

SENATE JUDICIARY COMMITTEE SUBSTITUTE FOR
SENATE BILL 220

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

AN ACT

RELATING TO MANAGED HEALTH CARE; AMENDING AND ENACTING SECTIONS
OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE
ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO
ESTABLISH PROVIDER CREDENTIALING REQUIREMENTS AND DEFINE
"CREDENTIALING"; REPEALING A SECTION OF THE NEW MEXICO
INSURANCE CODE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of Chapter 59A, Article 22 NMSA
1978 is enacted to read:

"NEW MATERIAL PROVIDER CREDENTIALING--REQUIREMENTS--
DEADLINE.--

A. The superintendent shall adopt and promulgate
rules to provide for a uniform and efficient provider
credentialing process. The rules shall establish a single

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underscored material = new
[bracketed material] = delete

1 credentialing application form for the credentialing of
2 providers.

3 B. An insurer shall not require a provider to
4 submit information not required by the uniform credentialing
5 application established pursuant to Subsection A of this
6 section.

7 C. The provisions of this section apply equally to
8 credentialing applications and applications for
9 recredentialing.

10 D. The rules that the superintendent adopts and
11 promulgates pursuant to Subsection A of this section shall
12 require primary credential verification no more frequently than
13 every three years.

14 E. The rules that the superintendent adopts and
15 promulgates pursuant to Subsection A of this section shall
16 establish that an insurer or an insurer's agent shall:

17 (1) assess and verify the qualifications of a
18 provider applying to become a participating provider within
19 forty-five calendar days of receipt of a complete credentialing
20 application and issue a decision in writing to the applicant
21 approving or denying the credentialing application; and

22 (2) within ten working days after receipt of a
23 credentialing application, send a written notification, via
24 United States certified mail, to the applicant requesting any
25 information or supporting documentation that the insurer

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1 requires to approve or deny the credentialing application. The
2 notice to the applicant shall include a complete and detailed
3 description of all of the information or supporting
4 documentation required and the name, address and telephone
5 number of a person who serves as the applicant's point of
6 contact for completing the credentialing application process.
7 Any information required pursuant to this section shall be
8 reasonably related to the information in the application.

9 F. Except as provided pursuant to Subsection G of
10 this section, an insurer shall reimburse a provider for covered
11 health care services, in accordance with the carrier's standard
12 reimbursement rate, for any claims from the provider that the
13 insurer receives with a date of service more than forty-five
14 calendar days after the date on which the insurer received a
15 credentialing application for that provider; provided that:

16 (1) the provider has submitted a complete
17 credentialing application and any supporting documentation that
18 the insurer has requested in writing within the time frame
19 established in Paragraph (2) of Subsection E of this section;

20 (2) the insurer has failed to approve or deny
21 the applicant's credentialing application within the time frame
22 established pursuant to Paragraph (1) of Subsection E of this
23 section;

24 (3) the provider has no past or current
25 license sanctions or limitations, as reported by the New Mexico

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1 medical board or another pertinent licensing and regulatory
2 agency, or by a similar out-of-state licensing and regulatory
3 entity for a provider licensed in another state; and

4 (4) the provider has professional liability
5 insurance or is covered under the Medical Malpractice Act.

6 G. In cases where a provider is joining an existing
7 practice or group that has contracted reimbursement rates with
8 an insurer, the insurer shall pay the provider in accordance
9 with the terms of that contract.

10 H. The superintendent shall adopt and promulgate
11 rules to provide for the resolution of disputes relating to
12 reimbursement and credentialing arising in cases where
13 credentialing is delayed beyond forty-five days after
14 application.

15 I. An insurer shall reimburse a provider pursuant
16 to the circumstances set forth in Subsection F of this section
17 until the earlier of the following occurs:

18 (1) the insurer's approval or denial of the
19 provider's credentialing application; or

20 (2) the passage of three years from the date
21 the carrier received the provider's credentialing application.

22 J. A dispute between a provider and an insurer
23 regarding credentialing or recredentialing shall be governed by
24 Section 59A-57-6 NMSA 1978.

25 K. As used in this section:

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underscored material = new
~~[bracketed material] = delete~~

1 (1) "credentialing" means the process of
2 obtaining and verifying information about a provider and
3 evaluating that provider when that provider seeks to become a
4 participating provider; and

5 (2) "provider" means a physician or other
6 individual licensed or otherwise authorized to furnish health
7 care services in the state."

