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SENATE BILL

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO MANAGED HEALTH CARE; ENACTING THE HEALTH CARE PROVIDER PROTECTION ACT; PROVIDING PROTECTIONS FOR HEALTH CARE PROVIDERS WORKING WITH MANAGED HEALTH CARE PLANS; ESTABLISHING PROVIDER REIMBURSEMENT PROCEDURES FOR MANAGED HEALTH CARE PLANS; LIMITING RECOUPMENT REQUESTS BY MANAGED HEALTH CARE PLANS; REQUIRING MANAGED HEALTH CARE PLANS TO PROVIDE TECHNICAL ASSISTANCE AND TRAINING AND EDUCATIONAL PROGRAMS TO PROVIDERS; PROVIDING CREDENTIALING AND RECREDENTIALING PROCESSES FOR HEALTH CARE PROVIDERS WORKING WITH MANAGED HEALTH CARE PLANS; ENACTING THE MANAGED HEALTH CARE OMBUDSMAN ACT; CREATING A MANAGED HEALTH CARE OMBUDSMAN OFFICE; ENACTING SECTIONS OF THE NMSA 1978.

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

SECTION 1. SHORT TITLE.--Sections 1 through 7 of this act

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1 may be cited as the "Health Care Provider Protection Act".

2 SECTION 2. DEFINITIONS.--As used in the Health Care
3 Provider Protection Act:

4 A. "covered person" or "patient" means an
5 individual who is entitled to receive health care benefits
6 provided by a managed health care plan;

7 B. "division" means the insurance division of the
8 public regulation commission;

9 C. "health care facility" means an institution
10 providing health care services, including a hospital or other
11 licensed inpatient center; an ambulatory surgical or treatment
12 center; a skilled nursing center; a residential treatment
13 center; a home health agency; a laboratory; a diagnostic or
14 imaging center; and a rehabilitation or other therapeutic
15 health setting;

16 D. "health care insurer" means a person that has a
17 valid certificate of authority in good standing under the New
18 Mexico Insurance Code to act as an insurer, health maintenance
19 organization, nonprofit health care plan or prepaid dental
20 plan;

21 E. "health care professional" means a physician or
22 other health care practitioner, including a pharmacist, a
23 certified nurse practitioner in advanced practice as provided
24 in Sections 61-3-23.2 through 61-3-23.4 NMSA 1978 and a
25 certified nurse midwife, who is licensed, certified or

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1 otherwise authorized by the state to provide health care
2 services consistent with state law;

3 F. "health care provider" or "provider" means a
4 person that is licensed or otherwise authorized by the state to
5 furnish health care services and includes health care
6 professionals and health care facilities;

7 G. "managed health care plan" or "plan" means a
8 health care insurer or a provider service network that, when
9 offering a benefit, either requires a covered person to use or
10 creates incentives, including financial incentives, for a
11 covered person to use health care providers managed, owned,
12 under contract with or employed by the health care insurer or
13 provider service network, including networks offering medicaid
14 services. "Managed health care plan" or "plan" does not
15 include a health care insurer or provider service network
16 offering a traditional fee-for-service indemnity benefit or a
17 benefit that covers only short-term travel, accident-only,
18 limited benefit or specified disease policies; or student
19 health plans;

20 H. "person" means an individual or other legal
21 entity;

22 I. "provider service network" means two or more
23 health care providers affiliated for the purpose of providing
24 health care services to covered persons on a capitated or
25 similar prepaid flat-rate basis that hold a certificate

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1 authority pursuant to the Provider Service Network Act;

2 J. "reimbursement recoupment" means a managed
3 health care plan's request to a health care provider for
4 repayment of claim payments paid to the provider for a patient
5 later deemed ineligible for plan benefits;

6 K. "superintendent" means the superintendent of
7 insurance;

8 L. "uniform credentialing form" means a
9 credentialing or recredentialing form issued either by the New
10 Mexico hospital services corporation or the council for
11 affordable quality healthcare; and

12 M. "utilization review" means a system for
13 reviewing the appropriate and efficient allocation of health
14 care services given or proposed to be given to a patient or
15 group of patients.

16 SECTION 3. REIMBURSEMENT FROM A MANAGED HEALTH CARE
17 PLAN--SERVICES RENDERED.--

18 A. A managed health care plan shall make a
19 reimbursement determination in a timely manner as required by
20 the exigencies of the situation and in accordance with sound
21 medical principles. Such determination shall not exceed
22 twenty-four hours for emergency care and seven days for all
23 other determinations. If the plan is unable to make a
24 reimbursement determination within ten days, the plan shall
25 notify the provider in writing about the reasons for the delay

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1 and when a decision may be expected.

