TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 22 MANAGED HEALTH CARE PLAN COMPLIANCE

13.10.22.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Division of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.
[13.10.22.1 NMAC - Rp, 13.10.13.1 NMAC, 09/01/2009]

13.10.22.2 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. This rule relates to and should be read in conjunction with 13.10.13, 13.10.16, 13.10.17, 13.10.21 and 13.10.23 NMAC.
[13.10.22.2 NMAC - Rp, 13.10.13.2 NMAC, 09/01/2009]

13.10.22.3 STATUTORY AUTHORITY: Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-16-12, 59A-16-12.1, 59A-16-13, 59A-16-22, 59A-18-17, 59A-18-27.1, 59A-22-32, 59A-22-32.1, 59A-22A-4, 59A-22A-5, 59A-23-4, 59A-44-34, 59A-44-41, 59A-46-7, 59A-46-9, 59A-46-10, 59A-46-11, 59A-46-23, 59A-46-25, 59A-46-27, 59A-46-30, 59A-46-35, 59A-46-36, 59A-47-27, 59A-47-29, 59A-47-33, 59A-57-2, 59A-57-4, 59A-57-5, 59A-57-6, 59A-57-8, and 59A-57-11 NMSA 1978.
[13.10.22.3 NMAC - Rp, 13.10.13.3 NMAC, 09/01/2009]

13.10.22.4 DURATION: Permanent.
[13.10.22.4 NMAC - Rp, 13.10.13.4 NMAC, 09/01/2009]

13.10.22.5 EFFECTIVE DATE: September 1, 2009, unless a later date is cited at the end of a section.
[13.10.22.5 NMAC - Rp, 13.10.13.5 NMAC, 09/01/2009]

13.10.22.6 OBJECTIVE: The purpose of this rule is to ensure the availability, accessibility, and quality of health care services provided by health care insurers through managed health care plans, and to regulate trade practices in the insurance business and related businesses by prohibiting unfair or deceptive acts or practices.
[13.10.22.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.22.7 DEFINITIONS: In addition to the following, this rule is subject to the definitions found in the Grievance Procedures Rule, 13.10.17 NMAC.

A. "Claim" means:

(1) any request by an insured for indemnification by a MHCP; and

(2) any direct services provided to an individual.

B. "Direct services" means:

(1) services rendered to an individual by a health insurer or a health care professional, facility or other provider;

(2) case management, disease management, health education and promotion, preventive services, quality incentive payments to providers or individuals; and

(3) any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act.

C. "Earned premium" means paid premiums for the year plus uncollected premiums minus premiums paid in advance.

D. "**Health care facility**" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

E. "**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, prepaid dental plan, a multiple employer welfare arrangement or any other person providing a plan of health insurance or a managed health care plan subject to state insurance law and regulation.

F. **"Health care professional"** means a physician or other health care professional, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

G. "**Health care services**" means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

H. **"Incurred claims"** means paid-on-incurred claims for the year, plus a reserve for claims incurred but not yet paid, plus the change in any other reserve held, plus expenses incurred during the year.

I. **"Incurred health care expenses"** means health care coverage that is provided by a health maintenance organization, as defined in Article 46 of the New Mexico Insurance Code, on a service rather than reimbursement basis.

J. **"Loss Ratio"** means incurred claims or incurred health care expenses to earned premiums.

K. "**Managed health care plan (MHCP or plan)**" means a policy, contract, certificate or agreement offered or issued by a health care insurer, provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, except as otherwise provided in this subsection. A MHCP 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, provider service network, or plan administrator. Effective immediately, a MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies. For purposes of this section, "plan administrator" shall include and apply to an HMO or other health care insurer not required to be licensed under Section 59A-12A-2 NMSA 1978, but which is acting as a "plan administrator" as defined under the act." A MHCP includes a health benefits plan as defined under NMSA 1978 Section 59A-22A-3(D) as "the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available."

L. **"Premium"** means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitation payments, recoveries from third parties or other insurers, interest and administrative fees received and claim payments made by:

(1) an administrator or third party administrator pursuant to Chapter 59A, Article 12A NMSA 1978;

(2) a health maintenance organization;

(3) a nonprofit health care plan; or

(4) an insurer.

M. **"Small group health insurance market"** means plans offered to small employers pursuant to Article 23C of the New Mexico Insurance Code.