8 SECTION 2. A new section of Chapter 59A, Article 23 NMSA
9 1978 is enacted to read:

10 "NEW MATERIAL PROVIDER CREDENTIALING--REQUIREMENTS--
11 DEADLINE.--

12 A. The superintendent shall adopt and promulgate
13 rules to provide for a uniform and efficient provider
14 credentialing process. The rules shall establish a single
15 credentialing application form for the credentialing of
16 providers.

17 B. An insurer shall not require a provider to
18 submit information not required by the uniform credentialing
19 application established pursuant to Subsection A of this
20 section.

21 C. The provisions of this section apply equally to
22 credentialing applications and applications for
23 recredentialing.

24 D. The rules that the superintendent adopts and
25 promulgates pursuant to Subsection A of this section shall

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1 require primary credential verification no more frequently than
2 every three years.

3 E. The rules that the superintendent adopts and
4 promulgates pursuant to Subsection A of this section shall
5 establish that an insurer or an insurer's agent shall:

6 (1) assess and verify the qualifications of a
7 provider applying to become a participating provider within
8 forty-five calendar days of receipt of a complete credentialing
9 application and issue a decision in writing to the applicant
10 approving or denying the credentialing application; and

11 (2) within ten working days after receipt of a
12 credentialing application, send a written notification, via
13 United States certified mail, to the applicant requesting any
14 information or supporting documentation that the insurer
15 requires to approve or deny the credentialing application. The
16 notice to the applicant shall include a complete and detailed
17 description of all of the information or supporting
18 documentation required and the name, address and telephone
19 number of a person who serves as the applicant's point of
20 contact for completing the credentialing application process.
21 Any information required pursuant to this section shall be
22 reasonably related to the information in the application.

23 F. Except as provided pursuant to Subsection G of
24 this section, an insurer shall reimburse a provider for covered
25 health care services, in accordance with the carrier's standard

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1 reimbursement rate, for any claims from the provider that the
2 insurer receives with a date of service more than forty-five
3 calendar days after the date on which the insurer received a
4 credentialing application for that provider; provided that:

5 (1) the provider has submitted a complete
6 credentialing application and any supporting documentation that
7 the insurer has requested in writing within the time frame
8 established in Paragraph (2) of Subsection E of this section;

9 (2) the insurer has failed to approve or deny
10 the applicant's credentialing application within the time frame
11 established pursuant to Paragraph (1) of Subsection E of this
12 section;

13 (3) the provider has no past or current
14 license sanctions or limitations, as reported by the New Mexico
15 medical board or another pertinent licensing and regulatory
16 agency, or by a similar out-of-state licensing and regulatory
17 entity for a provider licensed in another state; and

18 (4) the provider has professional liability
19 insurance or is covered under the Medical Malpractice Act.

20 G. In cases where a provider is joining an existing
21 practice or group that has contracted reimbursement rates with
22 an insurer, the insurer shall pay the provider in accordance
23 with the terms of that contract.

24 H. The superintendent shall adopt and promulgate
25 rules to provide for the resolution of disputes relating to

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underscored material = new
~~[bracketed material] = delete~~

1 reimbursement and credentialing arising in cases where
2 credentialing is delayed beyond forty-five days after
3 application.

4 I. An insurer shall reimburse a provider pursuant
5 to the circumstances set forth in Subsection F of this section
6 until the earlier of the following occurs:

7 (1) the insurer's approval or denial of the
8 provider's credentialing application; or

9 (2) the passage of three years from the date
10 the carrier received the provider's credentialing application.

11 J. A dispute between a provider and an insurer
12 regarding credentialing or recredentialing shall be governed by
13 Section 59A-57-6 NMSA 1978.

14 K. As used in this section:

15 (1) "credentialing" means the process of
16 obtaining and verifying information about a provider and
17 evaluating that provider when that provider seeks to become a
18 participating provider; and

19 (2) "provider" means a physician or other
20 individual licensed or otherwise authorized to furnish health
21 care services in the state."

