

TITLE 7 HEALTH
CHAPTER 1 HEALTH GENERAL PROVISIONS
PART 31 STATEWIDE HEALTH CARE CLAIMS DATABASE

7.1.31.1 ISSUING AGENCY: New Mexico Department of Health.
[7.1.31.1 NMAC - N, 04/20/2021]

7.1.31.2 SCOPE: These regulations govern the creation and maintenance of a repository of healthcare claims data to be used to increase the quality and effectiveness of health care delivered in New Mexico.
[7.1.31.12 NMAC - N, 04/20/2021]

7.1.31.3 STATUTORY AUTHORITY: The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Subsection E of Section 9-7-6, NMSA 1978, and the Health Information System Act, 24-14A-1 et seq. NMSA 1978.
[7.1.31.3 NMAC - N, 04/20/2021]

7.1.31.4 DURATION: Permanent.
[7.1.31.4 NMAC - N, 04/20/2021]

7.1.31.5 EFFECTIVE DATE: April 20, 2021, unless a later date is cited at the end of a section.
[7.1.31.5 NMAC - N, 04/20/2021]

7.1.31.6 OBJECTIVE: The objective of this rule is to establish provisions that govern the creation, maintenance, and usage of a repository of healthcare claims data for the purpose of improving health care cost and quality.
[7.1.31.6 NMAC - N, 04/20/2021]

7.1.31.7 DEFINITIONS:

A. “Allowed amount” means the negotiated amount eligible for payment for a health care service or item rendered by a provider.

B. “Billed amount” means the amount billed by a provider requesting payment for health care services or items rendered.

C. “Claim” means a financial accounting of or a request for payment for health care items or services rendered by a provider.

D. “Data” means the data required by this rule to be submitted to this database, including data on the following health factors: mortality and natality, including accidental causes of death; morbidity; health behavior; disability; health system costs, availability, utilization and revenues; environmental factors; health personnel; demographic factors; social, cultural and economic conditions affecting health, including language preference; family status; medical and practice outcomes as measured by nationally accepted standards and quality of care; and participation in clinical research trials.

E. “Data provider” means a person that possesses health information, including any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third-party payer and any public entity that has health information.

F. “Database” means the statewide all-payer health care claims database established in this rule.

G. “Department” means the department of health.

H. “Direct patient identifier” means a data variable that identifies an individual, including: names; telephone numbers; fax numbers; social security number; medical record numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; web universal resource locators; internet protocol address numbers; biometric identifiers, including finger and voice prints; elements of dates more granular than a year; un-aggregated ages over 89; geographic subdivisions smaller than the state, except the first three digits of ZIP, full face photographic images and any comparable images; and any other unique identifying number, characteristic, or code, except as permitted by 45 C.F.R 164.514 (c).

I. “ERISA plan” means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents under the Employee Retirement Income Security Act of 1974 directly

or through insurance, reimbursement or other means.

J. “Health information” or “health data” means any data relating to health care; health status, including environmental, social and economic factors; a health system or provider; health costs, financing, and including data that would customarily be collected in the ordinary course of business for the data provider; annual audited financial statements customarily prepared by a data provider; information on major capital expenditures; data established by regulation to be collected to carry out the requirements of the Health Information System Act; data required to be collected by other state or federal laws; and annual surveys or collection of data may be used as an alternative to collection of health data from some health service providers to the extent it can be shown that the information collected will meet validity and quality standards.

K. “Health information system” or “HIS” means the health information system established by the Health Information System Act, Sections 24-14A-1 to 24-14A-10, NMSA 1978.

L. “Health insurance carrier” means any entity that offers the following:

- (1) group health and dental coverage governed by the provisions of the Health Care Purchasing Act;
- (2) individual health and dental insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;
- (3) health and dental multiple-employer welfare arrangements governed by the provisions of Section 59A-15-20 NMSA 1978;
- (4) group and blanket health and dental insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;
- (5) individual and group health and dental health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law Chapter 59A, Article 46 NMSA 1978; and
- (6) individual and group health and dental nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law Chapter 59A, Article 47 NMSA 1978.

M. “Indirect patient identifier” means a data variable that may identify an individual when combined with other information.

N. “Proprietary financial information” means information that derives independent economic value, actual or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

O. “Secretary” means the secretary of the New Mexico department of health.

P. “Unique identifier” means an obfuscated identifier assigned to an individual represented in the database to establish a basis for following the individual longitudinally throughout different payers and encounters in the data without revealing the individual’s identity.

