This rule was filed as 13 NMAC 10.16.

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 16 PROVIDER GRIEVANCES

13.10.16.1 ISSUING AGENCY: New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.
[12/1/98; Recompiled 11/30/01]

13.10.16.2 SCOPE: This rule applies to health care insurers that are required to obtain a certificate of authority or licensure in this state and which provide, offer, or administer managed health care plans.
[12/1/98; Recompiled 11/30/01]

13.10.16.3 STATUTORY AUTHORITY: Sections 59A-57-1 through 59A-57-11 NMSA 1978.
[12/1/98; Recompiled 11/30/01]

13.10.16.4 DURATION: Permanent.
[12/1/98; Recompiled 11/30/01]

13.10.16.5 EFFECTIVE DATE: December 1, 1998, unless a later date is cited at the end of a section or paragraph.
[12/1/98; Recompiled 11/30/01]
[Compiler's note: The words or paragraph, above, are no longer applicable.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.]

13.10.16.6 OBJECTIVE: The purpose of this rule is to ensure that managed health care plans adopt consistent systems to address provider terminations and grievances.
[12/1/98; Recompiled 11/30/01]

13.10.16.7 DEFINITIONS: For purposes of this rule:

A. **"Enrollee"** means an individual who is entitled to receive health care benefits provided by a managed health care plan.

B. **"Grievance"** means a concern that a provider may have regarding:

(1) the operation of a managed health care plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network; or

(2) the existence of adequate cause to terminate a provider's participation with a managed health care plan to the extent that the relationship is terminated for cause.

C. **"Health care insurer"** means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan.

D. **"Managed health care plan (MHCP or plan)"** means a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies.

E. **"Provider"** means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals and health care facilities.

F. **"Termination"** means the discontinuance of a provider's employment, contractual relationship, or other business relationship with a plan that is instituted by the plan and is involuntary on the part of the provider.
[12/1/98; Recompiled 11/30/01]

13.10.16.8 GRIEVANCE PROCESS FOR PROVIDERS' CONCERNS REGARDING OPERATION OF A MANAGED HEALTH CARE PLAN:

A. Each MHCP shall develop, adopt, and implement a process so that providers who are employed by the MHCP or are participants in the MHCP's network may raise concerns they have regarding the operation of the plan.

B. On or before December 15, 1998, each MHCP currently doing business in New Mexico shall submit to the superintendent for approval a written plan describing the process the MHCP plans to adopt and implement regarding provider grievances related to operation of the MHCP.

(1) At a minimum, the provider grievance plan shall include the right of the provider to present the provider's concerns to a MHCP committee responsible for the substantive area addressed by the concern. In addition, the MHCP should describe in its provider grievance plan the mechanism by which the committee responsible for the particular substantive area that is the subject of a provider's grievance will relay the provider's concern to the MHCP's governing body.

(2) The provider grievance plan shall also list what substantive committees the MHCP will establish to address substantive concerns of providers and shall list the titles of MHCP staff members who will comprise such committees.

(3) The provider grievance plan shall include a requirement that the MHCP forward a written decision of the MHCP to the provider pursuing a grievance within 20 days after the committee has obtain all information concerning the provider's grievance.

C. The superintendent shall approve or reject a MHCP's provider grievance plan within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

D. A MHCP new to this state shall submit a process plan to the superintendent as part of its application for licensure.

[12/1/98; Recompiled 11/30/01]

13.10.16.9 GRIEVANCE PROCESS FOR PROVIDER TERMINATIONS:

A. Terminations based on cause. Each MHCP shall develop, adopt, and implement a fair hearing process so that a provider may dispute whether the MHCP has adequate cause to terminate a provider's participation with the plan if the provider's relationship with the MHCP is in fact being terminated for cause.

(1) The fair hearing process should provide, at a minimum, for the following:

(a) the right of the provider to appear in person before a fair hearing officer or fair hearing committee appointed by the MHCP prior to the proposed termination date;

(b) the right of the provider to present his or her case to the fair hearing officer or fair hearing committee;

(c) the right of the provider to submit supporting material both before and at the fair hearing;

(d) the right of the provider to ask questions of any representative of the MHCP who attends the hearing;

(e) the right of the provider to be represented by an attorney or by any other person of the provider's choice; and

(f) the right to an expedited hearing in those instances where the MHCP has not provided advance written notice of termination to the provider because the MHCP has a good faith and reasonable belief that further care by the provider would result in imminent and significant harm to enrollees.

(2) Each MHCP shall issue a written decision within 20 days after the fair hearing, and shall forward a copy of the written decision to the provider as soon as the decision is issued.

(3) On or before December 15, 1998, each MHCP currently doing business in New Mexico shall submit to the superintendent for approval a written plan describing the fair hearing process the MHCP plans to utilize in those instances where a provider is terminated for cause.

(4) The superintendent shall approve or reject a MHCP's fair hearing plan within 45 days after the plan is submitted to the superintendent. If the superintendent rejects a plan submitted by a MHCP, the superintendent shall state in writing in a letter addressed to the MHCP the specific grounds for rejection.

(5) A MHCP new to this state shall submit a fair hearing plan to the superintendent as part of its application for licensure.

B. Other terminations. Each MHCP that proposes to terminate a provider from the MHCP shall provide a written explanation to the provider for its proposed termination, and shall deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination. Such notice shall be delivered if the termination is for cause as described in 13 NMAC 10.13.9.1 [now Subsection A of 13.10.16.9 NMAC], if the

termination is at the convenience of the MHCP, if the termination is by virtue of a fixed termination date in the provider contract or if the MHCP does not intend to offer renewal of the provider contract.

(1) "Reasonable advance written notice" is a minimum of thirty days, except when the quality of care provided to enrollees is the basis of the MHCP's proposed termination.

(2) When the quality of care provided to enrollees is the basis for termination and the MHCP has a good faith and reasonable belief that further care by the provider would result in imminent and significant harm to enrollees, the MHCP is not required to provide advance written notice, but shall follow the expedited fair hearing process provided in 13 NMAC 10.13.9.1.1 [now Paragraph (1) of Subsection A of 13.10.16.9 NMAC].

C. Nothing contained in 13 NMAC 10.16.9 shall be construed to prohibit a MHCP from terminating a provider without cause.

[12/1/98; Recompiled 11/30/01]

[**Compiler's note:** Paragraph (2) of Subsection B of 13.10.16.9 NMAC contains a reference to 13 NMAC 10.13.9.1.1, which appears to be a reference to 13 NMAC 10.16.9.1.1, now Paragraph (1) of Subsection A of 13.10.16.9 NMAC.]

13.10.16.10 REVIEW OF PROVIDER GRIEVANCES BY THE SUPERINTENDENT:

A. A provider that is dissatisfied with the results of the MHCP's internal grievance procedure and that has exhausted the MHCP's internal grievance procedure may file a complaint with the superintendent regarding the subject of the provider's grievance to the MHCP.

B. A provider seeking the superintendent's review of a MHCP's grievance decision shall file a written request with the superintendent within 30 days from receipt of a written decision of the MHCP concerning the grievance. After appropriate investigation of a provider's complaint, the superintendent may schedule and conduct a hearing pursuant to Article 4 of the Insurance Code.

[12/1/98; Recompiled 11/30/01]

HISTORY OF 13.10.16 NMAC: [RESERVED]