This rule was filed as 7 NMAC 1.22.

TITLE 7 HEALTH
CHAPTER 1 HEALTH GENERAL PROVISIONS
PART 22 CONSUMER HEALTH INFORMATION REPORTS

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

7.1.22.2 SCOPE: This rule applies to consumer health information reports issued by the commission.
[8/30/97; Recompiled 10/31/01]

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

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

7.1.22.5 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[Compiler's note: The words *or paragraph*, above, are no longer applicable.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.]

7.1.22.6 OBJECTIVE: The purpose of this rule is to effectuate 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, by specifying the process for issuance of consumer health information reports.
[8/30/97; Recompiled 10/31/01]

7.1.22.7 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. "Administrative database" means any automated data supplied by the data provider, its contracted providers and vendors or public agencies.

B. "Consumer health information report" means a report that provides the public 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.

C. "Data provider" means a data source that has provided data to the Health Information System on a regular basis.

D. "Data source" has the meaning given in Section 24-14A-2 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and includes those categories of persons or entities that possess health information, including any public or private sector licensed hospital, health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, pharmacy, third-party payer and any public entity that has health information.

E. "Director" means the director of the commission.

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

G. "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.

H. "Health care survey" means a survey of health care consumers or health care providers or any other type of subjective assessment of health care.

I. "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.

J. "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.

K. "Medical record" means the paper or electronic record of patient visits, treatments and test results assembled by the collective accumulation of notes kept by all health care providers who treat the patient.

L. "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.

M. "Patient" means a person for whom health information is contained in the health information system.

N. "Patient confidential information" means the medical record and claims history of an individual patient.

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

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

Q. "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.

R. "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.

S. "Reporting year" means the calendar year in which the health care services that are the subject of a consumer health information report were delivered.

T. "Risk adjustment" means a method of analyzing patient-level data that accounts for patient risk factors, such as age, sex, severity of illness and presence of multiple diseases, that could affect patient outcomes or resource use. Risk adjustment is intended to provide more accurate comparisons among health care providers than would exist without risk adjustment.

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

7.1.22.8 GENERAL PROVISIONS:

A. Issuance of reports: The commission annually shall issue, pursuant to the requirements of this rule, one or more consumer health information reports designed to assist health care consumers in comparatively evaluating the quality of care and performance of health care providers and organizations in New Mexico. Consumer health information reports may include information reported from any data provider where release of the information in a consumer health information report would effectuate the purposes of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and be in compliance with this rule. Consumer health information reports shall be issued by December 31 of the year following the reporting year.

B. Contents of reports: Consumer health information reports may contain, but are not limited to, the following information:

(1) performance measures that are intended to assist consumers in evaluating health care services, health care providers, organizations and payers;

(2) subjective measures obtained from health care surveys, if surveys are conducted pursuant to 7 NMAC 1.22.10 [now 7.1.22.10 NMAC]; and

(3) educational information to assist consumers in placing the information in the context of health care and the health care system.

C. Risk adjustment: The commission shall apply nationally recognized standards for risk adjustment in analyzing the data contained in consumer health information reports, to the extent feasible given the availability of appropriate data and scientifically valid methodologies.

D. Proprietary and confidential information:

(1) Proprietary information and patient confidential information shall not be disclosed in or as part of a consumer health information report by the commission.

(2) A data provider that objects on proprietary grounds to the potential release in a consumer health information report of its reported data or information derived from its reported data shall submit to the director a written request for confidentiality. This request shall explicitly and specifically identify the data and/or derived

information 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 data provider. A data provider may appeal the director's denial of the request to the commission. The commission shall make a final determination on the request.
[8/30/97; Recompiled 10/31/01]

7.1.22.9 EDITORIAL BOARD:

A. The commission shall establish annually a five member editorial board selected from the HIS advisory committee, including representatives of data providers and consumers. A commission staff member shall be the nonvoting chair of the editorial board. The editorial board shall plan, review and recommend to the commission the report format, performance and survey measures, and educational information to be included in consumer health information reports.