N. **"Usual, customary and reasonable rate"** means health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area.
[13.10.22.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.22.8 ACCESS TO HEALTH CARE SERVICES:

A. **Provider network adequacy**: Each health care insurer through its MHCP shall maintain and have available an adequate network of licensed primary care practitioners (PCPs) to provide comprehensive basic health care services to its enrolled population at all times. Those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval an access plan addressing all of the criteria of this section. A MHCP new to this state shall submit a preliminary access plan to the division as part of its application for licensure. A MHCP new to this state shall file a follow-up access plan with the superintendent within six months after it obtains a certificate of authority. The superintendent shall approve or reject an access plan submitted by a MHCP within 45 days after the access plan is submitted to the division. In considering whether to approve or reject an access plan, the superintendent shall determine whether the MHCP meets all of the following criteria; however, the superintendent may make reasonable exceptions to the criteria on a case by case basis when the MHCP demonstrates the need for such exceptions.

(1) Whether, in population areas of 50,000 or more residents, two PCPs are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, whether two PCPs are available in any county or service area within no more than 60 miles or 60

minutes average driving time for 90 percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care.

(2) Whether the MHCP has a sufficient number of PCPs to meet the primary care needs of the enrolled population, using, as guidelines for calculation, the following criteria: 1) that each covered person will have four primary care visits annually, averaging a total of one hour; 2) that each PCP will see an average of four patients per hour; and 3) that one full-time equivalent PCP will be available for every 1,500 covered persons.

(3) Whether the MHCP demonstrates that the projected PCP network is sufficient to meet the primary care needs of adult, pediatric, and obstetric-gynecological patients. Each MHCP should show the adequacy of PCP availability by verifying that the PCPs committed to provide sufficient time for new patients so that projected clinic hour needs of the projected enrollment by service area are met.

(4) Whether the MHCP provides reasonable and reliable access for its covered persons to qualified health care professionals in those specialties that are covered by the MHCP. In developing its access plan, the MHCP should: 1) demonstrate that a sufficient number of licensed medical specialists are available to covered persons for specialty care when referral to such care is determined to be medically necessary by the PCP or other treating health care professional in consultation with the MHCP; and 2) attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population. A MHCP shall not restrict PCPs, in consultation with the MHCP, from referring covered persons to providers outside the network, even when geographically distant from the covered person's residence, when access to such treatment by such provider is medically necessary and no other provider can provide comparable treatment in-network or on a more cost-effective basis.

(5) Whether the MHCP has contracts, or other arrangements acceptable to the superintendent, with institutional providers - so that: 1) the need for services covered by the MHCP is satisfied; 2) the medical needs of covered persons are met 24 hours per day, seven days per week; and 3) the institutional services are geographically accessible to covered persons. In its access plan, the MHCP should demonstrate that in population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number of residents in the county or service area and given the community's standard of care.

(6) Whether a sufficient number of health care professionals, such as registered and licensed practical nurses, are available to covered persons to ensure the delivery of covered health care services.

(7) Whether the MHCP has made surgical facilities including acute care hospitals for major surgery, hospitals for minor surgical procedures, licensed ambulatory surgical facilities, and medicare eligible surgical practices reasonably available, given the population of the service area and the institutional facilities available in or around the service area.

(8) Whether the MHCP has a policy assuring access to tertiary and specialized services as evidenced by contract or other agreement acceptable to the superintendent. In its access plan, the MHCP should describe the geographic location of and covered persons' accessibility to the following such services:

(a) at least one hospital providing regional perinatal services, if maternity coverage is offered as a health care service;

(b) a hospital offering tertiary pediatric services;

(c) a hospital offering diagnostic cardiac catheterization services;

(d) inpatient psychiatric services for adults and children, if provided as a covered health care service; and

(e) a residential substance abuse treatment center, if provided as a covered health care service.

(9) Whether the MHCP has a policy assuring access to the specialized services listed below, as evidenced by contract or other agreement acceptable to the superintendent. The MHCP should demonstrate in its access plan the geographic location of and covered persons' accessibility to the following such services:

(a) a therapeutic radiation provider;

(b) magnetic resonance imaging center;

(c) diagnostic radiology provider, including x-ray, ultrasound, and CAT scan; and

(d) a licensed renal dialysis center.

(10) Whether the MHCP has at least one licensed home health care professional available to serve each service area where 3,000 or more covered persons reside, if home health care is provided as a covered health care service.

