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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credentialing application form for the credentialing of providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. As used in this section:

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

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

SECTION 2. A new section of Chapter 59A, Article 23 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 credentialing application form for the credentialing of providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. As used in this section:

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

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

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

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

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A. "basic health care services":

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

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

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

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

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

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

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provider;

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

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

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

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

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

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

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dependents;

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

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

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

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

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

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

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

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

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

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

[~~T.~~] U. "person" means an individual or other legal entity;

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

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

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

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

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

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

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

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

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

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

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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 credentialing application form for the credentialing of providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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provider; and

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

SECTION 6. A new section of Chapter 59A, Article 47 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 credentialing application form for the credentialing of providers.

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

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

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

E. The rules that the superintendent adopts and

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

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

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

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

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

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

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

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

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

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

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

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credentialing is delayed beyond forty-five days after application.

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

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

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

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

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

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