[7.1.31.7 NMAC - N, 04/20/2021]

7.1.31.8 STATEWIDE ALL-PAYER CLAIMS DATABASE–DUTIES-CONTRACT WITH DATA VENDOR:

A. Duties of the department:

(1) The department shall establish a statewide all-payer claims database to support transparent public reporting of health care information. The database must improve transparency to: assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices, enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost. The database must systematically collect all medical claims for covered medical services, pharmacy claims, dental claims, member eligibility and enrollment data, and provider data with necessary identifiers from private and public payers, with data from all settings of care that permit the systematic analysis of health care delivery.

(2) The department shall convene subcommittees to the HIS advisory committee with the approval of the secretary, including:

- (a) a subcommittee on data policy development;
- (b) a subcommittee to establish a data release process consistent with the requirements of this rule and to provide advice regarding formal data release requests. The advisory subcommittees must include in-state representation from key providers, hospitals, public health and health maintenance organizations, large and small private purchasers, consumer organizations, and the two largest carriers supplying claims data to the database; and

- (c) other subcommittees as needed.

B. Duties of the department in contract with data vendor:

- (1) The department will conduct, or may engage a data vendor to perform, data collection, processing, aggregation, extracts, and analytics. The department or data vendor must:
 - (a) establish a secure data submission process with data providers;
 - (b) review data submitters' files per standards established by the department;
 - (c) assess each record's alignment with established format, frequency, and consistency criteria;
 - (d) maintain responsibility for quality assurance, including, but not limited to:
 - (i) the completeness, accuracy and validity of data provider's data;
 - (ii) accuracy of dates of service spans;
 - (iii) maintaining consistency of record layout and counts; and
 - (iv) identifying duplicate records;
 - (e) assign unique identifiers, as defined in this rule, to individuals represented in the database;
 - (f) ensure that direct patient identifiers, indirect patient identifiers, and proprietary information are released only in compliance with federal and state privacy laws and the terms of applicable confidentiality requirements;
 - (g) demonstrate internal controls and affiliations with separate organizations as appropriate to ensure safe data collection, security of the data with state of the art encryption methods, actuarial support, and data review for quality assurance;
 - (h) store data in a manner compliant with the federal Health Insurance Portability and Accountability Act and regulations, with access to the data strictly controlled and limited to staff with appropriate training, clearance, and background checks; and
 - (i) maintain state of the art security standards for transferring data to approved data requestors.
- (2) The data vendor must submit detailed descriptions to the department's chief information security officer to ensure robust security methods are in place.
- (3) The department is responsible for internal governance, management, funding, and operations of the database. The department shall work with the data vendor to:
 - (a) collect claims data from data providers as provided in this rule;
 - (b) design data collection mechanisms with consideration for the time and cost incurred by data providers and others in submission and collection and the benefits that measurement would achieve, ensuring the data submitted meet quality standards and are reviewed for quality assurance;
 - (c) ensure protection of collected data and store and use of data in a manner that protects patient privacy and complies with this section. All patient-specific information must be secured with required standard encryption algorithms;
 - (d) consistent with requirements of this rule, make information from the database available as a resource for public and private entities, including carriers, employers, providers, hospitals, and purchasers of health care;
 - (e) report performance on cost and quality pursuant to this rule.
 - (f) develop protocols and policies, including prerelease review by any entity identified by the department, to ensure the quality of data releases and reports;
 - (g) the department may not charge providers or data providers fees other than fees directly related to requested reports.

[7.1.31.8 NMAC - N, 04/20/2021]

7.1.31.9 SUBMISSION OF CLAIMS DATA TO DATABASE:

A. All-payer claims database data providers:

- (1) Data providers must submit all available data and health information with necessary identifiers to the database as described in the APCD-Common Data Layout (APCD-CDL™, Version 2.1 with errata, Copyright 2018-2020 by APCD Council, National Association of Health Data Organizations, the University of New Hampshire) within the time frames in this rule and in accordance with procedures established herein.
- (2) Any data provider used by an entity that participates in the database such as a third-party administrator or pharmacy benefit manager must provide claims data to the department or the data vendor upon request of the entity.