2 B. All reimbursement requests to a managed health
3 care plan are governed by the provisions of Section 59A-16-21.1
4 NMSA 1978.

5 C. At least quarterly, a managed health care plan
6 shall provide a report to health care providers that have
7 submitted claims for reimbursement for services provided to
8 covered persons during the quarter, listing any reimbursement
9 request that did not qualify as a "clean claim", as that term
10 is defined in Subsection A of Section 59A-16-21.1 NMSA 1978.
11 The managed health care plan shall list the reasons that the
12 claim did not qualify as a clean claim and provide a contact
13 number for the provider to call to receive assistance in
14 qualifying the claim.

15 SECTION 4. REIMBURSEMENT RECOUPMENT FROM HEALTH CARE
16 PROVIDERS BY MANAGED HEALTH CARE PLAN.--

17 A. A managed health care plan shall not request
18 reimbursement recoupment for a covered health care service
19 provided to a covered person by a provider who relied upon the
20 verbal or written authorization of the plan prior to providing
21 the service to the covered person, except in those cases where
22 there was material misrepresentation or fraud.

23 B. When requesting reimbursement recoupment from a
24 health care provider, a managed health care plan shall:

- 25 (1) submit one reimbursement recoupment

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1 request per individual claim to the health care provider;

2 (2) notify the provider in writing, separate
3 and apart from the plan's benefits and claim summary, of the
4 reason that the plan is seeking reimbursement recoupment and of
5 the patient's coverage under the plan; and

6 (3) allow the provider an opportunity to
7 dispute the reimbursement recoupment request in accordance with
8 the process outlined in Section 7 of this act.

9 C. A managed health care plan shall not request
10 reimbursement recoupment from a health care provider for a
11 claim more than twelve months from the date the claim was
12 submitted to the plan by the provider.

13 D. A managed health care plan shall notify a health
14 care provider of any condition affecting payment for health
15 care services under the plan within fifteen calendar days of
16 the determination by the plan of such condition and shall
17 provide a copy of the letter to the covered person under the
18 plan.

19 E. A managed health care plan shall not seek
20 reimbursement recoupment from a health care provider if the
21 plan erroneously assigns benefits and pays for health care
22 services to a covered person that are not part of the plan.

23 F. The provisions of this section shall apply to
24 contracts between a managed health care plan and a health care
25 provider entered into after July 1, 2011.

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1 SECTION 5. TECHNICAL ASSISTANCE FOR HEALTH CARE

2 PROVIDERS--TRAINING AND EDUCATION.--

3 A. Each managed health care plan shall establish a
4 technical assistance program to provide training for health
5 care providers in using information technology pursuant to plan
6 requirements.

7 B. At the managed health care plan's expense, each
8 plan shall provide administrative and financial training and
9 educational programs related to the plan's administrative and
10 financial procedures to health care providers. The plan shall
11 offer providers training and educational programs at least
12 quarterly in several locations around the state.

13 C. If a dispute arises between a health care
14 provider and a managed health care plan over the provisions of
15 this section, either party may ask the superintendent to review
16 the matter and issue a decision.

17 D. The superintendent shall promulgate rules to
18 implement this section.

19 SECTION 6. HEALTH CARE PROVIDER CREDENTIALING AND
20 RE-CREDENTIALING.--

21 A. For health care provider credentialing or
22 recredentialing, a managed health care plan shall use uniform
23 credentialing forms. The forms may be used in electronic or
24 paper format. A plan shall not require a provider to submit
25 information not required by the uniform credentialing forms.

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1 B. Except as otherwise provided in this section, a
2 managed health care plan shall assess and verify the
3 qualifications of a health care provider within forty-five
4 calendar days of receipt of a complete uniform credentialing
5 form.

6 C. For all health care providers with no past or
7 current license sanctions, as reported by the New Mexico
8 medical board or other pertinent licensing and governing
9 agencies, or by similar out-of-state entities for providers
10 licensed in other states, a managed health care plan shall
11 assess and verify the qualifications of the provider within
12 thirty calendar days of receipt of a complete uniform
13 credentialing form. Providers with no past or current license
14 sanctions shall be reimbursed for all services provided to a
15 covered person during the thirty-day verification period,
16 unless the plan determines that the provider does not meet all
17 of the credentialing requirements.