B. Appointment waiting times: Each MHCP shall demonstrate that the network will meet the following criteria:

(1) emergencies shall be triaged through the PCP or by a hospital emergency room through medical screening or evaluation;

(2) urgent care shall be available within 48 hours of notification to the PCP or MHCP, or sooner as required by the medical exigencies of the case;

(3) for both emergent and urgent care, the MHCP shall ensure 7 day, 24 hour access to triage services, and that each PCP will have back-up coverage by another provider;

(4) the MHCP shall have an adequate number of PCPs with admitting privileges at one or more participating hospitals within the MHCP's service area so that necessary hospital admissions are made on a timely basis consistent with generally accepted practice parameters;

(5) routine appointments shall be scheduled as soon as is practicable given the medical needs of the covered person and the nature of the health care professional's medical practice;

(6) routine physical exams shall be scheduled within 4 months;

(7) in all instances of scheduling, the MHCP or its participating health care professionals shall have guidelines to assess when an appointment should be scheduled based on the type of health care service to be provided; upon request, the MHCP shall make such guidelines available to covered persons;

(8) all appointments shall be scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice.

C. Referrals: The MHCP shall implement a system that ensures routine referrals are made to other participating health care professionals.

(1) A covered person shall not be held liable for payment of services if the MHCP health care professional mistakenly makes a referral to a non-participating health care professional, unless the MHCP has notified the covered person in writing concerning the use of non-participating health care professionals and informed the covered person that the MHCP will not be responsible for future payment to the non-participating health care professionals.

(2) The MHCP shall bear the burden of showing that the covered person has been adequately informed by specific written notice of the MHCP's future refusal to pay for future care provided by the identified non-participating health care professional.

(3) The MHCP shall ensure that a covered person is not precluded from obtaining a referral from the covered person's PCP to a specialist or other health care professional that is within the MHCP's network, if the referral is reasonable.

D. Provider lists: A MHCP must provide a list of all providers to subscribers, enrollees, covered persons or prospective enrollees upon request.

(1) The list shall include specialty health care professionals and other health care professionals providing health care services, and shall specify the locations, including addresses, of such providers.

(2) The list shall identify those health care professionals who are not currently accepting new patients.

(3) The information shall be made available and upon request be provided to enrollees in the evidence of coverage.

(4) Information should be provided through toll-free phones and electronic means, as specified in 13.10.23.7 NMAC.

(5) MHCPS are encouraged to facilitate a covered person's ability to obtain a second opinion from a participating health care professional regarding the covered person's request for a second opinion from, or referral to, a non-participating health care professional.

E. Out-of-network services: In the event medically necessary covered services are not reasonably available through participating health care professionals, the MHCP shall provide in the contract terms that the MHCP and the PCP or other participating health care professional shall refer a covered person to a non-participating health care professional and shall fully reimburse the non-participating health care professional at the usual, customary, and reasonable rate or at an agreed upon rate. The contract must further state that before a MHCP may

deny such a referral to a non-participating physician or health care professional, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

F. Specialty care: Referrals to participating or non-participating specialty health care professionals must be accessible to covered persons on a timely and appropriate basis in accordance with generally accepted medical guidelines.

(1) If the MHCP requires covered persons to obtain prior authorization before referral to specialty care, the MHCP must provide covered persons the following information in the evidence of coverage:

(a) procedures a covered person must follow to obtain prior authorization for specialty referrals, including whether a covered person's PCP, the MHCP's medical director, or a committee must first authorize the specialty referral;

(b) the necessity, if any, of repeating prior authorization if the specialist care is to be ongoing; and

(c) procedures to obtain a second medical opinion.

(d) if a PCP referral is required under the MHCP, the MHCP must inform PCPs of their responsibility to provide written referrals; of any specific procedures that must be followed in providing such referrals; and that the PCP must refer patients to those participating health care professionals who are qualified to address the covered person's health care needs as determined by the PCP in consultation with the MHCP.

(2) The MHCP shall make determinations on requests for referrals in accordance with Subsection D of 13.10.13.19 NMAC.

(3) Covered persons denied referral to specialty care may initiate a grievance through the MHCP's grievance procedures pursuant to 13.10.17 NMAC.

