shall submit the  
20 budget to dispute resolution pursuant to Section 29 of the  
21 Health Security Act. An annual percentage increase in the  
22 amount allocated for a health facility operating budget shall be  
23 no greater than the change in the annual consumer price index  
24 for medical care prices, published annually by the bureau of  
25 labor statistics of the federal department of labor. The annual

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1 limitation in this subsection may be adjusted up or down by the  
2 commission based on a showing of special and unusual  
3 circumstances in a hearing before the commission.

4 B. Supplemental payment rates may be adopted to  
5 provide incentives to help ensure the delivery of needed health  
6 care services in rural and other underserved areas throughout  
7 the state.

8 C. Each health care provider employed by a health  
9 facility shall be paid from the facility's operating budget in a  
10 manner determined by the health facility.

11 D. The commission may establish a co-payment  
12 schedule if a required co-payment is determined to be an  
13 effective cost-control measure. A co-payment shall not be  
14 required for preventive care. When a co-payment is required,  
15 the health facility shall not waive it and if it remains  
16 uncollected, the health facility shall demonstrate a good-faith  
17 effort to have collected the co-payment.

18 Section 33. HEALTH RESOURCE CERTIFICATE-- COMMISSION  
19 RULES-- REQUIREMENT FOR REVIEW. --

20 A. The commission shall adopt rules stating when a  
21 health facility or health care provider participating in the  
22 health plan shall apply for a health resource certificate, how  
23 the application will be reviewed, how the certificate will be  
24 granted, how an expedited review is conducted and other matters  
25 relating to health resource projects.

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1           B. Except as provided in Subsection F of this  
2 section, a health facility or health care provider participating  
3 in the health plan shall not make or obligate itself to make a  
4 major capital expenditure without first obtaining a health  
5 resource certificate.

6           C. A health facility or health care provider shall  
7 not acquire through rental, lease or comparable arrangement or  
8 through donation all or a part of a capital project that would  
9 have required review if the acquisition had been by purchase  
10 unless the project is granted a health resource certificate.

11           D. A health facility or health care provider shall  
12 not engage in component purchasing in order to avoid the  
13 provisions of this section.

14           E. The commission shall grant a health resource  
15 certificate for a major capital expenditure or a capital project  
16 undertaken pursuant to Subsection C of this section only when  
17 the project is determined to be needed.

18           F. This section does not apply to:  
19               (1) the purchase, construction or renovation of  
20 office space for health care providers;  
21               (2) expenditures incurred solely in preparation  
22 for a capital project, including architectural design, surveys,  
23 plans, working drawings and specifications and other related  
24 activities, but those expenditures shall be included in the cost  
25 of a project for the purpose of determining whether a health

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1 resource certificate is required;

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

6 (4) major capital expenditures for nonclinical  
7 services when the nonclinical services are the primary purpose  
8 of the expenditure; and

9 (5) the replacement of equipment with equipment  
10 that has the same function and that does not result in the  
11 offering of new services.

12 G. No later than January 1, 2008, the commission  
13 shall report to the appropriate committees of the legislature on  
14 the capital needs of health facilities, including facilities of  
15 state and local governments, with a focus on underserved  
16 geographic areas with substantially below-average health  
17 facilities and investment per capita as compared to the state  
18 average. The report shall also describe geographic areas where  
19 the distance to health facilities imposes a barrier to care.  
20 The report shall include a section on health care transportation  
21 needs, including capital, personnel and training needs. The  
22 report shall make recommendations for legislation to amend the  
23 Health Security Act that the commission determines necessary and  
24 appropriate.

25 Section 34. ACTUARIAL REVIEW - AUDITS. --

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1           A. The commission shall provide for an annual  
2 independent actuarial review of the health plan and any funds of  
3 the commission or the plan.

4           B. The commission shall provide by rule requirements  
5 for independent financial audits of health care providers and  
6 health facilities.

7           C. The commission, through its staff or by contract,  
8 shall perform announced and unannounced audits, including  
9 financial, operational, management and electronic data  
10 processing audits of health care providers and health  
11 facilities. Audit findings shall be reported directly to the  
12 commission. The state auditor may be asked by the commission to  
13 review preliminary findings or to consult with audit staff  
14 before the findings are reported to the commission.

