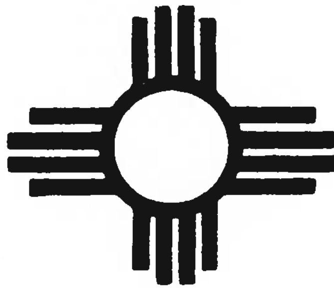

The Legislature

of the

State of New Mexico

49th Legislature, 1st Session

LAWS 2009

CHAPTER 143

HOUSE BILL 710, as amended

Introduced by

REPRESENTATIVE DANICE PICRAUX

REPRESENTATIVES JONI MARIE GUTIERREZ, MIMI STEWART, ANTONIO "MOE" MAESTAS, JAMES ROGER MADALENA, JIM R. TRUJILLO, RAY BEGAYE, BILL B. O'NEILL, ELISEO LEE ALCON, JOHN A. HEATON, MIGUEL P. GARCÍA, RHONDA S. KING, AL PARK, KAREN E. GIANNINI, JACK E. THOMAS, RICK MIERA, SANDRA D. JEFF, RODOLPHO S. MARTINEZ, NATHAN P. COTE, ELEANOR CHÁVEZ, BRIAN F. EGOLF, JR., JEFF STEINBORN AND LUCIANO "LUCKY" VARELA

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

Chapter 143

1 AN ACT

2 RELATING TO HEALTH CARE; DIRECTING THE HUMAN SERVICES
3 DEPARTMENT TO APPLY FOR A WAIVER OR STATE PLAN AMENDMENT TO
4 IMPLEMENT THE MEDICAL HOME PROGRAM; DIRECTING THE
5 SUPERINTENDENT OF INSURANCE TO CONVENE AN INSURANCE TASK FORCE
6 TO EXPLORE INCENTIVES FOR A MEDICAL HOME-BASED MANAGED CARE
7 MODEL.
8
9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:
10 Section 1. A new section of the Public Assistance Act
11 is enacted to read:
12 "MEDICAID, STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND
13 STATE COVERAGE INITIATIVE PROGRAM MEDICAL HOME WAIVER--
14 RULEMAKING--APPLICATION FOR WAIVER OR STATE PLAN AMENDMENT.--
15 A. Subject to the availability of state funds and
16 consistent with the federal Social Security Act, the
17 department shall work with its contractors that administer the
18 state's approved waiver programs to promote and, if
19 practicable, develop a program called the "medical home
20 program". The "medical home" is an integrated care management
21 model that emphasizes primary medical care that is continuous,
22 comprehensive, coordinated, accessible, compassionate and
23 culturally appropriate. Care within the medical home includes
24 primary care, preventive care and care management services and
25 uses quality improvement techniques and information technology

1 for clinical decision support. Components of the medical home
2 model may include:
3 (1) assignment of recipients to a primary
4 care provider, clinic or practice that will serve as a medical
5 home;
6 (2) promotion of the health commons model of
7 service delivery, whereby the medical home tracks recipients'
8 primary care, specialty, behavioral health, dental health and
9 social services needs as much as practicable;
10 (3) health education, health promotion, peer
11 support and other services that may integrate with health care
12 services to promote overall health;
13 (4) health risk or functional needs
14 assessments for recipients;
15 (5) a method for reporting on the
16 effectiveness of the medical home model and its effect upon
17 recipients' utilization of health care services and the
18 associated cost of utilization of those services;
19 (6) mechanisms to reduce inappropriate
20 emergency department utilization by recipients;
21 (7) financial incentives for the provision
22 of after-hours primary care;
23 (8) mechanisms that ensure a robust system
24 of care coordination for assessing, planning, coordinating and
25 monitoring recipients with complex, chronic or high-cost

1 health care or social support needs, including attendant care
2 and other services needed to remain in the community;
3 (9) implementation of a comprehensive,
4 community-based initiative to educate recipients about
5 effective use of the health care delivery system, including
6 the use of community health workers or promotoras;
7 (10) strategies to prevent or delay
8 institutionalization of recipients through the effective
9 utilization of home- and community-based support services;
10 (11) a primary care provider for each
11 recipient, who advocates for and provides ongoing support,
12 oversight and guidance to implement an integrated, coherent,
13 cross-disciplinary plan for ongoing health care developed in
14 partnership with the recipient and including all other health
15 care providers furnishing care to the recipient;
16 (12) implementation of evidence-based
17 medicine and clinical decision support tools to guide
18 decision-making at the point-of-care based upon recipient-
19 specific factors;
20 (13) use of comparative effectiveness to
21 make a cost-benefit analysis of health care practices;
22 (14) use of health information technology,
23 including remote supervision, recipient monitoring and
24 recipient registries, to monitor and track the health status
25 of recipients;

1 (15) development and use of safe and secure
2 health information technology to promote convenient recipient
3 access to personal health information, health services and web
4 sites with tools for patient self-management;
5 (16) implementation of training programs for
6 personnel involved in the coordination of care for recipients;
7 (17) implementation of equitable financial
8 incentive and compensation systems for primary care providers
9 and other staff engaged in care management and the medical
10 home model; and
11 (18) any other components that the secretary
12 determines will improve a recipient's health outcome and that
13 are cost-effective.
14 B. For the purposes of this section, "primary care
15 provider" means a medical doctor or physician assistant
16 licensed under the Medical Practice Act to practice medicine
17 in New Mexico or a certified nurse practitioner as defined in
18 the Nursing Practice Act who provides first contact and
19 continuous care for individuals under the physician's care and
20 who has the staff and resources to manage the comprehensive
21 and coordinated health care of each individual under the
22 primary care provider's care."
23
24
25

BEN LUJAN, SPEAKER
HOUSE OF REPRESENTATIVES

STEPHEN R. ARIAS, CHIEF CLERK
HOUSE OF REPRESENTATIVES

DIANE D. DENISH, PRESIDENT
SENATE

LENORE M. NARANJO, CHIEF CLERK
SENATE

Approved by me this 7th day of April, 2009

BILL RICHARDSON, GOVERNOR
STATE OF NEW MEXICO