SENATE BILL 511

44TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1999

INTRODUCED BY

Timothy Z. Jennings

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.--[~~Sections 1 through 11 of this act~~] 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 substantially all

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the required data elements necessary for accurate adjudication without the need for additional information from outside of the health maintenance organization's system and contains no material deficiency or impropriety, including lack of substantiating documentation currently required by the insurer or particular circumstances requiring special treatment that prevents timely payment from being made by the insurer;

B. "commission" means the New Mexico health policy commission as created according to 9-7-11.2 NMSA 1978;

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

[~~B. "covered person"~~] D. "enrollee" [~~"patient" or "consumer"~~] means an individual who is entitled to receive health care benefits provided by a [~~managed health care~~] plan;

[~~C.~~] E. "department" means the insurance [~~department~~] division;

[~~D.~~] 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

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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;

[~~E.~~] 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;

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

~~G.~~] 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;

[~~H.~~] 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;

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[~~I.~~] J. "health care services" includes, to the extent offered by the plan, physical health or community-based mental health or developmental disability services, including services for developmental delay;

[~~J. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that 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, student health plan or specified disease policies~~]

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

[~~K.~~] 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

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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;

[~~L.~~] N. "point-of-service plan" or "open plan" means a [~~managed health care~~] 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;

[~~M.~~] 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;

[~~N.~~] P. "superintendent" means the superintendent of insurance; and

[~~O.~~] 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

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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 [~~covered person enrolled~~] enrollee in a [~~managed health care~~] plan has the right to be treated fairly. A [~~managed health care~~] 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 [~~regulations~~] rules to implement the provisions of the Patient Protection Act and shall monitor and oversee a [~~managed health care~~] plan to ensure that each [~~covered person enrolled~~] enrollee in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting [~~regulations~~] rules to implement the provisions of Subparagraphs (a) and (b) of Paragraph [~~(3)~~] (13) and Paragraphs [~~(5)~~] 15 and [~~(6)~~] (19) 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. No rule shall be adopted by the department after July 30, 1999 that decreases either the quantity or the

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quality of patient protection afforded pursuant to rules in force on that date.

[~~B.~~] C. The [~~regulations~~] 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 annually thereafter, a [~~managed health care~~] plan shall provide [~~a summary of benefits and exclusions, premium information and a provider listing. Within a reasonable time after enrollment and at subsequent periodic times as appropriate, a managed health care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons~~] 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 the plan's:

(a) benefits and exclusions, limitations, premium information, provider listing, conditions of eligibility, prior authorization requirements, enrollee

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financial responsibility for payments, grievance procedures, appeal rights, customer service phone line and medical advice hotline information, and the enrollees' rights generally available to all patients;

(b) provisions for referrals for specialty care, behavioral health services and hospital services;

(c) incentives or disincentives to a provider relating to the provision of health care services to an enrollee, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists;

(d) provisions for after-hours and emergency care and how an enrollee may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 911 services;

(f) procedures for notifying enrollees of: 1) a change in or termination of any benefit; 2) if applicable, termination of a primary care provider, delivery office or site; and 3) if applicable, assistance available to enrollees affected by the termination of a primary care provider, delivery office or site;

(g) procedures, if any, for changing providers;

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(h) a summary of criteria used to determine if a service or drug is considered experimental or investigational and a complete, accurate and up-to-date listing of services and drugs considered experimental or investigational;

(i) a summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information;

(j) a description of any assistance provided to non-English-speaking enrollees or enrollees who are unable to interpret or ascertain any disclosures, instructions or other written materials or communication;

(k) a summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost-sharing differentials or other restrictions that affect coverage of drug prescriptions; and

(l) a summary of the insurer's annual report on denials, as submitted according to Section 59-57-4.3 NMSA 1978;

(2) upon request of an enrollee or prospective enrollee a plan shall provide written material that contains, in a clear, concise and readily understandable form, a full and fair disclosure of:

(a) the provisions of the Patient Protection Act;

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(b) rules related to the insurer's drug formulary;

(c) provisions for referrals for health care services;

