AN ACT

RELATING TO HEALTH; MAKING CHANGES IN THE PATIENT PROTECTION ACT; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978.

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

Section 1. Section 59A-57-1 NMSA 1978 (being Laws 1998, Chapter 107, Section 1) is amended to read:

"59A-57-1. SHORT TITLE.--Chapter 59A, Article 57 NMSA 1978 may be cited as the "Patient Protection Act"."

Section 2. Section 59A-57-3 NMSA 1978 (being Laws 1998, Chapter 107, Section 3) is amended to read:

"59A-57-3. DEFINITIONS.--As used in the Patient Protection Act:

A. "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 insurer's or plan's system and contains no material deficiency or impropriety, including lack of substantiating documentation currently required by the insurer or particular or unusual circumstances requiring special treatment that prevents timely payment from being made by the insurer or plan;

B. "commission" means the New Mexico health policy commission;

C. "continuous quality improvement" means an ongoing and systematic effort to measure, evaluate and improve a plan's process in order to improve continually the quality of health care services provided to enrollees;

D. "enrollee" means an individual who is entitled

to receive health care benefits provided by a plan;

E. "department" means the insurance division;

F. "emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement to a person;

G. "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;

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

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

J. "health care services" includes, to the extent offered by the plan, physical health or behavioral health or

developmental disability services, including services for developmental delay;

K. "insurer" means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, managed care organization, provider service network, plan or prepaid dental plan;

L. "person" means an individual or other legal entity;

M. "plan" means an insurer or a provider service network when offering a benefit that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the insurer or provider service network. "Plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies;

N. "point-of-service plan" or "open plan" means a plan that allows enrollees to use health care providers other than providers under direct contract with or employed by the plan, even if the plan provides incentives, including financial incentives, for covered persons to use the plan's designated participating providers;

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

certificate of authority pursuant to the Provider Service Network Act;

P. "superintendent" means the superintendent of insurance; and

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

Section 3. Section 59A-57-4 NMSA 1978 (being Laws 1998, Chapter 107, Section 4) is amended to read:

"59A-57-4. PATIENT RIGHTS--DISCLOSURES--RIGHTS TO BASIC AND COMPREHENSIVE HEALTH CARE SERVICES--GRIEVANCE PROCEDURE-- UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM.--

A. Each enrollee in a plan has the right to be treated fairly. A plan shall arrange for the delivery of good quality and appropriate health care services to enrollees as defined in the particular subscriber agreement. The department shall adopt rules to implement the provisions of the Patient Protection Act and shall monitor and oversee a plan to ensure that each enrollee in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting rules to implement the provisions of Subparagraphs (a) and (b) of Paragraph (5) and Paragraphs (7) and (10) of Subsection B of this section regarding health care standards and specialists, utilization review programs and continuous quality improvement programs, the department shall cooperate with and seek advice from the department of health.

B. The rules adopted by the department to protect

patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment and at subsequent periodic times as appropriate, a plan shall provide to all enrollees either directly or, in the case of a group policy, through their employer a written description of the plan that contains, in a clear, concise and readily understandable form, a full and fair disclosure of:

(a) the plan's benefits and exclusions, limitations, premium information, provider listing, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and customer service phone line information;

(b) the plan's provisions for referrals or authorizations for specialty care, behavioral health services and hospital services;

(c) the plan's procedures, if any, for changing providers; and

(d) a summary of enrollees' rights established pursuant to the Patient Protection Act and rules adopted pursuant to that act;

(2) upon request of an enrollee, a plan shall provide information on the rules and provisions that are directly related to an enrollee's health care, including formularies, enrollees' and providers' referral procedures and utilization review;

(3) if a patient or enrollee is responsible for paying any portion of a bill, an insurer or health care provider shall provide the enrollee with a copy of an

intelligible bill, including the portion and amount paid by the insurer. This requirement does not apply to a flat co-pay paid by the enrollee at the time the service is required;

(4) a plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

(5) in providing reasonably accessible health care services that are available in a timely manner, a plan shall ensure that:

(a) the plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the plan's enrollees;

(b) health care providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all basic health care services that are required of them by a plan;

(c) reasonable access is provided to out-of-network health care providers if medically necessary covered services are not reasonably available through participating health care providers or, if necessary, to provide continuity of care during brief transition periods;

(d) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs;

(e) reimbursement for emergency care or ambulance services shall not be contingent upon time

constraints of less than seven days for notification by the enrollee to the insurer or any other entity that the care or services have been used; and

