SENATE CORPORATIONS AND TRANSPORTATION COMMITTEE SUBSTITUTE FOR SENATE BILL 22

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

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.

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

SECTION 1. SHORT TITLE.--This act may be cited as the "Health Care Provider Protection Act".

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

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

B. "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 laboratory; a diagnostic or imaging center; and a rehabilitation or other therapeutic health setting;

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

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

E. "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;

F. "health care service" means a service or product furnished an individual for the purpose of preventing, alleviating, curing or healing human illness or injury and includes services and products incidental to furnishing the described services or products. "Health care service" does not include any service paid for by medicare or medicaid;

G. "managed health care plan" or "plan" means a health care insurer or a provider service network that, when offering a benefit, either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "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 or specified disease policies; or student health plans;

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

I. "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

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authority pursuant to the Provider Service Network Act;

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

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

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

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

A. A managed health care plan shall make a decision on all prior authorization requests in a timely manner as required by the exigencies of the situation and in accordance with sound medical principles. Such determination shall not exceed twenty-four hours for emergency care and seven business days for all other determinations.

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

C. A managed health care plan shall maintain a web site listing the status of all claims submitted to the plan by health care providers. Upon request of a health care provider,

a managed health care plan shall provide a report listing the reasons why any claim did not qualify as a clean claim or was otherwise denied and provide a contact number for the provider to call to receive assistance in qualifying the claim.

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

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

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

(1) submit one reimbursement recoupment request per individual claim to the provider;

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

(3) allow the provider an opportunity to dispute the reimbursement recoupment request in accordance with the process outlined in Section 7 of the Health Care Provider Protection Act.

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

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

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

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

SECTION 5. TECHNICAL ASSISTANCE FOR HEALTH CARE PROVIDERS--TRAINING AND EDUCATION.--

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

B. At the managed health care plan's expense, each plan shall provide training and educational programs related to

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the plan's administrative and financial procedures to health care providers. The plan shall offer providers training and educational programs at least quarterly in several locations around the state.

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

SECTION 6. HEALTH CARE PROVIDER CREDENTIALING AND RECREDENTIALING.--

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

B. A managed health care plan shall assess and verify the qualifications of a health care provider within forty-five calendar days of receipt of a complete uniform credentialing form.

C. Within ten business days of receipt of an incomplete uniform credentialing form from a health care provider, the managed health care plan shall notify the provider in writing, by certified mail or by electronic mail, of all missing or incomplete information or supporting documents. The notice shall include a complete and detailed description of all of the missing or incomplete information or supporting documents and the name, address and telephone number

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of a credentialing staff person who will serve as the contact person for the provider.

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

E. Any dispute between a health care provider and managed health care plan regarding credentialing or recredentialing shall be governed by the process set forth in Section 7 of the Health Care Provider Protection Act.

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

A. A managed health care plan shall adopt and implement a process pursuant to which a health care provider may raise with the plan concerns regarding the credentialing and recredentialing process, the provider's reimbursement request or the plan's reimbursement recoupment request. 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. In addition, a plan shall adopt and implement a fair hearing procedure that permits a provider to dispute the existence of adequate cause to terminate the provider's participation with the plan due to conflicts over credentialing, recredentialing,

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provider reimbursement requests or plan reimbursement recoupment requests. This grievance and hearing procedure may be combined with requirements of Section 59A-57-6 NMSA 1978.

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

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

SECTION 8. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2011.

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