This is an amendment to 13.10.31 NMAC, Section 12, effective 01/01/2023.

13.10.31.12 [~~RESERVED~~] EVALUATION OF PRIOR AUTHORIZATION POLICY AND PROVIDER PERFORMANCE:

A. Applicability. This section of the rule shall only apply to fully-insured commercial coverages regulated by the superintendent.

B. Review of covered benefits that require prior authorizations. Annually, beginning in 2023, a carrier shall review its prior authorization requirements for all covered benefits, except for inpatient admissions to acute-care hospitals, including transfers, in order to assess the continued utility of each requirement.

(1) At a minimum, a carrier's assessment shall consider the following elements:

(a) the approval rate for each covered benefit for which a prior authorization was required;

(b) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit protects patient safety or generates better health outcomes, or both;

(c) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit prevents the need for higher cost services;

(d) whether based on demonstrable evidence, including claims and clinical data, the prior authorization requirement of each covered benefit has deterred any reasonable suspicion of insurance fraud, waste, or abuse;

(e) whether, based on demonstrable evidence, including claims, clinical and operational data, and considering both the providers' and the carrier's experience, the costs and other administrative burdens associated with the prior authorization requirement for a covered benefit outweigh the demonstrated benefits of the requirement; and

(f) whether the prior authorization requirement for a covered benefit, based on demonstrable evidence including provider and member grievances, appeals and complaints, and claims and clinical data, contributed to unreasonable or unnecessary delays in treatment or adverse health outcomes for a covered person.

(2) A carrier shall conduct and complete the review by the end of the second quarter of each calendar year, beginning in 2023, and shall evaluate the prior authorizations issued during the prior calendar year.

(3) A carrier shall identify those covered benefits, with the exception of inpatient admissions to acute care hospitals, for which ninety percent of the prior authorization requests for that benefit are approved.

(4) A carrier shall prepare a report of its annual assessment that, at a minimum, contains its findings based on the elements listed above, and identifies any change in prior authorization requirements.

(a) The report shall be submitted to the superintendent no later than October 31, 2023 and no later than September 30th of every year thereafter, beginning in 2024.

(b) The report shall be submitted in the form and manner proscribed by annual guidance issued pursuant to Subsection G of this Section.

(5) A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation during its second full calendar year in the market.

(6) If no protection of patient safety or no better health outcomes related to prior authorization of a covered benefit can be shown by the carrier, the prior authorization requirement must be eliminated for 12 months or until the carrier is able to demonstrate additional evidence to support its position.

C. Assessment of prior authorization request outcomes. Beginning in the first quarter of 2023, a carrier shall annually evaluate its network providers' patterns of adherence to the carrier's prior authorization criteria and policies in the preceding calendar year. For the first year, prior authorization requests for admissions to general acute care hospitals, psychiatric hospitals, and rehabilitation hospitals, and durable medical equipment, including oxygen and disposable medical supplies, shall be excluded from this evaluation. The superintendent may include these services in subsequent years pursuant to the annual guidance issued in accordance with Subsection G of this Section.

(1) A carrier shall identify providers who are the most frequent submitters of prior authorizations, and who have a consistent pattern of adherence to prior authorization requirements and criteria as evidenced by prior authorization approval rates of ninety percent or greater (a "high compliance provider").

(2) A carrier shall select no less than thirty percent of its high compliance providers and shall:

(a) enter into an agreement with each selected high-compliance provider on an alternative to the standard requirement to submit a prior authorization request for a discreet service or set of services that otherwise require one (an alternate arrangement); and

(b) the agreement with each provider shall clearly describe the terms of the alternate arrangement, including under what conditions the agreement can be terminated by a carrier or a provider. The agreement shall include how the provider's ordering and prescribing performance during the course of the alternative arrangement will be monitored and evaluated, how results will be communicated, and how the agreement can be extended beyond the base period of the agreement. At a minimum, the agreement will be effective for 12 months.

(3) The high compliance providers selected for alternate arrangements shall be representative of the various eligible types of providers, including specialists, that participate in a carrier's network, and the spectrum of covered benefits.

(4) The first year's alternative arrangements shall go into effect on January 1, 2024, and all subsequent years' agreements shall go into effect on the first day of the year.

(5) After the first year, a carrier shall increase the number of high compliance providers with which it enters into alternate arrangements by at least fifty percent of providers who had alternative arrangements in the first year. If a carrier is not able to increase the number of providers with alternate arrangements by at least fifty percent compared to the prior year, the carrier shall request an exception according to guidance issued by the superintendent. The exception request will be subject to the approval of the superintendent.

(6) After the second year, a carrier shall comply with specific performance requirements identified in guidance issued pursuant to Subsection G of this Section.

(7) A carrier may elect to remove a prior authorization requirement at any time, in accordance with Paragraph (3) of Subsection C of Section 13.10.31.8 NMAC above.

D. Annual Report. A carrier shall, by September 30th of each year, submit a report to the superintendent that:

(1) describes the evaluation process and criteria used to identify high compliance providers;

(2) lists the providers identified, the providers with whom an alternate arrangement was made, and the providers with whom negotiations are ongoing; and

(3) describes, in general, the terms of the alternate arrangements entered into, including the effective dates of the agreement, the services involved, performance evaluation, and communication provisions; and

(4) describes experiences making these alternate arrangements, the results of the alternate arrangements when known, lessons learned, and recommendations to the superintendent.

E. New carriers. A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation in its second full calendar year in the market unless the carrier has not met a threshold enrollment of more than 500 members in which case the carrier shall file the first year after it meets that enrollment threshold

F. Data confidentiality and use. Information reported to the superintendent concerning a specific, identifiable, provider shall be deemed confidential pursuant to Subsection B of Section 59A-2-12 NMSA 1978. The superintendent may publish and use any other reported information for any regulatory purpose, including development and promulgation of rules to specify minimum prior authorization incentive and corrective action programs.

G. Guidance. The superintendent shall annually publish guidance for carriers for the upcoming plan year. This guidance shall include, at minimum, procedural reporting requirements, and any specific performance requirements.

[13.10.31.12 NMAC - N, 01/01/2022; A, 01/01/2023]