(f) through provider selection, provider education, the provision of additional resources or other means, it reasonably addresses the cultural and linguistic diversity of its enrollee population;

(6) a plan adopt and implement a prompt and fair grievance procedure for resolving enrollee complaints and addressing enrollee questions and concerns regarding any aspect of the plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network and the grievance procedure shall require notification of enrollees of their right to obtain review by the plan, their right to obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Patient Protection Act;

(7) a plan adopt and implement a comprehensive utilization review program in which:

(a) the basis of a decision to deny care shall be disclosed to an affected enrollee;

(b) the decision to approve or deny care to an enrollee shall be made in a timely manner; and

(c) the final decision shall be made by a qualified health care professional;

(8) a plan's utilization review program ensure that enrollees have proper access to health care services, including referrals to necessary specialists;

(9) a decision made in a plan's utilization

review program be subject to the plan's grievance procedure and appeal to the superintendent; and

(10) a plan adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the plan."

Section 4. A new Section 59A-57-4.1 NMSA 1978 is enacted to read:

"59A-57-4.1. REPORTS OF DENIAL OF CARE--DISCIPLINARY ACTION.--

A. The department shall file a report with the legislature annually that includes at a minimum:

(1) a summary of the aggregate data regarding denial of care categorized by:

(a) access issues;

(b) benefit or claim limitations; and

(c) administrative issues;

(2) a summary of the aggregate data regarding internal grievances and appeals; and

(3) any need for additional statutory direction to achieve its duties and objectives.

B. The superintendent may hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978 to determine if an insurer is excessively denying care or denying care unjustly. The superintendent may issue an order against an insurer that he deems necessary or appropriate to protect consumers regarding the denial of care, including ordering the prompt delivery of appropriate care, impositions of sanctions or the taking of disciplinary action that may include fines or license revocation."

Section 5. Section 59A-57-5 NMSA 1978 (being Laws 1998, Chapter 107, Section 5) is amended to read:

"59A-57-5. CONSUMER ASSISTANCE--CONSUMER ADVISORY BOARDS--REPORTS TO CONSUMERS--SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS--DUTIES OF THE DEPARTMENT AND THE SUPERINTENDENT--POWERS OF THE DEPARTMENT AND THE SUPERINTENDENT.--

A. A plan shall establish and adequately staff a consumer assistance office. The purpose of the consumer assistance office is to respond to consumer questions and concerns and assist patients in exercising their rights and protecting their interests as consumers of health care.

B. A plan shall establish a consumer advisory board. The board shall meet at least quarterly and shall advise the plan about the plan's general operations from the perspective of the enrollee as a consumer of health care. The board shall also review the operations of and be advisory to the plan's consumer assistance office.

C. The department in conjunction with the commission shall:

(1) prepare an annual report assessing the operations of managed health care plans subject to the department's oversight, including information about consumer complaints;

(2) develop or utilize standardized, quantitative performance measurements of plans based on a five point rating scale;

(3) survey high-use health care consumers, purchasers and providers to assess the quality of clinical and service-related aspects of health care arranged for or

provided by plans in accordance with measurements developed pursuant to Paragraph (1) of this subsection; and

(4) develop or utilize, test, refine and produce one or more managed health care performance grade cards to provide consumers with accurate, reliable and timely comparisons of plans.

D. A person adversely affected may file a complaint with the superintendent regarding a violation of the Patient Protection Act or the rules adopted by the department pursuant to that act. Prior to issuing any remedial order regarding violations of the Patient Protection Act or its rules, the superintendent shall hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978. The superintendent may issue any order he deems necessary or appropriate, including ordering the delivery of appropriate care, to protect consumers and enforce the provisions of the Patient Protection Act and rules adopted pursuant to that act. The superintendent shall adopt special procedures to govern the submission of emergency appeals to him in health emergencies."

Section 6. Section 59A-57-6 NMSA 1978 (being Laws 1998, Chapter 107, Section 6) is amended to read:

"59A-57-6. FAIRNESS TO HEALTH CARE PROVIDERS--GAG RULES PROHIBITED--GRIEVANCE PROCEDURE FOR PROVIDERS.--

A. No plan may:

(1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with an enrollee even if the plan does not approve of the option;

(2) include in any of its contracts with

health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an enrollee; or

(3) require a health care provider to violate any recognized fiduciary duty of his profession or place his license in jeopardy.