22 **SECTION 3.** Section 59A-46-2 NMSA 1978 (being Laws 1993,
23 Chapter 266, Section 2, as amended) is amended to read:

24 "59A-46-2. DEFINITIONS.--As used in the Health
25 Maintenance Organization Law:

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1 A. "basic health care services":

2 (1) means medically necessary services
3 consisting of preventive care, emergency care, inpatient and
4 outpatient hospital and physician care, diagnostic laboratory,
5 diagnostic and therapeutic radiological services and services
6 of pharmacists and pharmacist clinicians; but

7 (2) does not include mental health services or
8 services for alcohol or drug abuse, dental or vision services
9 or long-term rehabilitation treatment;

10 B. "capitated basis" means fixed per member per
11 month payment or percentage of premium payment wherein the
12 provider assumes the full risk for the cost of contracted
13 services without regard to the type, value or frequency of
14 services provided and includes the cost associated with
15 operating staff model facilities;

16 C. "carrier" means a health maintenance
17 organization, an insurer, a nonprofit health care plan or other
18 entity responsible for the payment of benefits or provision of
19 services under a group contract;

20 D. "copayment" means an amount an enrollee must pay
21 in order to receive a specific service that is not fully
22 prepaid;

23 E. "credentialing" means the process of obtaining
24 and verifying information about a provider and evaluating that
25 provider when that provider seeks to become a participating

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1 provider;

2 ~~[E.]~~ F. "deductible" means the amount an enrollee
3 is responsible to pay out-of-pocket before the health
4 maintenance organization begins to pay the costs associated
5 with treatment;

6 ~~[F.]~~ G. "enrollee" means an individual who is
7 covered by a health maintenance organization;

8 ~~[G.]~~ H. "evidence of coverage" means a policy,
9 contract or certificate showing the essential features and
10 services of the health maintenance organization coverage that
11 is given to the subscriber by the health maintenance
12 organization or by the group contract holder;

13 ~~[H.]~~ I. "extension of benefits" means the
14 continuation of coverage under a particular benefit provided
15 under a contract or group contract following termination with
16 respect to an enrollee who is totally disabled on the date of
17 termination;

18 ~~[I.]~~ J. "grievance" means a written complaint
19 submitted in accordance with the health maintenance
20 organization's formal grievance procedure by or on behalf of
21 the enrollee regarding any aspect of the health maintenance
22 organization relative to the enrollee;

23 ~~[J.]~~ K. "group contract" means a contract for
24 health care services that by its terms limits eligibility to
25 members of a specified group and may include coverage for

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1 dependents;

2 ~~[K.]~~ L. "group contract holder" means the person to
3 whom a group contract has been issued;

4 ~~[H.]~~ M. "health care services" means any services
5 included in the furnishing to any individual of medical,
6 mental, dental, pharmaceutical or optometric care or
7 hospitalization or nursing home care or incident to the
8 furnishing of such care or hospitalization, as well as the
9 furnishing to any person of any and all other services for the
10 purpose of preventing, alleviating, curing or healing human
11 physical or mental illness or injury;

12 ~~[M.]~~ N. "health maintenance organization" means any
13 person who undertakes to provide or arrange for the delivery of
14 basic health care services to enrollees on a prepaid basis,
15 except for enrollee responsibility for copayments or
16 deductibles;

17 ~~[N.]~~ O. "health maintenance organization agent"
18 means a person who solicits, negotiates, effects, procures,
19 delivers, renews or continues a policy or contract for health
20 maintenance organization membership or who takes or transmits a
21 membership fee or premium for such a policy or contract, other
22 than for ~~[himself]~~ that person, or a person who advertises or
23 otherwise ~~[holds himself out]~~ makes any representation to the
24 public as such;

25 ~~[O.]~~ P. "individual contract" means a contract for

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1 health care services issued to and covering an individual and
2 it may include dependents of the subscriber;

3 [P-] Q. "insolvent" or "insolvency" means that the
4 organization has been declared insolvent and placed under an
5 order of liquidation by a court of competent jurisdiction;

6 [Q-] R. "managed hospital payment basis" means
7 agreements in which the financial risk is related primarily to
8 the degree of utilization rather than to the cost of services;

9 [R-] S. "net worth" means the excess of total
10 admitted assets over total liabilities, but the liabilities
11 shall not include fully subordinated debt;

