F I S C A L I M P A C T R E P O R T

SPONSOR SPAC **ORIGINAL DATE** 2/14/16 **LAST UPDATED** 2/17/16 **HB**

SHORT TITLE Health Provider Credentialing by Insurers **SB** CS/234/SPACS

ANALYST Clark

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		No Fiscal Impact				

Parenthesis ( ) indicate expenditure decreases

SOURCES OF INFORMATION
LFC Files

Responses Received From
Attorney General's Office (AGO)
Office of Superintendent of Insurance (OSI)

SUMMARY

Synopsis of Bill

The Senate Public Affairs Committee Substitute for Senate Bill 234 would amend multiple sections of law related to health plan requirements.

Section 1 amends NMSA 1978, Section 59-16-21.1, "Health Plan Requirements," adding a definition for "eligible provider" and "participating provider" as well as amending the definition of "clean claim" and "health plan."

Sections 2, 3, 4, and 5 amend Sections 59A-22-54, 59A-23-14, 59A-46-54, and 59A-47-49, respectively, pertaining to the credentialing, and provisional credentialing, of providers. The superintendent of insurance is given authority to determine how to provide for provisional credentialing for up to one year. In addition, the amendments referenced in these sections clarify the reimbursement rates that insurers shall pay to providers who are employed by a practice/group that has a contract with an insurer as well as those that do not. Currently, the payment requirement applies only to providers enrolled in their network. These sections also increase the maximum number of forms for credentialing applications from one to two.

Section 6 requires the superintendent of insurance to promulgate rules to implement these changes by September 1, 2016.

Section 7(A) provides that the provisions of Section 1 shall apply to claims submitted for payment on or after January 1, 2017. Under Section 7(B), the provisions of Sections 3 through 5 shall apply to applications for provider credentialing made on or after January 1, 2017.

FISCAL IMPLICATIONS

There is no fiscal impact.

SIGNIFICANT ISSUES

The substitute provides a specific list of entities qualifying as a health plan and excludes managed care organizations (MCOs), addressing concerns from the Human Services Department regarding the original bill's more general language, which the agency reported could potentially disrupt the current provider enrollment process for Medicaid MCO providers.

The substitute also addresses a concern noted by the Office of Superintendent of Insurance (OSI) regarding the original bill's exclusion of non-profit insurance plans from the definition of "health plan." The substitute now includes this as part of the definition, matching generally accepted definitions. However, OSI notes Section A(2) defines "eligible provider"; however, revisions may be needed to clarify the definition. It might be helpful to combine Subsections (a) and (b) to define an "eligible provider" as "an individual or entity that is a participating provider that a health plan has credentialed after assessing and verifying the provider's qualifications."

Changing the application forms from one to two types is consistent with the current regulations in place.

ADMINISTRATIVE IMPLICATIONS

OSI reports since the enactment of SB 220 after the 2015 regular legislative session, the agency has not received any complaints filed by providers regarding carrier response. Therefore, it is not anticipated that this will impact staff time significantly.

JC/jle/jo