B. No contract or element of a contract between an insurer or plan and a provider shall include any provision that has the effect of relieving either party of liability for its actions or inactions.

C. An insurer shall:

(1) provide in a timely manner the necessary authorization or response to any inquiry by a provider required to provide health care services; and

(2) reasonably exhaust available local remedies if requested by the enrollee or his designee for providing necessary health care services.

D. A plan that proposes to terminate a health care provider from the plan shall explain in writing the rationale for its proposed termination and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

E. A plan shall adopt and implement a process pursuant to which providers may raise with the plan concerns that they may have regarding operation of the plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network. The process shall include, at a minimum, the right of the provider to present the provider's concerns to a plan committee responsible for

the substantive area addressed by the concern and the assurance that the concern will be conveyed to the plan's governing body. In addition, a plan shall adopt and implement a fair hearing process that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation with the plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism.

F. Nothing in this section prohibits a plan from taking action against a health care provider if the health plan has evidence that the provider's actions are illegal, constitute medical malpractice or are contrary to accepted medical practices."

Section 7. A new Section 59A-57-7.1 NMSA 1978 is enacted to read:

"59A-57-7.1. PENALTY FOR LATE PAYMENT FOR SERVICES.--NOTICE FOR CLAIMS RECEIVED--STANDARD FORMS.--

A. Any contract entered into between an insurer or plan and a participating provider shall provide that if the insurer or plan fails to make payment to that provider within thirty days after a clean claim has been submitted by the provider to the insurer or plan, the insurer or plan shall be liable for the amount due and unpaid plus interest on that amount at the rate of one and one-half percent per month, computed on a daily basis.

B. If an insurer or plan contests a claim of a participating provider, that insurer or plan shall notify the participating provider in writing within thirty days of receipt of the claim with the specific reason why it is not

liable for the claim or request additional information necessary to determine liability for the claim.

C. If a portion of the claim submitted to the insurer or plan by the provider for payment is in dispute, the insurer or plan shall pay any other portion of that claim that is clean and uncontested in accordance with provisions of Subsection A of this section.

D. By December 1, 1999, the department shall promulgate rules to require insurers and plans to:

(1) provide timely notice to providers of claims received, both for claims received electronically and for claims submitted manually; and

(2) utilize standardized forms for all claims, authorization and other official communication between a provider and the insurer or plan regarding payment for health care services.

E. For the purposes of this section, an "insurer" includes an insurer or plan that maintains a contract with the state for the purposes of providing health care services to recipients of medicaid."

Section 8. Section 59A-57-10 NMSA 1978 (being Laws 1998, Chapter 107, Section 10) is amended to read:

"59A-57-10. APPLICATION OF ACT TO MEDICAID PROGRAM.--

A. Except as otherwise provided in this section, the provisions of the Patient Protection Act and rules adopted by the department pursuant to that act apply to the medicaid program operation in the state. A plan offered through the medicaid program shall grant enrollees and providers the same rights and protections as are granted to enrollees and providers in any other plan subject to the

provisions of the Patient Protection Act.

B. Nothing in the Patient Protection Act shall be construed to limit the authority of the human services department to administer the medicaid program, as required by law. Consistent with applicable state and federal law, the human services department shall have sole authority to determine, establish and enforce medicaid eligibility criteria, the scope, definitions and limitations of medicaid benefits and the minimum qualifications or standards for medicaid service providers.

C. Medicaid recipients and applicants retain their right to appeal decisions adversely affecting their medicaid benefits to the human services department, pursuant to the Public Assistance Appeals Act. The superintendent may refer to the human services department any appeal filed with the superintendent pursuant to the Patient Protection Act if the complainant is a medicaid beneficiary and the matter in dispute is subject to the provisions of the Public Assistance Appeals Act.

D. Any managed health care plan participating in the medicaid managed care program as of July 1, 1998 and that is in compliance with contractual and regulatory requirements applicable to that program shall be deemed to comply with any requirements established in accordance with the Patient Protection Act until July 1, 1999. Effective July 1, 1999, the rules promulgated by the department to implement the Patient Protection Act shall apply to medicaid managed care plans except when and to the extent such rules are in conflict with rules or conditions imposed on the state or on such plans by the federal government."

Section 9. A new Section 59A-57-13 NMSA 1978 is enacted to read:

"59A-57-13. CONFIDENTIALITY.--Nothing in the Patient Protection Act requires disclosure of information that is otherwise privileged or confidential under any other provision of law."