12 [S-] T. "participating provider" means a provider
13 as defined in Subsection [U] X of this section who, under an
14 express contract with the health maintenance organization or
15 with its contractor or subcontractor, has agreed to provide
16 health care services to enrollees with an expectation of
17 receiving payment, other than copayment or deductible, directly
18 or indirectly from the health maintenance organization;

19 [T-] U. "person" means an individual or other legal
20 entity;

21 V. "pharmacist" means a person licensed as a
22 pharmacist pursuant to the Pharmacy Act;

23 W. "pharmacist clinician" means a pharmacist who
24 exercises prescriptive authority pursuant to the Pharmacist
25 Prescriptive Authority Act;

1 ~~[U.]~~ X. "provider" means a physician, pharmacist,
2 pharmacist clinician, hospital or other person licensed or
3 otherwise authorized to furnish health care services;

4 ~~[V.]~~ Y. "replacement coverage" means the benefits
5 provided by a succeeding carrier;

6 ~~[W.]~~ Z. "subscriber" means an individual whose
7 employment or other status, except family dependency, is the
8 basis for eligibility for enrollment in the health maintenance
9 organization or, in the case of an individual contract, the
10 person in whose name the contract is issued; and

11 ~~[X.]~~ AA. "uncovered expenditures" means the costs
12 to the health maintenance organization for health care services
13 that are the obligation of the health maintenance organization,
14 for which an enrollee may also be liable in the event of the
15 health maintenance organization's insolvency and for which no
16 alternative arrangements have been made that are acceptable to
17 the superintendent

18 ~~[Y. "pharmacist" means a person licensed as a
19 pharmacist pursuant to the Pharmacy Act; and~~

20 ~~Z. "pharmacist clinician" means a pharmacist who
21 exercises prescriptive authority pursuant to the Pharmacist
22 Prescriptive Authority Act]."~~

23 **SECTION 4.** A new section of the Health Maintenance
24 Organization Law is enacted to read:

25 "[NEW MATERIAL] PROVIDER CREDENTIALING--REQUIREMENTS--

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1 DEADLINE.--

2 A. The superintendent shall adopt and promulgate
3 rules to provide for a uniform and efficient provider
4 credentialing process. The rules shall establish a single
5 credentialing application form for the credentialing of
6 providers.

7 B. A carrier shall not require a provider to submit
8 information not required by the uniform credentialing
9 application established pursuant to Subsection A of this
10 section.

11 C. The provisions of this section apply equally to
12 credentialing applications and applications for
13 recredentialing.

14 D. The rules that the superintendent adopts and
15 promulgates pursuant to Subsection A of this section shall
16 require primary credential verification no more frequently than
17 every three years.

18 E. The rules that the superintendent adopts and
19 promulgates pursuant to Subsection A of this section shall
20 establish that a carrier or a carrier's agent shall:

21 (1) assess and verify the qualifications of a
22 provider applying to become a participating provider within
23 forty-five calendar days of receipt of a complete credentialing
24 application and issue a decision in writing to the applicant
25 approving or denying the credentialing application; and

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1 (2) within ten working days after receipt of a
2 credentialing application, send a written notification, via
3 United States certified mail, to the applicant requesting any
4 information or supporting documentation that the carrier
5 requires to approve or deny the credentialing application. The
6 notice to the applicant shall include a complete and detailed
7 description of all of the information or supporting
8 documentation required and the name, address and telephone
9 number of a person who serves as the applicant's point of
10 contact for completing the credentialing application process.
11 Any information required pursuant to this section shall be
12 reasonably related to the information in the application.

13 F. Except as provided pursuant to Subsection G of
14 this section, a carrier shall reimburse a provider for covered
15 health care services, in accordance with the carrier's standard
16 reimbursement rate, for any claims from the provider that the
17 carrier receives with a date of service more than forty-five
18 calendar days after the date on which the carrier received a
19 credentialing application for that provider; provided that:

20 (1) the provider has submitted a complete
21 credentialing application and any supporting documentation that
22 the carrier has requested in writing within the time frame
23 established in Paragraph (2) of Subsection E of this section;

24 (2) the carrier has failed to approve or deny
25 the applicant's credentialing application within the time frame

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1 established pursuant to Paragraph (1) of Subsection E of this
2 section;

3 (3) the provider has no past or current
4 license sanctions or limitations, as reported by the New Mexico
5 medical board or another pertinent licensing and regulatory
6 agency, or by a similar out-of-state licensing and regulatory
7 entity for a provider licensed in another state; and

8 (4) the provider has professional liability
9 insurance or is covered under the Medical Malpractice Act.