(d) information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria, but utilization review criteria that is proprietary shall be subject to verbal disclosure only;

(e) a description of the insurer's efforts to monitor and improve the quality of health care services; and

(f) a complete and accurate listing of all state and national advocates, ombudsmen or attorneys who offer advice or assistance to enrollees in the New Mexico grievance or appeals process;

(3) upon the filing of a grievance by an enrollee, a plan shall provide written material that contains, in a clear, concise and readily understandable form, a full and fair disclosure of:

(a) detailed information on the insurer's grievance and appeal procedures and how to contact a person employed by the insurer who is available to assist the enrollee in the grievance and appeal procedure;

(b) detailed information on the

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department's grievance and appeal procedures and how to contact any person employed by the department who is available to assist the enrollee in the grievance and appeal procedure;

(c) information on how to access the complaint line of the department; and

(d) a complete and accurate listing of all state and national advocates, ombudsmen or attorneys who offer advice or assistance to enrollee in the New Mexico grievance or appeals process;

(4) whenever a patient or enrollee is responsible for paying any portion of a bill, an insurer or health care provider shall provide the patient or enrollee with a copy of an explicit and intelligible bill containing descriptive language sufficient to be understood by the average patient or enrollee, but this requirement does not apply to a flat co-pay paid by the enrollee or enrollee at the time the service is required;

(5) any health care provider who is licensed, credentialed or registered by a state licensing board must wear a name tag that indicates by words, letters, abbreviations or insignia the profession or occupation of the individual whenever the health care provider is rendering health care services to a patient, unless wearing the name tag would create a safety or health risk to the patient;

(6) an insurer shall establish a procedure by

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which an enrollee may apply for a standing referral to a health care provider who is a specialist, specifying the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral if a referral to a specialist is required for coverage;

(7) all clinical decisions regarding length of stay in a health care facility, transfer between levels of care, medical treatment and follow-up care shall be made by the treating provider in consultation with the patient, as appropriate;

(8) if the insurer has a prescription drug formulary, it shall have:

(a) a written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary, including the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and

(b) a written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary;

(9) an enrollee may change participating primary care physicians at will, except that the enrollee may be restricted to making changes no more frequently than two

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times in any twelve-month period and may be limited to designating only those participating primary care physicians accepting new patients;

(10) an enrollee who has had a claim denied for any reason or who has been denied a referral by an insurer is entitled to seek the medical advice from another medical professional of his choice at his own cost and that after an enrollee has obtained a second opinion an insurer shall conduct another review process at the request of the enrollee and take into consideration the second opinion when determining the validity of the claim or referral; and

(11) an enrollee may appeal an insurer's decision to deny care to the superintendent;

[~~(2)~~] (12) a [~~managed health care~~] plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

[~~(3)~~] (13) in providing reasonably accessible health care services that are available in a timely manner, a [~~managed health care~~] 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 and to prevent undue waiting periods;

(b) health care providers that are

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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 [~~managed health care~~] 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~~] and ambulance service are immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; [~~and~~]

(e) reimbursement for emergency care or ambulance services shall not be contingent upon time constraints for notification by the enrollee to the insurer that the care or services have been used; and

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

[~~(4)~~] (14) a [~~managed health care~~] plan shall adopt and implement a prompt and fair grievance procedure for resolving [~~patient~~] enrollee complaints and addressing [~~patient~~] enrollee questions and concerns regarding any aspect

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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 [~~notify patients~~] 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;

[~~(5)~~] (15) a [~~managed health care~~] plan shall 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;

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

(17) A decision made in a plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the superintendent; [~~and~~]

(18) the procedures for internal utilization review appeals shall be reasonable and shall include:

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(a) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination and shall be provided, on request, a clear and concise statement of the clinical basis for the adverse determination;

(b) a list of documents needed to be submitted by the appealing party to the utilization review agent for the appeal;

(c) a provision that appeal decisions shall be made by a physician but, if the appeal is denied and within ten working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the adverse determination;

(d) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized enrollees that includes requirements for a review by a health care provider who has not previously reviewed the case and completion no later than one working day following the day on which the appeal, including all information necessary to