G. Ongoing specialty care: If, in the best medical judgment of the covered person's PCP, the covered person's health condition requires ongoing specialty care, such as for chronic illnesses requiring medical supervision beyond the capability or training of the PCP, the PCP may, after consultation with the specialist and the MHCP, refer the covered person to the appropriate specialist for ongoing care as the severity of the condition warrants.

(1) The ultimate determination, however, of whether the covered person should have ongoing care from the specialist shall remain with the PCP.

(2) In such cases, neither the PCP nor the covered person will be required to obtain a prior authorization from the MHCP for subsequent specialist visits.

(3) The MHCP may review such referrals to specialist care on an annual basis to determine whether ongoing specialist care continues to be medically necessary. In conducting such a review, the MHCP shall consult with the covered person's primary care physician and the specialist to whom the covered person has been referred.

(4) Nothing in Subsection G of 13.10.22.8 NMAC prohibits a MHCP from requiring that covered persons receive ongoing specialist care from those specialists who are considered "participating health care professionals" by the MHCP, unless there are no participating specialists of the type required to manage the patient's condition. In such instances, the MHCP shall make indemnity or other payment arrangements for the patient's care, and covered persons will not be assessed higher or additional co-payments as a result of such arrangements.

(5) A MHCP must allow qualified health care professionals who are specialists to act as PCPs for patients with chronic medical conditions of sufficient severity to require primary coordination of care by a specialist as determined by the covered person, the covered person's current treating health care professional, the covered person's PCP if different than the treating health care professional, and the MHCP, provided that:

(a) the specialist offers all basic health care services that are required of them by the MHCP; and

(b) the specialist meets the MHCP's eligibility criteria for health care professionals who provide primary care.

H. Out of state providers: A MHCP is encouraged to enter into contracts or other arrangements with out of state providers in order to meet the access requirements of this rule.

I. Access to non-allopathic health care services: In order to maximize covered persons' access to all types of health care services, the division affirmatively encourages each health care insurer or MHCP to enter into appropriate contracts with qualified health care professionals, including but not limited to, doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives to provide both allopathic and non-allopathic health care services.

J. Reliance on nationally recognized accreditation standards to meet access standards: If the MHCP utilizes an open network pursuant to NMSA 1978, Section 59A-22A-5, then in lieu of the provisions of

13.10.22.8 NMAC, Subsections A-I, the MHCP shall present to the superintendent written verification either that the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission/URAC (URAC) determined that the MHCP has achieved one of the two highest ratings for all factors regarding availability of health care professionals and accessibility of services, under contemporaneous NCQA or URAC standards.

(1) In lieu of the above, the plan shall present evidence to the superintendent that it would achieve these ratings if evaluated by the NCQA or URAC, in addition to member survey results.

(2) Plans shall also take into account that the division will utilize the standards described in Subsections D, H and I of 13.10.22.8 NMAC, and the "medical necessity" and "usual, customary, and reasonable rate" standards found in Subsection E of 13.10.22.8 NMAC.

[13.10.22.8 NMAC - Rp, 13.10.13.11 NMAC, 09/01/2009]

13.10.22.9 UTILIZATION MANAGEMENT:

A. Utilization management program: The health care insurer through its MHCP shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care services. The program shall be under the direction of a medical director responsible for the medical services provided by the MHCP in New Mexico and who is a licensed physician in New Mexico, and shall be based on a written plan that is reviewed at least annually. At a minimum, the plan shall identify the following:

(1) scope of utilization management activities;

(2) procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;

(3) mechanisms to detect underutilization and overutilization;

(4) clinical review criteria and protocols used in decision-making;

(5) mechanisms to ensure consistent application of review criteria and uniform decisions;

(6) development of outcome and process measures for evaluating the utilization management program; and

(7) a mechanism to evaluate member and provider satisfaction with the complaint and appeals systems set forth at 13.10.17 NMAC; such evaluation shall be coordinated with the performance monitoring activities conducted pursuant to the continuous quality improvement program to include care coordination between utilization management, case management and disease management services as set forth in 13.10.22.10 NMAC.

B. Utilization management determinations shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other health professionals and providers within the MHCP's net network. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to affected providers and covered persons. The MHCP shall have the burden of showing that information requested by affected providers or covered persons is in fact proprietary. Nothing in this section shall be construed to prevent a MHCP from incorporating into its clinical protocols criteria from outside sources.