10 G. In cases where a provider is joining an existing
11 practice or group that has contracted reimbursement rates with
12 a carrier, the carrier shall pay the provider in accordance
13 with the terms of that contract.

14 H. The superintendent shall adopt and promulgate
15 rules to provide for the resolution of disputes relating to
16 reimbursement and credentialing arising in cases where
17 credentialing is delayed beyond forty-five days after
18 application.

19 I. A carrier shall reimburse a provider pursuant to
20 the circumstances set forth in Subsection F of this section
21 until the earlier of the following occurs:

22 (1) the carrier's approval or denial of the
23 provider's credentialing application; or

24 (2) the passage of three years from the date
25 the carrier received the provider's credentialing application.

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1 J. A dispute between a provider and a carrier
2 regarding credentialing or recredentialing shall be governed by
3 Section 59A-57-6 NMSA 1978."

4 SECTION 5. Section 59A-47-3 NMSA 1978 (being Laws 1984,
5 Chapter 127, Section 879.1, as amended) is amended to read:

6 "59A-47-3. DEFINITIONS.--As used in Chapter 59A, Article
7 47 NMSA 1978:

8 A. "health care" means the treatment of persons for
9 the prevention, cure or correction of any illness or physical
10 or mental condition, including optometric services;

11 B. "item of health care" includes any services or
12 materials used in health care;

13 C. "health care expense payment" means a payment
14 for health care to a purveyor on behalf of a subscriber, or
15 such a payment to the subscriber;

16 D. "purveyor" means a person who furnishes any item
17 of health care and charges for that item;

18 E. "service benefit" means a payment that the
19 purveyor has agreed to accept as payment in full for health
20 care furnished the subscriber;

21 F. "indemnity benefit" means a payment that the
22 purveyor has not agreed to accept as payment in full for health
23 care furnished the subscriber;

24 G. "subscriber" means any individual who, because
25 of a contract with a health care plan entered into by or for

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1 the individual, is entitled to have health care expense
2 payments made on the individual's behalf or to the individual
3 by the health care plan;

4 H. "underwriting manual" means the health care
5 plan's written criteria, approved by the superintendent, that
6 defines the terms and conditions under which subscribers may be
7 selected. The underwriting manual may be amended from time to
8 time, but amendment will not be effective until approved by the
9 superintendent. The superintendent shall notify the health
10 care plan filing the underwriting manual or the amendment
11 thereto of the superintendent's approval or disapproval thereof
12 in writing within thirty days after filing or within sixty days
13 after filing if the superintendent shall so extend the time.
14 If the superintendent fails to act within such period, the
15 filing shall be deemed to be approved;

16 I. "acquisition expenses" includes all expenses
17 incurred in connection with the solicitation and enrollment of
18 subscribers;

19 J. "administration expenses" means all expenses of
20 the health care plan other than the cost of health care expense
21 payments and acquisition expenses;

22 K. "health care plan" means a nonprofit corporation
23 authorized by the superintendent to enter into contracts with
24 subscribers and to make health care expense payments;

25 L. "agent" means a person appointed by a health

1 care plan authorized to transact business in this state to act
2 as its representative in any given locality for soliciting
3 health care policies and other related duties as may be
4 authorized;

5 M. "solicitor" means a person employed by the
6 licensed agent of a health care plan for the purpose of
7 soliciting health care policies and other related duties in
8 connection with the handling of the business of the agent as
9 may be authorized and paid for the person's services either on
10 a commission basis or salary basis or part by commission and
11 part by salary;

12 N. "chiropractor" means any person holding a
13 license provided for in the Chiropractic Physician Practice
14 Act;

15 O. "doctor of oriental medicine" means any person
16 licensed as a doctor of oriental medicine under the Acupuncture
17 and Oriental Medicine Practice Act;

18 P. "pharmacist" means a person licensed as a
19 pharmacist pursuant to the Pharmacy Act; ~~and~~

20 Q. "pharmacist clinician" means a pharmacist who
21 exercises prescriptive authority pursuant to the Pharmacist
22 Prescriptive Authority Act;

23 R. "credentialing" means the process of obtaining
24 and verifying information about a provider and evaluating that
25 provider when that provider seeks to become a participating

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1 provider; and

2 S. "provider" means a physician or other individual
3 licensed or otherwise authorized to furnish health care
4 services in the state."