(3) The following plans or entities may voluntarily provide claims data to the database within the time frames and in accordance with procedures established by the department:

(a) Employer sponsored plans subject to the Employee Retirement Income Security Act of 1974; and

(b) any governmental or tribal program or facility that provides health care services to American Indians and Alaska Natives.

(4) Health insurance carriers that only offer the following excepted benefit coverages are not required to report:

(a) specific disease;

(b) accident or injury;

(c) hospital indemnity and other fixed indemnity;

(d) disability;

(e) long-term care; and

(f) vision coverage.

(5) Medicaid managed care organizations provide claims data to the New Mexico human services division (HSD), and who will then submit that data to the department of health.

(6) Health insurance carriers covering less than 500 individuals are not required to submit files to the database but are required to report the number of individuals with coverage during the previous year on March 1st.

B. Data submission procedures:

(1) The department shall:

(a) utilize an internet-based user interface (or similar technology) that allows for secure submission and acceptance of data submissions;

(b) perform quality assurance and validation of all submitted data and provide feedback to the data providers; and

(c) provide data submissions procedures to data providers in a data submission guide that is based on a current version of the APCD-Common Data Layout.

(2) Data submission frequency: data shall be submitted at least monthly.

(3) Data providers shall make every effort to initially submit complete, accurate, and valid data in the APCD-Common Data Layout and shall correct all identified errors within the timelines established by the department or its designee.

(4) An initial test submission of data may be required.

(5) Data dating to January 1, 2020 must be submitted initially.

(6) The department may sanction data providers who do not comply with this rule.

(7) Data shall be submitted beginning January 1, 2023.

[7.1.31.9 NMAC - N, 04/20/2021; A, 4/25/2023]

7.1.31.10 CLAIMS DATA AND DATABASE - EXEMPTIONS FROM PUBLIC DISCLOSURE:

A. Public record:

(1) The claims data provided to the database, the database itself, including the data compilation, and any raw data received from the database are not public records and are generally exempt from public disclosure in accordance with the Inspection of Public Records Act, Subsections A and H of Section 14-3-1, NMSA 1978, the Health and Hospital Records Act, 14-6-1, NMSA 1978, and the Health Information Systems Act, Sections 24-14A-6 & 8, NMSA 1978.

(2) Claims data obtained, distributed, or reported in the course of activities undertaken pursuant to or supported under this rule are strictly confidential and shall not be a matter of public record or accessible to the public. The department shall not disclose data except to the extent that they are included in a compilation of aggregate data. Any forms of data collected by and furnished for the department shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. The department may release or disseminate aggregate data, which shall be public records if the release of these data does not violate state or federal law relating to the privacy and confidentiality of individually identifiable health information. In accordance with Paragraph (6) of Subsection D of Section 24-14A-3 NMSA 1978, Section 24-14A-4.3 NMSA 1978, and Subsection D of Section 24-14A-6, NMSA 1978 of the HIS Act, data may be reported routinely to authorized federal, state, and local public agencies.

[7.1.31.10 NMAC - N, 04/20/2021]

7.1.31.11 GENERAL PROVISIONS ON ACCESS TO THE CLAIMS DATABASE DATA:

A. Access requirements: Data and reports based on the claims database may be obtained only in accordance with the requirements of the HIS Act and this rule. Any request for information that would not be contained in previously prepared and published reports will require a data request from the department.

B. Evaluation of requests: In addition to other requirements stated in this rule, all requests for claims data and reports, other than routine reports, shall be evaluated by the department and shall not be released unless the requests satisfy the following criteria for approval.

(1) The specific intended use of the data shall comport with the purposes of the HIS Act, as stated in 24-14A-3A, NMSA 1978 and rules promulgated pursuant to the HIS Act, including use of data to assist in:

(a) the performance of health planning, policy making functions, and research conducted for the benefit of the public;

(b) informed health care decision making by consumers;

(c) surveillance for the control of disease and conditions of public health significance as required by Public Health Act, Subsection C of 24-1-3 NMSA 1978, and

(d) administration, monitoring, and evaluation of a statewide health plan.

(2) The request shall be consistent with the responsibilities of the department in accomplishing the priorities of the HIS.

C. Request procedures: All requests for data shall be made to the department.

D. Fees: Fees for access to data and reports shall be paid pursuant to the requirements of this rule.

E. Time period to fulfill request: The department will endeavor to fulfill requests within one month of receiving the request, although the time period for fulfillment of a request may vary depending on the complexity of the request and other factors.