C. Utilization management staff availability:

(1) A registered professional nurse or physician shall be immediately available by telephone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(2) The MHCP shall provide all covered persons and providers with a toll-free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis. The MHCP may provide a separate telephone number for covered persons and for providers.

(3) All covered persons must have immediate telephone access seven days a week, 24 hours a day, to their primary care physician or the physician's authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

D. Utilization management determinations:

(1) All determinations to authorize an admission, service, procedure or extension of stay shall be rendered by either a physician, registered professional nurse, or other qualified health professional.

(2) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician, either after application of uniform criteria established by the plan in consultation with specialists acting within the scope of their license or after consultation with specialists acting within the scope of their license. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the MHCP's New Mexico covered persons. Such determinations shall be made in accordance with clinical and medically necessary criteria developed pursuant to Subsection A of 13.10.22.9 NMAC and the evidence of coverage.

(3) All determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed 24 hours for emergency care and seven days for all other determinations. If the MHCP is unable to complete a referral within ten days due to unforeseen circumstances, the MHCP shall inform the covered person in writing about the reasons for the delay and when a decision may be expected.

(4) A MHCP may not retroactively deny reimbursement for a covered service provided to a covered person by a provider who relied upon the verbal or written authorization of the MHCP or its agents prior to providing the service to the covered person, except in those cases where there was material misrepresentation or fraud. Retroactive reimbursement for a covered service shall not be denied when the covered person provides authorization information, such as a MHCP referral number, directly to the provider, except in those cases where there was material misrepresentation or fraud.

(5) An enrollee must receive a written notice of all determinations to deny coverage or authorization for health care services, which shall contain the reasons why coverage or authorization was denied, and which shall be subject to review in accordance with the specific grievance procedures outlined in 13.10.17 NMAC. The written notice shall advise the covered person that review of the MHCP's denial of coverage or authorization is available. In addition, the notice shall describe the procedures necessary for commencing an internal review as outlined in 13.10.17 NMAC.

E. Accreditation by nationally recognized accrediting entity. Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[13.10.22.9 NMAC - Rp, 13.10.13.19 NMAC, 09/01/2009]

13.10.22.10 CONTINUOUS QUALITY IMPROVEMENT

A. Under the direction of a medical director or his or her designated physician, the MHCP shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to covered persons. This program shall be based on a written plan which is reviewed at least annually and revised as necessary. The plan shall describe at least:

(1) the scope and purpose of the program;

(2) the organizational structure of quality improvement activities;

(3) duties and responsibilities of the medical director and/or designated physician responsible for continuous quality improvement activities;

(4) contractual arrangements, where appropriate, for delegation of quality improvement activities;

(5) confidentiality policies and procedures;

(6) specification of standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources utilized;

(7) a system of ongoing evaluation activities, including individual case reviews as well as pattern analysis;

(8) a system of focused evaluation activities, particularly for frequently performed and/or highly specialized procedures;

(9) a system for monitoring random covered person satisfaction and network provider's response and feedback on MHCP operations;

(10) a system for verification of providers' credentials, recertification, performance reviews and for obtaining information about any disciplinary action against a provider available from any state licensing board applicable to the provider;

(11) the procedures for conducting peer review activities, which shall include providers within the same discipline and area of clinical practice;

(12) a system for evaluation of the effectiveness of the continuous quality improvement program to include care coordination between utilization management, case management and disease management services.

B. The board of directors or other management body of the MHCP shall be kept apprised of continuous quality improvement activities and be provided at least annually with regular written reports from the program delineating quality improvements, performance measures used and their results, and demonstrated improvements in clinical and service quality.

C. There shall be a multidisciplinary continuous quality improvement committee responsible for the implementation and operations of the program. The structure of the committee shall include representation from the medical, nursing and administrative staff, with substantial involvement of the medical director of the MHCP.

D. The program shall monitor the availability, accessibility, continuity and quality of care on an ongoing basis. Indicators for evaluating the quality of health care services provided by all participating providers shall be identified and established and may include:

(1) a mechanism for monitoring patient appointment and triage procedures, discharge planning services, linkage between all modes and levels of care and appropriateness of specific diagnostic and therapeutic procedures, as selected by the continuous quality improvement program;

(2) a mechanism for evaluating all providers of care that is supplemental to each provider's quality improvement system;

(3) a system to monitor provider and covered person access to utilization management services, including, at a minimum, waiting times to respond to phone requests for service authorization, covered person urgent care inquiries, and other services required by this rule.

