This rule was filed as 7 NMAC 1.21.

TITLE 7 HEALTH
CHAPTER 1 HEALTH GENERAL PROVISIONS
PART 21 DATA REPORTING REQUIREMENTS FOR HEALTH PLANS

7.1.21.1 ISSUING AGENCY: New Mexico Health Policy Commission.
[8-30-97; Recompiled 10/31/01]

7.1.21.2 SCOPE: This rule applies to all reporting health plans in New Mexico.
[8-30-97; Recompiled 10/31/01]

7.1.21.3 STATUTORY AUTHORITY: This rule is promulgated pursuant to Sections 24-14A-3D(5) and (6); 24-14A-5A through C; 24-14A-8A and B; and 24-14A-9 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.
[8-30-97; Recompiled 10/31/01]

7.1.21.4 DURATION: Permanent.
[8-30-97; Recompiled 10/31/01]

7.1.21.5 EFFECTIVE DATE: August 30, 1997, unless a later date is cited at the end of a section or paragraph.
[8-30-97; Recompiled 10/31/01]
[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.1.21.6 OBJECTIVE: The purpose of this rule is to specify the data reporting requirements for health plans pursuant to the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.
[8-30-97; Recompiled 10/31/01]

7.1.21.7 DEFINITIONS: In addition to the definitions in the health information system Act, Section 24-14A-1 et seq. NMSA 1978, the following definitions apply for purposes of this rule:

A. **Consumer health information report** means a report that provides the public with information on which to base health care purchasing decisions, published by the commission pursuant to Sections 24-14A-3D(11) and 24-14A-3.1D(2) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and 7 NMAC 1.22 [now 7.1.22 NMAC].

B. **Director** means the director of the commission

C. **Health care** means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

D. **Health care professional** means any individual licensed, certified or otherwise authorized or permitted by law to provide health care in the practice of a profession.

E. **Health care provider** means any individual, corporation, partnership, organization, facility, institution or other entity licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

F. **Health information system** or **HIS** means the health information system established by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

G. **Health plan report** means the document or electronic submission required by this rule to be submitted annually to the commission, containing the HEDIS® reporting set and additional core performance measures required by the commission. ®NCQA registered trademark.

H. **Health plan reporting period** means the calendar year in which a reporting health plan delivers the services included in the health plan report. To illustrate, the 1996 reporting period is for services delivered in 1996.

I. **HEDIS** means the Health Plan Employer Data and Information set published by the national committee for quality assurance (NCQA).

J. **HEDIS data elements** means the rate, numerator, denominator, size of the eligible population and data collection methodology for non-tabular measures that are reported as percentages and are contained in HEDIS.

K. **HEDIS reporting set** means the full set of measures designated by the national committee for Quality Assurance as reporting measures in the current version of HEDIS.

L. **HEDIS reporting version** means the version of HEDIS published by the national committee for quality assurance applicable to the same reporting period designated by the national committee for quality assurance as the health plan reporting period defined in this rule.

M. **HEDIS specifications** means the specifications contained in the latest version or technical update of HEDIS applicable to the health plan reporting period, which may include separate reports for service populations and product types, such as health maintenance organization products, point of service products, preferred provider organization products, medicare risk products, and medicaid managed care products.

N. **HIS advisory committee** means the committee the commission establishes pursuant to Section 24-14A-3.1 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

O. **Managed health care plan** means a health benefit plan offered by a health care insurer that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in such plans through its own employed health care professionals or by contracting with selected or participating health care providers that conform to explicit selection standards, or both, and which either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, employed by, or under contract with the managed health care plan or health care insurer.

P. **Outcome measures** means changes in patient health status and satisfaction resulting from specific medical and health interventions, as distinguished from the effects of other factors that influence patient health and satisfaction.

Q. **Patient** means a person for whom health information is contained in the health information system.

R. **Performance measures** include, but are not limited to, quality indicators, outcome measures and health care service information.

S. **Proprietary information** means confidential technical information, administrative information, and/or business methods that are the property of the reporting health plan and are perceived to confer a competitive position in the health care market by not being openly known by competitors.

T. **Quality compass[SM]** means a national database maintained and disseminated by the NCQA which includes plan-specific comparative and descriptive information on managed health care plan performance.

U. **Quality indicator** means a standardized and nationally or professionally recognized measure of a discrete element or aspect of health care useful for the purpose of monitoring quality of care.

V. **Quality of care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes or are consistent with current professional knowledge. The provision of health services should reflect appropriate use of the most current knowledge about scientific, clinical, technical, interpersonal, manual, cognitive, and organizational and management elements of health care.

W. **Reporting health plan** means a health care insurer that:

(1) is required to obtain a certificate of authority or licensure in New Mexico;

(2) has a total premium volume in excess of $5,000,000 in the year prior to the health plan reporting period; and

(3) offered one or more managed health care plans in New Mexico during the health plan reporting period.

X. **Total premium volume** means the annual premium volume in dollars reported by a health care insurer in its annual statement to the superintendent of insurance.

[8-30-97; Recompiled 10/31/01]

7.1.21.8 HEALTH PLAN REPORT:

A. **Components of report:** The health plan report required by this rule shall consist of the following components:

(1) the HEDIS reporting set; and

(2) an additional core set of performance measures specific to the needs of New Mexico consumers, as required by the commission.