F. Restrictions on access to confidential sensitive data: The department shall deny access to information from the claims database where the use or disclosure of the information could result in a violation of health information confidentiality or purposes for which the department has determined is not consistent with the purposes or intent of the act.

G. Compliance with other laws: The department shall ensure that any access to data that is subject to restrictions on use pursuant to state, federal, or tribal law or regulation, or any other legal agreement, complies with those restrictions.

H. Disclaimer: The department shall include a disclaimer in all claims data and reports released pursuant to this rule stating that the accuracy of the original data is the responsibility of the submitting data provider and that the department assumes no responsibility for any use made of or conclusions drawn from the data.

I. Agency contractors:

(1) A state or federal agency that receives claims data or reports under an agreement with the department pursuant to this rule shall be solely responsible for fulfillment of the agreement, including responsibility for the actions of any subcontractor engaged to perform services that require access to claims data or reports.

(2) A state or federal agency subcontractor that is provided access to claims data or reports shall be subject to the full provisions of the HIS Act and this rule.

J. Proprietary and confidential information:

(1) Proprietary information and protected health information shall not be disclosed in or as part of a public health information report by the department.

(2) A data provider that objects to the potential release of its reported data or information derived from its reported data shall submit to the department a written request to exempt its data from such disclosures. By the end of each fiscal year (June 30th), data providers must notify the department in writing regarding data items that they deem proprietary. Application for an exemption must be addressed by a representative of the data provider to the department.

[7.1.31.11 NMAC - N, 04/20/2021]

7.1.31.12 ACCESS TO HEALTH CARE DATA REPORTS:

A. Access to routine and published reports: The department shall release reports to the public on a periodic schedule as determined by the department and in accordance with the HIS Act.

B. Access to aggregate data and reports for individuals: Pursuant to the requirements of the NM Inspection of Public Records Act (IPRA), any person may obtain access to existing aggregate data or reports based on the subset or portion of the claims database that is relevant to the individual's stated purpose. Any access to aggregate data or reports that have not yet been generated is subject to approval by the department pursuant to the requirements of this rule.

C. Access to data and reports for state agencies: The department shall establish policies and procedures for access to data and reports by state agencies.
[7.1.31.12 NMAC - N, 04/20/2021]

7.1.31.13 FEES FOR DATA AND REPORTS:

A. Fees for routine reports:

(1) **Generally:** The fees for copies of available reports produced for public use shall be as follows:

(a) single copies of any claims data reports or annual reports shall be provided free of charge upon request; and

(b) all other reports shall be provided for a fee of no more than \$1.00 per page.

(2) **Data providers:** Data providers may receive one free copy of the department's routine reports upon request.

B. Previously-prepared reports: The fee for copies of available previously-prepared, non-routine reports provided to persons other than the original requestor for whom the report was prepared shall be \$20.00 per report.

C. Fees for data and non-routine reports: The fee for preparing data and non-routine reports that have not been previously prepared shall be charged at the hourly rate of the analyst(s) preparing the data or report, as follows:

- (1) data providers shall be charged a rate of \$50.00 per analyst hour;
- (2) state agencies shall be charged a rate of \$75.00 per analyst hour; and
- (3) all others shall be charged a rate of \$100.00 per analyst hour.

D. Electronic media reports: Fees for reports made available on electronic media may include charges for the cost of the magnetic tape, diskette, CD-ROM, or other electronic media, in addition to the fees required by this section.

E. Waiver or reduction of fees:

(1) **Standard for waiver or reduction:** The department may reduce or waive the fee for routine reports, data, and non-routine reports when the department determines that the requestor's proposed use of the information would be of value to the department in fulfilling its statutory mandates to a degree equal to or greater than the fee reduction or waiver.

(2) **Payment upon failure to perform:** When a fee waiver or reduction has been granted, and the research for which the fee was waived or reduced is not completed or the product for which the fee was waived or reduced is not delivered to the department, the full fee shall be assessed in accordance with this rule.

F. Statement of fees: The department shall prepare a statement of the fee for requests made pursuant to this rule and provide it to the requestor prior to tender of the requested data or report. Payment is required in advance of the requestor receiving the data or report.

[7.1.31.13 NMAC - N, 04/20/2021]

HISTORY OF 7.1.31 NMAC: [RESERVED]