E. The MHCP shall follow up on findings from the program to assure that effective corrective actions have been taken, including, at a minimum, policy revisions, procedural changes and implementation of educational activities for covered persons and providers.

F. Continuous quality improvement activities shall be coordinated with other performance monitoring activities including utilization management, risk management, and monitoring of covered person and provider complaints.

G. The MHCP shall maintain documentation of the quality improvement program in a confidential manner. This documentation shall be available to the superintendent, shall be submitted as part of the health care insurer's annual report to the superintendent, and shall include:

(1) minutes of quality improvement committee meetings;

(2) records of evaluation activities, performance measures, quality indicators and corrective plans and their results or outcomes.

H. External quality audit:

(1) Upon request by the superintendent, each MHCP shall have an external quality audit conducted by an IQRO approved by the division, and shall submit proof to the superintendent that such an audit and report has been completed.

(2) The report must describe in detail the MHCP's conformance to performance standards established by the IQRO, other national standard-setting bodies for MHCPs, and the standards set out in this rule. The report shall also describe in detail any corrective actions proposed and/or undertaken and approved by the IQRO. The report shall be submitted to the division within 60 days of its receipt in final form by the MHCP.

(3) The superintendent may grant a MHCP a deferral of the above requirement for an external quality audit for a 12-month period if it is in the initial three years of start-up operations.

I. Performance and outcome measures.

(1) The division may develop a performance and outcome measurement system for monitoring the quality of care provided to MHCP covered persons. The data collected through this system may be used by the division to:

(a) assist MHCPs and their providers in quality improvement efforts;

(b) provide the division with information on the performance of MHCPs for regulatory oversight;

(c) support efforts to inform consumers about MHCP performance;

(d) promote the standardization of data reporting by MHCPs and providers; and for

(e) any other purpose consistent with the policies and provisions of this rule and the Insurance Code.

(2) The performance and outcome measures may include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. To minimize costs to health care insurers, MHCPs, providers, and the division, performance measures will incorporate, when possible, data routinely

collected or available to the division from other sources. Data for these performance measures may include but not be limited to the following:

(a) indicator data collected by MHCPs from chart reviews and administrative data bases;

(b) satisfaction surveys of covered persons;

(c) provider surveys;

(d) all reports submitted by MHCPs to the superintendent as required by this rule;

(e) data collected by the division for administrative, epidemiological and other purposes, such as the state cancer registry, vital records, and hospital records.

(3) MHCPs shall submit such performance and outcome data as the division may request from time to time.

(4) The division shall provide each MHCP an opportunity to comment on the compilation and interpretation of the data before its release to consumers.

(5) The division may conduct or arrange for periodic satisfaction surveys of covered persons. Upon request by the superintendent, the MHCP shall provide the division with the mailing list of covered persons to be used to select samples of the MHCP's membership for the surveys. Upon request by the superintendent, the MHCP shall also provide the division with a mailing list of former covered persons who are no longer covered by the MHCP, which the division may use to select samples of the MHCP's former covered persons for surveys.

(6) The division shall ensure the confidentiality of patient specific information.

(7) The division shall take all necessary measures to reduce duplicative reporting of information to state agencies. Any performance and outcome measurement system developed by the division shall not be duplicative of the health information system created by the Health Information System Act, Chapter 24, Article 14A NMSA 1978, and implemented by the New Mexico health policy commission.

(8) In developing a performance and outcome measurement system, the division shall take into consideration data reporting standards of nationally recognized accrediting entities, such as, for example, the health plan employer data and information set (HEDIS), and shall attempt to avoid duplication of such reporting standards, so that a MHCP may, where possible, submit the same data to the division that the MHCP submits to a private accrediting entity.

J. Accreditation by nationally recognized accrediting entity: Nothing in this section shall prohibit a MHCP from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where a MHCP seeks to meet the requirements of this section through accreditation by a private accrediting entity, the MHCP shall submit to the division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the MHCP has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the MHCP and upon which accreditation of the MHCP was based. A MHCP accredited by the private accrediting entity that has submitted all of the requisite information to the division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the MHCP obtained accreditation is recognized and approved by the superintendent.