18 D. Within ten business days of receipt of an
19 incomplete uniform credentialing form from a health care
20 provider, the managed health care plan shall notify the
21 provider in writing, by certified mail, of all missing or
22 incomplete information or supporting documents. The notice
23 shall include a complete and detailed description of all of the
24 missing or incomplete information or supporting documents and
25 the name, address and telephone number of a credentialing staff

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1 person who will serve as the contact person for the provider.

2 E. A managed health care plan shall notify a health
3 care provider that recredentialing is required at least one
4 hundred twenty calendar days prior to the recredentialing
5 deadline. The credentialing requirements of this section apply
6 equally to applications for recredentialing.

7 F. Any dispute between a health care provider and
8 managed health care plan regarding credentialing or
9 recredentialing shall be governed by the process set forth in
10 Section 7 of this act.

11 SECTION 7. GRIEVANCE PROCEDURE FOR HEALTH CARE
12 PROVIDERS.--

13 A. A managed health care plan shall adopt and
14 implement a process pursuant to which a health care provider
15 may raise with the plan concerns regarding the credentialing
16 and recredentialing process, the provider's reimbursement
17 request or the plan's reimbursement recoupment request. The
18 process shall include, at a minimum, the right of the provider
19 to present the provider's concerns to a plan committee
20 responsible for the substantive area addressed by the concern
21 and the assurance that the concern will be conveyed to the
22 plan's governing body. In addition, a plan shall adopt and
23 implement a fair hearing procedure that permits a provider to
24 dispute the existence of adequate cause to terminate the
25 provider's participation with the plan due to conflicts over

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1 credentialing, recredentialing, provider reimbursement requests
2 or plan reimbursement recoupment requests. This grievance and
3 hearing procedure may be combined with requirements of Section
4 59A-57-6 NMSA 1978.

5 B. If a dispute arises between a health care
6 provider and a managed health care plan over the provisions of
7 this section or Section 59A-57-6 NMSA 1978, either party may
8 ask the superintendent to review the matter and issue a
9 decision.

10 C. The superintendent shall promulgate rules to
11 implement this section.

12 SECTION 8. SHORT TITLE.--Sections 8 through 16 of this
13 act may be cited as the "Managed Health Care Ombudsman Act".

14 SECTION 9. DEFINITIONS.--As used in the Managed Health
15 Care Ombudsman Act:

16 A. "division" means the insurance division of the
17 public regulation commission;

18 B. "health care facility" means an institution
19 providing health care services, including a hospital or other
20 licensed inpatient center; an ambulatory surgical or treatment
21 center; a skilled nursing center; a residential treatment
22 center; a home health agency; a laboratory; a diagnostic or
23 imaging center; and a rehabilitation or other therapeutic
24 health setting;

25 C. "health care insurer" means a person that has a

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1 valid certificate of authority in good standing pursuant to the
2 New Mexico Insurance Code to act as an insurer, health
3 maintenance organization, nonprofit health care plan or prepaid
4 dental plan;

5 D. "health care professional" means a physician or
6 other health care practitioner, including a pharmacist,
7 certified nurse practitioner in advanced practice as provided
8 in Sections 61-3-23.2 through 61-3-23.4 NMSA 1978 and certified
9 nurse midwife, who is licensed, certified or otherwise
10 authorized by the state to provide health care services
11 consistent with state law;

12 E. "health care provider" or "provider" means a
13 person that is licensed or otherwise authorized by the state to
14 furnish health care services and includes health care
15 professionals and health care facilities;

16 F. "managed health care plan" or "plan" means a
17 health care insurer or a provider service network that, when
18 offering a benefit, either requires a covered person to use or
19 creates incentives, including financial incentives, for a
20 covered person to use, health care providers managed, owned,
21 under contract with or employed by the health care insurer or
22 provider service network, including networks offering medicaid
23 services. "Managed health care plan" or "plan" does not
24 include a health care insurer or provider service network
25 offering a traditional fee-for-service indemnity benefit or a

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1 benefit that covers only short-term travel, accident-only,
2 limited benefit or specified disease policies; or student
3 health plans;

4 G. "ombudsman program" means the ombudsman program
5 created by the Managed Health Care Ombudsman Act or any
6 authorized representative of that program;

7 H. "patient" means an individual who is entitled to
8 receive health care benefits provided by a managed health care
9 plan;

10 I. "serious mental illness" means a diagnosable
11 disorder of a person's emotional process, thoughts or cognition
12 resulting in functional impairment that substantially
13 interferes with or limits one or more major life activities,
14 but "serious mental illness" does not mean a developmental
15 disability; and