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complete the appeal, is made to the utilization review agent; and

(e) written notification to the appealing party of the determination of the appeal that is made as soon as practical, but in no case later than the thirtieth day after the date the utilization agent receives the appeal and, if the appeal is denied, the written notification shall include a clear and concise statement of the clinical basis for the appeal's denial, the specialty of the physician making the denial and notice of the appealing party's right to seek review of the denial by the department and the procedures for obtaining that review; and

(f) in a circumstance involving an enrollee's life threatening condition, that the enrollee is entitled to an immediate appeal to the department and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination. For purposes of this subparagraph, "life threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted; and

[~~(6)~~] (19) a [~~managed health care~~] plan shall adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the plan."

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

"59A-57-4.1. [NEW MATERIAL] HEALTH CARE LIABILITY.--

A. A managed care entity has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an enrollee proximately caused by the entity's failure to exercise such ordinary care.

B. A managed care entity is liable for damages for harm to an enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) apparent agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control that results in the failure to exercise ordinary care.

C. It is a defense to an action asserted against a managed care entity that:

(1) neither the managed care entity nor an employee, agent, apparent agent or representative for whose conduct the managed care entity is liable pursuant to Subsection B of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the managed care entity did not deny or

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delay payment for any treatment prescribed or recommended by a provider to the enrollee.

D. The standards in Subsections A and B of this section create no obligation on the part of the managed care entity to provide to an enrollee treatment that is not covered by the health care plan of the entity.

E. This section does not create liability of an employer, an employer group purchasing organization or a pharmacy licensed by the board of pharmacy that purchases coverage or assumes risk on behalf of its employees.

F. A managed care entity may not remove a health care provider from its plan or refuse to renew the health care provider's participation in its plan for advocating for appropriate and medically necessary health care for an enrollee.

G. A managed care entity may not enter into a contract with a health care provider or pharmaceutical company that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity.

H. In an action against a managed care entity, a finding that a health care provider is an employee, agent, apparent agent or representative of the managed care entity shall not be based solely on proof that the person's name appears in a listing of approved health care providers made available to enrollees under a health care plan.

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I. No civil action against a managed care entity may be brought pursuant to this section unless the affected enrollee or the enrollee's representative:

(1) has exhausted the administrative appeals and review remedies available pursuant to the Patient Protection Act; and

(2) before instituting the action:

(a) gives written notice of the claim as provided by Subsection J of this section; and

(b) agrees to submit the claim to a review by the department as required by Subsection K of this section.

J. The notice required by Paragraph (2) of Subsection I of this section must be delivered or mailed to the managed care entity against whom the action is brought not later than the thirtieth day before the date the civil action is filed.

K. The enrollee or the enrollee's representative must submit the claim to a review by the department if the managed care entity against whom the claim is made requests the review not later than the fourteenth day after the date the notice pursuant to Subparagraph (a) of Paragraph (2) of Subsection I of this section is received by the managed care entity. If the managed care entity does not request the review within the period specified by this subsection, the

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enrollee or the enrollee's representative is not required to submit the claim to the department.

L. Subject to Subsection M of this section, if the enrollee has not complied with Subsection I of this section, an action pursuant to this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other non-binding alternative dispute resolution and may abate the action for a period of not to exceed thirty days for those purposes. Such an order of the court is the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection I of this section.

M. An enrollee is not required to comply with Subsection K of this section, and no abatement or other order pursuant to Subsection L of this section for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the managed care entity or because of an act or omission of an employee, agent, apparent agent or representative of the entity for whose conduct it is liable pursuant to this section; and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant entity finds after hearing that the pleading was not made in good

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faith in which case the court may enter an order pursuant to Subsection M of this section.

O. If the enrollee or the enrollee's representative seeks to exhaust the administrative appeals and review available pursuant to the Patient Protection Act or provides notice, as required by Subsection I of this section, before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the thirtieth day after the date the enrollee or the enrollee's representative has exhausted the process for administrative appeals and review pursuant to the Patient Protection Act; or

(2) the fortieth day after the date the enrollee or enrollee's representative gives notice pursuant to Subparagraph (a) of Paragraph (2) of Subsection I of this section.