[13.10.22.10 NMAC - Rp, 13.10.13.20 NMAC, 09/01/2009]

13.10.22.11 CULTURAL AND LINGUISTIC DIVERSITY: The MHCP must ensure that information and services are available in languages other than English, that services are provided in a manner that takes into account cultural aspects of the covered person population, and that accommodations are provided for covered persons with disabilities. Each MHCP shall develop, implement, and maintain a plan that reasonably addresses the cultural and linguistic diversity of its covered person population.

A. MHCPs that have not already done so and are currently doing business in New Mexico shall submit to the superintendent for approval a plan of how the MHCP will address the cultural and linguistic diversity of its covered person population. At a minimum, the plan shall address:

(1) how the MHCP will identify the language needs of covered persons;

(2) measures to be taken to ensure access for limited-English-proficient (LEP) covered persons in both administrative and health care encounters with the plan and its providers;

(3) steps the MHCP will take to ensure availability of adequate interpretation services within its network, which shall include a description of specific contracts or other arrangements for interpretation and identification of interpreters for the deaf;

(4) whether interpreting services are available to covered persons on a 24-hour basis for emergency care;

(5) whether linguistic and cultural needs are explicitly addressed in the MHCP's continuous quality improvement program;

(6) how the MHCP will conduct outreach to ensure that covered persons with particular cultural and linguistic needs are identified by the MHCP and made aware of the services available to them to address their needs;

(7) any guidelines or training regarding cultural and linguistic needs of covered persons that the MHCP will utilize with its own staff and providers within its network;

(8) the extent to which the MHCP contracts with community clinics and other local providers that offer linguistic and culturally appropriate services to covered persons in their areas; and

(9) physical accessibility to persons with disabilities of MHCP information and administrative services as well as the provider network.

B. A MHCP new to this state shall submit a plan for addressing cultural and linguistic diversity to the superintendent as part of its application for licensure. The plan shall address all of the factors listed Subsection A of 13.10.22.11 NMAC.

C. The superintendent shall approve or reject a plan submitted by a MHCP 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. [13.10.22.11 NMAC - Rp, 13.10.13.29 NMAC, 09/01/2009]

13.10.22.12 CONTRACTS WITH PROVIDERS IN THE STATE OF NEW MEXICO: This section shall apply only to health care professionals practicing in and health care facilities located in the state of New Mexico.

A. A health care insurer shall, either directly or indirectly, enter into contracts with participating professionals and health care facilities through which health care services are provided on a recurring basis to its covered persons. The health care insurer shall file an annual certificate with the superintendent certifying that all health care professional contracts and contracts with health care facilities located in the state of New Mexico through which health care services are being provided on a recurring basis meet the criteria of this section.

B. Each contract shall contain a description of the specific health care services for which the health care professional or health care facility will be responsible, including any limitations or conditions on such services.

C. Each contract shall contain the specific hold harmless provision specifying protection of covered persons set forth as follows: "Health care professional/health care facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall health care professional/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, covered person, or person acting on behalf of the covered person, for health care services provided pursuant to this agreement. This does not prohibit health care professional/health care facility from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

D. Each contract shall contain a provision clearly stating the rights and responsibilities of the MHCP, and of the contracted health care professionals and health care facilities, with respect to administrative policies and programs, including, but not limited to, payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

E. Each contract shall contain a provision regarding the availability and confidentiality of those health records maintained by health care professionals and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity and appropriateness of health care services provided to covered persons. The provision shall include terms requiring the health care professional or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of covered persons, and requiring the health care professional or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

F. Each contract shall provide that contractual rights and responsibilities may not be assigned or delegated by the provider without the prior written consent of the contracting MHCP.

G. Each contract shall contain a provision requiring the health care professional or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the health care

professional or health care facility to notify the health care insurer or MHCP not more than ten days after the provider's receipt of notice of any reduction or cancellation of such coverage.

H. Each contract shall require the health care professional or health care facility to observe, protect, and promote the rights of covered persons as patients.

I. Each contract shall require the health care professional or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the health care professional or health care facility appropriately does not render services due to limitations arising from the health care professional's or health care facility's lack of training, experience, or skill, or due to licensing restrictions. Each contract shall require the health care insurer or MHCP to provide interpreters for limited English proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Such interpretive services will be made available to provider's office at no cost to the provider.

J. Each contract shall contain a provision detailing the specifics of any obligation on the health care professional or health care facility to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week.