B. **Additional core set:**

(1) **Recommendations:** The HIS advisory committee shall adopt a process for determining which performance measures, in addition to those in the HEDIS reporting set, should be included in a core set of performance measures to be regularly reported to the commission and provided to consumers as consumer health information. The HIS advisory committee shall evaluate and recommend to the commission the adoption of additional performance measures that are in accordance with the criteria in 7 NMAC 1.22.9.2 [now Subsection B of 7.1.22.9 NMAC] and relevant to the health status and needs of New Mexico health care consumers.

(2) **Adoption:** Upon recommendation of the HIS advisory committee, the commission may require reporting health plans to report a core set of performance measures in addition to those in HEDIS, provided that these measures shall be in accordance with the criteria in 7 NMAC 1.22.9.2 [now Subsection B of 7.1.22.9 NMAC] and relevant to the health status and needs of New Mexico health care consumers.

(3) **Periodic review:** The HIS advisory committee periodically shall review and recommend to the commission changes in the additional core set of performance measures, as appropriate. The HIS advisory committee and the commission shall endeavor to maintain the consistency of the additional core set over time for longitudinal comparison purposes.

C. **Notification of required data:**

(1) **HEDIS reporting set:** The HEDIS reporting version for the health plan reporting period shall serve as notice of the data that shall be provided to the commission in the HEDIS reporting set.

(2) **Additional core set:** The commission shall notify reporting health plans by August 1 of the year preceding the health plan reporting period of any additional performance measures that shall be reported in the health plan report. For performance measures that are complex or time-consuming to collect, the commission shall provide as much additional advance notice of the reporting requirement as reasonably necessary to afford reporting health plans sufficient time to comply while meeting the needs of New Mexico consumers for comparative health care data.

[8-30-97; Recompiled 10/31/01]

7.1.21.9 REPORTING REQUIREMENTS:

A. **Mandatory reporting:** Reporting health plans shall submit to the commission a health plan report as follows:

(1) For the 1996 health plan reporting period, the health plan report shall be submitted by October 1, 1997 and shall consist of the HEDIS reporting set only.

(2) For all subsequent health plan reporting periods, the health plan report shall be submitted by August 1 of the year following the health plan reporting period. To illustrate, for the 1997 health plan reporting period the health plan report shall be submitted by August 1, 1998.

B. **HEDIS data elements:** Reporting health plans shall provide to the commission in the health plan report the HEDIS data elements for each reporting measure, to be used by the commission for data quality verification or policy and planning purposes as defined in Section 24-14A-3 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978. The commission recommends that reporting health plans capture the data elements identified by NCQA in their HEDIS specifications.

C. **Required specifications:** In submitting the HEDIS reporting set component of the health plan report, reporting health plans shall use the complete HEDIS specifications, templates, electronic data submission formats and any other documents provided by the commission or made directly available to the plans by the NCQA, all of which shall be consistent with those published by the NCQA.

D. **Submission to NCQA's quality compass:** Reporting health plans that submit a HEDIS report to the quality compass program maintained by the NCQA may submit to the commission electronically or on electronic media a copy of that report. This submission shall meet the HEDIS reporting set requirements of this rule if the HEDIS report submitted to quality compass[SM] is specific to New Mexico.

[8-30-97; Recompiled 10/31/01]

7.1.21.10 ELECTRONIC REPORTING REQUIREMENTS: All reporting health plans shall submit the health plan report by electronic media (includes computer tape, cartridge or diskette) or by direct electronic transmission, beginning no later than the health plan report submitted in 1999 for the 1998 health plan reporting period.

[8-30-97; Recompiled 10/31/01]

7.1.21.11 MODIFICATION OR EXEMPTION FROM REPORTING COMPLIANCE: A reporting health plan may submit to the director a written request for modification or exemption from compliance with the reporting requirements of this rule. The director may grant the request if the reporting health plan makes a reasonable showing that compliance would require unreasonable costs, would be unduly burdensome given the particular circumstances of the reporting health plan, is not feasible due to no fault of the reporting health plan, or would constitute disclosure of proprietary information. The reporting health plan may appeal the director's decision to the commission, which shall make a final determination on the request.
[8-30-97; Recompiled 10/31/01]

7.1.21.12 PUBLIC RELEASE OF HEDIS DATA ELEMENTS: A reporting health plan that objects on proprietary grounds to the potential release of its reported HEDIS data elements pursuant to 7 NMAC 1.20.10.2 [now Subsection B of 7.1.20.10 NMAC] shall submit to the director a written request for confidentiality. This request shall explicitly and specifically identify the HEDIS® data elements considered to be proprietary and provide a justification for this position. The director may consult with the HIS advisory committee in determining the merits of the request and shall provide a written decision to the reporting health plan. A reporting health plan may appeal the director's denial of the request to the commission. The commission shall make a final determination on the request. ®NCQA registered trademark.
[8-30-97; Recompiled 10/31/01]

7.1.21.13 PENALTIES FOR RULE VIOLATION: In addition to the penalties provided in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, for violation of the data reporting requirements of the Act and its rules, the commission may impose any or all of the following sanctions for violation of this rule:

A. a statement in a relevant consumer health information report indicating the failure of the reporting health plan to comply with the requirements of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and this rule; and

B. temporary or permanent denial of access to health information system data or reports.

[8-30-97; Recompiled 10/31/01]

HISTORY OF 7.1.21 NMAC: [RESERVED]