B. The editorial board's recommendations, and any subsequent adoption of a consumer information report by the commission, shall take into account the relevancy of the performance and survey measures to the health status of New Mexico health care consumers and shall be guided by the following criteria:

(1) Availability - whether the performance or survey measure is or should be available from a source readily accessible to the data provider or survey administrator, or whether provision of the information can be achieved without extraordinary effort by the data provider or survey administrator;

(2) Comparability - whether the performance or survey measure allows for comparisons among data providers or categories of data providers, or whether mechanisms are available to the commission to adjust for variations in patient risk factors if comparability across data providers is limited;

(3) Confidentiality - whether patient confidential information can be protected;

(4) Cost - whether the overall cost to compile or submit the performance or survey measure meets standards of reasonableness as required by Sections 24-14A-3D(14) and 24-14A-3.1D(3) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978;

(5) Meaningfulness - whether the performance or survey measure meets minimum standards of statistical reliability, validity, and accuracy and the performance or survey measure's reliability, validity and accuracy can be validated by an independent audit or verified by analysis of the component data elements of the measure;

(6) Rationale - whether the performance or survey measure has relevance to consumer decision-making, or whether there is a consumer-based reason for including the performance or survey measure;

(7) Specifications - whether there is a standardized method to quantify the performance or survey measure;

(8) Standard - whether there is a desired level of performance that has gained acceptance nationally or professionally for the performance or survey measure.
[8/30/97; Recompiled 10/31/01]

7.1.22.10 HEALTH CARE SURVEYS: Upon recommendation of the editorial board, the commission may contract for health care surveys to be conducted. Data providers shall participate in the survey process upon request of the commission. The surveys shall be undertaken based upon the criteria in 7 NMAC 1.22.9.2 [now Subsection B of 7.1.22.9 NMAC] and upon the following factors:

A. National standardized survey: The commission shall use a national standard health care survey instrument or instruments, verified and tested by scientific methods. Where practical, the commission shall adopt for use a standard survey instrument that is in accordance with generally accepted industry practices.

B. Independently administered: Standard surveys shall be independently administered by independent contractors, using the protocol or specifications provided with the surveys where available and as applicable to the health information needs of New Mexico health care consumers. As appropriate and practical, surveys shall be conducted by a firm certified by the generally recognized industry association or quality-certifying entity.

C. Coordination among state agencies: If feasible the commission shall coordinate its survey efforts with other state agencies that have regulatory or contractual oversight of data providers to avoid redundant reporting requirements.

D. Burden on survey populations: Where possible the commission shall limit redundant requests of the survey target populations, and when feasible coordinate survey efforts with other public and private entities, to ease any burden imposed by multiple survey efforts.

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

7.1.22.11 OPPORTUNITY FOR ADVANCE REVIEW:

A. Review by data providers: Data providers whose data is included in a consumer health information report and who submit the required data by the submission deadline shall be provided a draft of the report that contains the provisional statewide aggregate results for each included performance measure, the presentation style of the performance measures, the educational information, and results of any surveys conducted. For the 1996 reporting year, the commission shall make every effort to provide the draft report by October 30, 1997. For all subsequent reporting years the commission shall make every effort to provide the draft report by September 1 of the following year. Data providers shall have a 30 day review period from the postmarked date of the draft report to review the draft. Data providers may submit to the commission written corrections and comments by the last date of the review period, either by facsimile or by mail postmarked as of that date. Upon request of the data provider, the commission shall publish these written comments in the final consumer health information report, subject to editing by the commission for length, clarity and suitability, provided that the commission's edits shall attempt to fairly and accurately represent the substance of the data provider's comments. Data shall be considered final when the review period has elapsed.

B. Review by the HIS advisory committee: The HIS advisory committee, in accordance with its functions under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, shall review consumer health information reports prior to their issuance and make recommendations to the commission on content, format and any other pertinent factors.

C. Review by the commission: The commission shall review and approve consumer health information reports prior to their issuance.

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

7.1.22.12 VERIFICATION OF SUBMITTED DATA:

A. Audit requirement: In order to verify the validity, reliability and comparability of data submitted by a data provider, the commission may conduct or contract for an independent audit or approve a plan-contracted audit conducted by an independent organization certified by NCQA to perform HEDIS® audits. Data providers shall participate in the audit process upon request of the commission. ®NCQA registered trademark.

B. Audit process: The commission may design and conduct an audit process solely for the purpose of verifying submitted data that may include one or more of the following activities concerning a data provider:

(1) an audit of the data provider's data collection and reporting processes, including its administrative database;

(2) one or more site visits;

(3) review and verification of the data provider's specifications, source codes, and data elements for each reporting measure;

(4) review of patient confidential information, which shall be limited to cases selected for verification purposes; and

(5) any other reasonable activities necessary to satisfy the purposes of the audit requirement.

C. Confidentiality requirements: All audits of data provider reports shall be conducted in a manner that protects the privacy of individual patients and patient confidential information to the extent consistent with the purposes of the audit. No information obtained during an audit shall be used for any purpose other than to satisfy the audit requirements.

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

HISTORY OF 7.1.22 NMAC: [RESERVED]