16 J. "superintendent" means the superintendent of
17 insurance.

18 SECTION 10. MANAGED HEALTH CARE OMBUDSMAN OFFICE.--

19 A. The division shall establish and operate a
20 "managed health care ombudsman office".

21 B. The superintendent shall designate the managed
22 health care ombudsman.

23 C. The ombudsman shall serve on a full-time basis
24 and shall, personally or through representatives of the office:

25 (1) identify, investigate and resolve

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1 complaints by patients and health care providers as they relate
2 to the patients' and health care providers' rights as set forth
3 in the Patient Protection Act and the Health Care Provider
4 Protection Act;

5 (2) work with each managed health care plan's
6 consumer assistance office, evaluate the effectiveness of the
7 plan's consumer assistance office and require the plan's
8 consumer assistance office to adopt measures to ensure that the
9 plan operates effectively to protect both patients' and health
10 care providers' rights under the Patient Protection Act and the
11 Health Care Provider Protection Act;

12 (3) attempt to resolve disputes through
13 advice, counseling, negotiation or other informal strategies,
14 if possible, before proceeding to formal administrative
15 remedies. Formal administrative remedies shall be pursued
16 before litigation is initiated, but the requirements of this
17 paragraph do not apply when, in the judgment of the ombudsman,
18 the medical or other exigencies of the case require expedited
19 action to prevent harm to the patient;

20 (4) research and identify ways to improve
21 treatment of persons who are covered by a managed health care
22 plan and are diagnosed with serious mental illness, including
23 providing ongoing training, education and support to health
24 care providers who provide health care services to such
25 persons; and

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- 1 (5) prepare an annual report that:
- 2 (a) describes the activities carried out
- 3 by the office in the year for which the report is prepared;
- 4 (b) contains and analyzes data
- 5 collected;
- 6 (c) evaluates the problems experienced
- 7 by and the complaints made by or on behalf of patients and
- 8 health care providers; and
- 9 (d) provides policy, regulatory and
- 10 legislative recommendations to solve identified problems, to
- 11 resolve complaints, to improve the quality of care of patients
- 12 and to ensure that a managed health care plan's administrative
- 13 practices do not unduly burden health care providers.

14 D. The ombudsman program shall maintain sufficient

15 numbers of staff, qualified by training and experience, to

16 perform the functions of the ombudsman program. Staff may

17 include employees, independent contractors performing services

18 pursuant to contract and volunteers.

19 **SECTION 11. OPERATIONS OF THE OMBUDSMAN PROGRAM THROUGH**

20 **CONTRACTUAL RELATIONSHIP.--**

21 A. The division shall contract with one or more

22 independent organizations or consortia of organizations to

23 operate the ombudsman program. The contractor has authority to

24 enter into subcontracts for performance of any part of the

25 duties required by the contract. The ombudsman program shall

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1 operate independently of any state agency or health care plan.

2 B. The criteria used in selecting a contractor or
3 contractors to operate the ombudsman program shall include
4 preference for:

5 (1) private, not-for-profit organizations
6 representing a broad spectrum of consumer interests in New
7 Mexico; and

8 (2) organizations that have, or whose
9 principals have, demonstrated interest and expertise in health
10 care issues and a background in consumer advocacy.

11 C. A person contracting to perform ombudsman
12 program functions shall not:

13 (1) be directly involved in the licensing,
14 certification or accreditation of health care facilities,
15 health care plans or health care providers;

16 (2) have a direct ownership or investment
17 interest in a health care facility, health care plan or health
18 care provider;

19 (3) be employed by or participate in the
20 management of a health care facility, health care plan or
21 health care provider; or

22 (4) have the right to receive remuneration
23 under a compensation arrangement with an owner or operator of a
24 health care facility, health care plan or health care provider.

25 D. The ombudsman program shall exercise its powers

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1 and duties independently of any state agency or health care
2 plan. To assure the independence of the ombudsman program, the
3 contract to operate the ombudsman program shall be awarded as a
4 multi-term contract for three-year terms. The contract shall
5 not be terminated by the division before its scheduled
6 expiration date except for lack of available funds or for
7 significant deficiencies in contract performance. Before the
8 contract may be terminated by the division on the basis of
9 deficiencies in contract performance, the division shall:

10 (1) give the contractor notice of the proposed
11 termination and a detailed written statement of deficiencies in
12 contract performance;

13 (2) give the contractor a reasonable
14 opportunity to respond to and correct the identified
15 deficiencies; and

16 (3) give timely public notice and an
17 opportunity for public comment on the proposed termination.