K. Each contract shall set forth procedures for the resolution of disputes arising out of the contract.

L. Each contract shall state that the hold harmless provision required by Subsection C of 13.10.22.12 NMAC shall survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health care insurer or MHCP.

M. Each contract shall provide that those terms used in the contract and that are defined by New Mexico statutes and division regulations will be used in the contract in a manner consistent with any definitions contained in said laws or regulations.

N. A health care insurer or MHCP is prohibited from including the following provisions in any of its contracts with health care professionals or health care facilities:

(1) offer an inducement, financial or otherwise, to provide less than medically necessary services to a covered person;

(2) penalize a health care professional or health care facility that assists a covered person to seek a reconsideration of the health care insurer's or MHCP's decision to deny or limit benefits to the covered person;

(3) prohibit a participating health care professional from discussing treatment options with covered persons irrespective of the health care insurer's or MHCP's position on treatment options, or from advocating on behalf of a patient or patients within the utilization review or grievance processes established by the MHCP or a person contracting with the health care insurer or MHCP;

(4) prohibit a participating health care professional from using disparaging language or making disparaging comments when referring to the health care insurer or MHCP; or

O. Each contract shall provide that a MHCP failing to pay a health care professional or failing to pay a covered person for out of pocket covered expenses within forty-five days after a clean claim has been received by the MHCP shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one half times the rate established by a bulletin entered by the superintendent in January of each calendar year. For the purposes of this section, "clean claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of the MHCP's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by the MHCP, or particular circumstances requiring special treatment that prevents timely payment from being made by the MHCP.

P. Except for the access requirements contained in 13.10.22.8 NMAC, nothing contained in this rule should be construed to either prohibit or limit a health care insurer from entering into contracts with qualified health care professionals other than allopathic physicians to provide primary care to covered persons, provided that the health care professional is acting within his or her scope of practice as defined under the relevant state licensing law.

Q. A health care insurer shall not, based upon a national policy of the insurer, uniformly reject contract terms that may be requested by New Mexico providers.

R. Retroactive adjustments by a health care insurer or MHCP for overpayment must be made within 18 months absent health care professional miscoding, claim submission error, suspected fraud and abuse; or retroactive adjustments required by other federal or state agencies.

[13.10.22.12 NMAC - Rp, 13.10.13.25 NMAC, 09/01/2009]

13.10.22.13 ADMINISTRATIVE COSTS AND BENEFIT DISCLOSURES:

A. Yearly reporting required: On a yearly basis, on or before April 15, each MHCP shall provide the superintendent with a loss ratio for individual contracts and a separate calculation for plans offered in the small group health insurance market by the MHCP. The superintendent may require that the information be prepared on a form supplied by the division.

B. Calculation of the ratio: Calculation of the loss ratio shall be based on the average of a plan's previous three years' experience. The superintendent shall apply or alter this calculation in a manner consistent with New Mexico law.

(1) If the plan has been in existence for less than three years, than the ratio shall be based on a two year past plan experience, with a statement as to the length of plan experience.

(2) If the plan has been in existence for less than two years, than the ratio shall be based on a one year past plan experience, with a statement as to the length of plan experience.

(3) If the plan is new or has been in existence less than one year, then the MHCP shall report to the superintendent a loss ratio for a similar plan with an explanation as to why that plan can be used as an estimated loss ratio for the new plan.

(4) The superintendent shall state on any materials distributed to the public the bases for the loss ratios.

(5) The superintendent shall provide notice to brokers, agents, and solicitors engaged in the sale of managed health care plans regarding the availability and use of the loss ratios for MHCPs.

(6) The superintendent may in the future require in addition to the ratio calculations, that each MHCP provide the division with sample premium costs for various plan designs, to be used by the superintendent as a guide to purchasing managed health care products in the state.

[13.10.22.13 NMAC - N, 09/01/2009]

13.10.22.14 PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

[13.10.22.14 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.22.15 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.22.15 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

HISTORY OF 13.10.22 NMAC:

Pre-NMAC History: none.

History of Repealed Material: [RESERVED]

NMAC History:

Only those applicable portions of 13.10.13 NMAC, Managed Health Care (filed 4/13/2007) were renumbered, amended, and replaced by 13.10.22 NMAC, Managed Health Care Plan Compliance, effective 09/01/2009.