15           D. Actuarial reviews, financial audits and internal  
16 audits are public documents after they have been released by the  
17 commission, provided that the reports protect private and  
18 confidential information of a patient or provider. Copies of  
19 reviews, audits and other reports shall be transmitted to the  
20 governor, the legislature and appropriate interim committees of  
21 the legislature as well as made available via the internet.

22           Section 35. STANDARD CLAIM FORMS FOR INSURANCE PAYMENT. --  
23 The commission shall adopt standard claim forms and electronic  
24 formats that shall be used by all health care providers and  
25 health facilities that seek payment through the health plan or

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1 from private persons, including private insurance companies, for  
2 health care services rendered in the state. Each claim form or  
3 electronic format may indicate whether a person is eligible for  
4 federal or other insurance programs for payment. To the extent  
5 practicable, the commission shall require the use of existing,  
6 nationally accepted standardized forms, formats and systems.

7 Section 36. COMPUTERIZED SYSTEM -- The commission shall  
8 require that all participating health care providers and health  
9 facilities participate in the health plan's computer network  
10 that provides for electronic transfer of payments to health care  
11 providers and health facilities; transmittal of reports,  
12 including patient data and other statistical reports; billing  
13 data, with specificity as to procedures or services provided to  
14 individual patients; and any other information required or  
15 requested by the commission. To the extent practicable, the  
16 commission shall require the use of existing, nationally  
17 accepted standardized forms, formats and systems.

18 Section 37. REPORTS REQUIRED-- CONFIDENTIAL INFORMATION. --

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

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1 the Health Security Act.

2 B. The commission shall establish uniform reporting  
3 requirements for health care providers and health facilities.

4 C. Information confidential pursuant to other  
5 provisions of law shall be confidential pursuant to the Health  
6 Security Act. Within the constraints of confidentiality,  
7 reports of the commission are public documents.

8 Section 38. CONSUMER, PROVIDER AND HEALTH FACILITY  
9 ASSISTANCE PROGRAM --

10 A. The commission shall establish a consumer, health  
11 care provider and health facility assistance program to take  
12 complaints and to provide timely and knowledgeable assistance  
13 to:

14 (1) eligible persons and applicants about their  
15 rights and responsibilities and the coverages provided in  
16 accordance with the Health Security Act; and

17 (2) health care providers and health facilities  
18 about the status of claims, payments and other pertinent  
19 information relevant to the claims payment process.

20 B. The commission shall establish a toll-free  
21 telephone line for the consumer, health care provider and health  
22 facility assistance program and shall have persons available  
23 throughout the state to assist beneficiaries, applicants, health  
24 care providers and health facilities in person.

25 Section 39. REIMBURSEMENT FOR OUT-OF-STATE SERVICES--

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1 HEALTH PLAN'S RIGHT TO SUBROGATION AND PAYMENT FROM OTHER  
2 INSURANCE PLANS. --

3 A. A beneficiary may obtain health care services  
4 covered by the health plan out of state; provided, however, that  
5 the services shall be paid at the same rate that would apply if  
6 the services were received in New Mexico. Higher charges for  
7 those services shall not be paid by the health plan unless the  
8 commission negotiates a reciprocity or other agreement with the  
9 other state or with the out-of-state health care provider or  
10 health facility.

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

15 C. When the health plan makes payments on behalf of  
16 a beneficiary, the health plan is subrogated to any right of the  
17 beneficiary against a third party for recovery of amounts paid  
18 by the health plan.

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

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

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

25 (b) a monetary recovery for damages for



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1 bodily injury, whether by judgment, contract for compromise or  
2 settlement;

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

5 (3) shall be effective as to the rights of any  
6 other beneficiaries whose rights can legally be assigned by the  
7 beneficiary.

8 Section 40. PRIVATE HEALTH INSURANCE COVERAGE LIMITED. --

9 A. After the date the health plan is operating, no  
10 person shall provide private health insurance to a beneficiary  
11 for health care that is covered by the health plan except for  
12 retiree health insurance plans that do not enter into contracts  
13 with the health plan. A beneficiary may purchase supplemental  
14 benefits.