18 SECTION 12. ACCESS TO INFORMATION.--

19 A. When the assistance of the ombudsman program has
20 been requested on behalf of a patient or health care provider,
21 the ombudsman program shall be granted access to the medical
22 and administrative records relevant to the issue presented;
23 provided that the ombudsman program has the permission of the
24 patient involved or the patient's designated representative.

25 B. The ombudsman program shall have access to the

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1 administrative records, policies and documents of health care
2 plans to the extent that the materials are not proprietary or
3 privileged.

4 C. The ombudsman program shall have access to
5 licensing and data reporting records with respect to health
6 care plans reported to the state, the federal government or
7 private accrediting agencies, to the extent that the
8 information is not proprietary or privileged.

9 D. State agencies, health care plans and health
10 care providers shall provide cooperation, assistance, data and
11 access to records necessary to enable the ombudsman program to
12 perform its duties under the Managed Health Care Ombudsman Act
13 and other applicable federal and state law. Charges for copies
14 of documents provided to the ombudsman program by a state
15 agency, plan or provider shall be the lesser of actual costs,
16 not to exceed the prevailing community market rates for
17 photocopying, or fifty cents (\$.50) a page.

18 E. Communications between the ombudsman program and
19 a person requesting the assistance of the ombudsman program are
20 privileged. The case files and records of the ombudsman
21 program are confidential and may be disclosed only as provided
22 in this subsection for purposes of fulfilling the duties of the
23 ombudsman program. Those files and records are not subject to
24 subpoena and are exempt from disclosure under the Inspection of
25 Public Records Act. The ombudsman program shall not disclose

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1 the identity of or any confidential information regarding any
2 individual who has requested the assistance of the ombudsman
3 program, unless:

4 (1) the patient, health care provider or the
5 patient or provider's designated representative consents to the
6 disclosure; or

7 (2) disclosure is ordered by a court of
8 competent jurisdiction.

9 F. Reports by the ombudsman program on operations
10 of the ombudsman program or systemic issues in managed health
11 care shall be prepared in a manner to ensure that the
12 identities of individuals served by the ombudsman program are
13 not disclosed and information shall be presented in a report in
14 such a way as to prevent identification of individuals served
15 by the ombudsman program.

16 SECTION 13. PROHIBITION ON INTERFERENCE WITH OMBUDSMAN
17 PROGRAM OR RETALIATION.--

18 A. No person shall willfully interfere with the
19 lawful actions of the ombudsman program.

20 B. No person shall engage in discriminatory,
21 disciplinary, retaliatory or other adverse action against any
22 person for contacting the managed health care ombudsman office,
23 requesting the assistance of the ombudsman program, providing
24 information to the ombudsman program or otherwise cooperating
25 with the ombudsman program.

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1 **SECTION 14. IMMUNITY FROM LIABILITY.**--No representative
2 of the ombudsman program is liable for the good-faith
3 performance of the functions of the ombudsman program pursuant
4 to the Managed Health Care Ombudsman Act.

5 **SECTION 15. AUTHORITY NOT EXCLUSIVE.**--The authority
6 granted the ombudsman program under the Managed Health Care
7 Ombudsman Act is in addition to the authority granted under the
8 provisions of any other statute or rule. The authority granted
9 to the ombudsman program does not limit or affect any rights or
10 remedies of managed health care plan enrollees.

11 **SECTION 16. SURCHARGE--MANAGED HEALTH CARE OMBUDSMAN**
12 **FUND--CREATED.**--

13 A. To ensure adequate funding for the operations of
14 the ombudsman program, a surcharge is assessed on premiums
15 received by insurers offering health care plans. The surcharge
16 is in the amount of one-tenth of one percent of the dollar
17 amount of premiums collected by the insurer for coverage of
18 enrollees in the insurer's health plans, whether for privately
19 paid insurance or for publicly funded programs, including the
20 medicaid program.

21 B. There is created in the state treasury a
22 "managed health care ombudsman fund". All money collected
23 pursuant to the provisions of subsection A of this section
24 shall be deposited in the managed health care ombudsman fund.
25 Balances in the fund and interest earned on money in the fund

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1 are appropriated to the division for the purpose of
2 administering and contracting for the ombudsman program as
3 provided in the Managed Health Care Ombudsman Act. Any
4 unexpended or unencumbered balance remaining at the end of a
5 fiscal year shall not revert.

6 SECTION 17. EFFECTIVE DATE.--The effective date of the
7 provisions of this act is July 1, 2011.

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