5 SECTION 6. A new section of Chapter 59A, Article 47 NMSA
6 1978 is enacted to read:

7 "[NEW MATERIAL] PROVIDER CREDENTIALING--REQUIREMENTS--
8 DEADLINE.--

9 A. The superintendent shall adopt and promulgate
10 rules to provide for a uniform and efficient provider
11 credentialing process. The rules shall establish a single
12 credentialing application form for the credentialing of
13 providers.

14 B. A health care plan shall not require a provider
15 to submit information not required by the uniform credentialing
16 application established pursuant to Subsection A of this
17 section.

18 C. The provisions of this section apply equally to
19 credentialing applications and applications for
20 recredentialing.

21 D. The rules that the superintendent adopts and
22 promulgates pursuant to Subsection A of this section shall
23 require primary credential verification no more frequently than
24 every three years.

25 E. The rules that the superintendent adopts and

1 promulgates pursuant to Subsection A of this section shall
2 establish that a health care plan or a health care plan's agent
3 shall:

4 (1) assess and verify the qualifications of a
5 provider applying to become a participating provider within
6 forty-five calendar days of receipt of a complete credentialing
7 application and issue a decision in writing to the applicant
8 approving or denying the credentialing application; and

9 (2) within ten working days after receipt of a
10 credentialing application, send a written notification, via
11 United States certified mail, to the applicant requesting any
12 information or supporting documentation that the insurer
13 requires to approve or deny the credentialing application. The
14 notice to the applicant shall include a complete and detailed
15 description of all of the information or supporting
16 documentation required and the name, address and telephone
17 number of a person who serves as the applicant's point of
18 contact for completing the credentialing application process.
19 Any information required pursuant to this section shall be
20 reasonably related to the information in the application.

21 F. Except as provided pursuant to Subsection G of
22 this section, a health care plan shall reimburse a provider for
23 covered health care services, in accordance with the carrier's
24 standard reimbursement rate, for any claims from the provider
25 that the insurer receives with a date of service more than

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1 forty-five calendar days after the date on which the insurer
2 received a credentialing application for that provider;
3 provided that:

4 (1) the provider has submitted a complete
5 credentialing application and any supporting documentation that
6 the insurer has requested in writing within the time frame
7 established in Paragraph (2) of Subsection E of this section;

8 (2) the insurer has failed to approve or deny
9 the applicant's credentialing application within the time frame
10 established pursuant to Paragraph (1) of Subsection E of this
11 section;

12 (3) the provider has no past or current
13 license sanctions or limitations, as reported by the New Mexico
14 medical board or another pertinent licensing and regulatory
15 agency, or by a similar out-of-state licensing and regulatory
16 entity for a provider licensed in another state; and

17 (4) the provider has professional liability
18 insurance or is covered under the Medical Malpractice Act.

19 G. In cases where a provider is joining an existing
20 practice or group that has contracted reimbursement rates with
21 a health care plan, the insurer shall pay the provider in
22 accordance with the terms of that contract.

23 H. The superintendent shall adopt and promulgate
24 rules to provide for the resolution of disputes relating to
25 reimbursement and credentialing arising in cases where

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1 credentialing is delayed beyond forty-five days after
2 application.

3 I. A health care plan shall reimburse a provider
4 pursuant to the circumstances set forth in Subsection F of this
5 section until the earlier of the following occurs:

6 (1) the insurer's approval or denial of the
7 provider's credentialing application; or

8 (2) the passage of three years from the date
9 the carrier received the provider's credentialing application.

10 J. A dispute between a provider and a health care
11 plan regarding credentialing or recredentialing shall be
12 governed by Section 59A-57-6 NMSA 1978."

13 SECTION 7. REPEAL.--Section 59A-2-9.5 NMSA 1978 (being
14 Laws 2003, Chapter 235, Section 3) is repealed.