15 B. Nothing in this section affects insurance  
16 coverage pursuant to the federal Employee Retirement Income  
17 Security Act of 1974 unless the state obtains a congressional  
18 exemption or a waiver from the federal government. Businesses  
19 that are covered by the provisions of that act may elect to  
20 participate in the health plan.

21 Section 41. HEALTH PLAN FUND CREATED-- FEDERAL HEALTH  
22 INSURANCE PROGRAM WAIVERS-- REIMBURSEMENT TO HEALTH PLAN FROM  
23 FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS. --

24 A. The "health plan fund" is created in the state  
25 treasury. All revenues received pursuant to the Health Security

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1 Act shall be deposited in the fund.

2 B. The commission shall provide for the collection  
3 of premiums from eligible beneficiaries, employers, state and  
4 federal agencies and other entities, which money when combined  
5 with other money appropriated to the fund shall be sufficient to  
6 provide the required health care services and to pay the  
7 expenses of the commission and its administrative functions.  
8 All premiums and other money appropriated to the fund shall be  
9 credited to the fund.

10 C. The fund shall be maintained in actuarially sound  
11 condition as evidenced by the annual written certification of a  
12 qualified independent actuary contracted by the commission.

13 D. The commission shall:

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

22 (2) except for those programs designated in  
23 Subsection B of Section 21 of the Health Security Act, identify  
24 other federal programs that provide federal funds for payment of  
25 health care services to individuals and apply for any waivers or

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

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

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

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

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1           Section 42. VOLUNTARY PURCHASE OF OTHER INSURANCE. --

2 Nothing in the Health Security Act shall be construed to  
3 prohibit the voluntary purchase of insurance coverage for health  
4 care services not covered by the health plan or for individuals  
5 not eligible for coverage under the health plan.

6           Section 43. INSURANCE RATES--SUPERINTENDENT OF INSURANCE  
7 DUTIES. --

8           A. The superintendent of insurance shall work  
9 closely with the legislative finance committee pursuant to  
10 Section 44 of the Health Security Act to identify premium costs  
11 associated with health care coverage in workers' compensation  
12 and automobile medical coverage. The superintendent of  
13 insurance shall develop an estimate of expected reduction in  
14 those costs based upon assumptions of health care services  
15 coverage in the health plan, and shall report the findings to  
16 the legislative finance committee to determine the financing of  
17 the health plan.

18           B. The superintendent of insurance shall lower  
19 workers' compensation and automobile insurance premiums on  
20 insurance policies written in New Mexico that have a medical  
21 payment component on the date the health plan is implemented.

22           Section 44. FINANCING THE HEALTH PLAN. --

23           A. The legislative finance committee shall determine  
24 financing options for the health plan. In making its  
25 determinations the committee shall be guided by the following

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1 requirements and assumptions:

2 (1) health care services to be included and for  
3 which costs are to be projected in determining the financing  
4 options shall be no less than the health care coverage afforded  
5 state employees; and

6 (2) options may set minimum and maximum levels  
7 of a beneficiary's premium payments, sliding scale premium  
8 payments and medicare credits and employer contributions, and an  
9 employer may cover all or part of an employee's premium provided  
10 that a collective bargaining agreement is not violated.

11 B. The legislative finance committee shall prepare a  
12 report of its determinations with the specific options and  
13 recommendations no later than December 15, 2005. The report  
14 shall be submitted for consideration for legislative  
15 implementation to the second session of the forty-seventh  
16 legislature.

17 Section 45. TEMPORARY PROVISION--TRANSITION PERIOD  
18 ARRANGEMENTS--PUBLICLY FUNDED HEALTH CARE SERVICE PLANS.--

19 A. A person who, on the date benefits are available  
20 under the Health Security Act health plan, receives health care  
21 benefits under private contract or collective bargaining  
22 agreement entered into prior to July 1, 2008 shall continue to  
23 receive those benefits until the contract or agreement expires  
24 or unless the contract or agreement is renegotiated to provide  
25 participation in the health plan.

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