P. This section does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment or relief under law if the requirement of exhausting the administrative process for appeal and review places the enrollee's health in serious jeopardy."

Section 5. A new Section 59A-57-4.2 NMSA 1978 is enacted to read:

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"59A-57-4.2. [NEW MATERIAL] CONTINUITY OF CARE.--

A. If enrollees are required to access services through selected primary care providers for coverage, the insurer shall prepare a written plan that provides for continuity of care in the event of contract termination between the insurer and any of the contracted primary care providers or general hospital providers. The written plan must:

(1) explain how the insurer will inform affected enrollees about termination at least thirty days before the termination is effective if the insurer has received at least one hundred twenty days' prior notice;

(2) explain how the insurer will inform the affected enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its enrollees from the terminating provider to the new provider to maintain continuity of care;

(3) explain the procedures by which enrollees will be transferred to other participating providers when special medical needs, special risks or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers; and

(4) explain who will identify enrollees with special medical needs or at special risk and what criteria

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will be used for this determination.

B. If the contract termination was not for cause, enrollees may request a referral to the terminating provider for up to one hundred twenty days if they have special medical needs or have other special circumstances, such as cultural or language barriers. The insurer can require medical records and other supporting documentation in support of the requested referral. Requests for referral to a terminating provider shall be considered by the insurer on a case-by-case basis.

C. If the contract termination was for cause, enrollees must be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible to the affected enrollees. The insurer is not required to refer an enrollee back to the terminating provider if the termination was for cause."

Section 6. A new Section 59A-57-4.3 NMSA 1978 is enacted to read:

"59A-57-4.3. [NEW MATERIAL] REVIEW ORGANIZATION--REPORTS OF DENIAL OF CARE--FILING--REVIEW--DISCIPLINARY ACTION.--

A. The superintendent shall designate as the managed care review organization an entity meeting all requirements of a professional standards review organization established pursuant to 42 U.S.C. Section 1320c-1, et seq., to gather and review information relating to the care and

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treatment of enrollees for the purposes of:

(1) evaluating and improving the quality of health care services rendered by health care providers;

(2) developing and publishing guidelines showing the norms of health care services in the state or specified areas of the state or norms developed on the basis of different classifications of health care providers;

(3) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care services;

(4) reviewing the nature, quality or cost of health care services provided to enrollees of plans; and

(5) recommending to the superintendent whether a health care provider's privileges should be limited, suspended or revoked.

B. An insurer must file a report with the review organization described in Subsection A of this section on a frequency and in a form specified in rules of the superintendent and that report shall include:

(1) a list of denied claims and a detailed description of the reason each claim was denied;

(2) a summary of the aggregate data regarding denial of claims categorized by:

(a) access problems;

(b) benefit or claim problems; and

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(c) administrative problems;

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

(4) a summary of current procedures and efforts, if any, to monitor and improve the quality of health services.

C. A plan is required to collect, on a voluntary basis, the performance measurements specified in Subsection B of this section and share that information with the review organization designated by the superintendent.

D. The review organization shall:

(1) develop standardized, quantitative measurements of insurers that have over five percent of denial of claims to assess the appropriateness of the approval process, appeals process or denial rate of the insurer;

(2) adopt and implement a prompt and fair hearing procedure to determine a finding of excessive or unjust denial of claims in providing adequate health care services, which hearing shall be open to the public and notice about the hearing shall be given no later than thirty days prior to the hearing, but the review organization has no authority to sanction or discipline an insurer under this process;

(3) carry out the activities specified in this subsection with the objective of minimizing the

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occurrence of denial of claims without cause, utilizing, to the greatest extent feasible, the public hearing report and testimony from the insurer, health professionals, enrollees, consumer advocates and, if available, nationally developed quality assessment tools;

(4) submit a recommendation of sanction or disciplinary action against an insurer to the superintendent for consideration if the review organization finds the denial of claims are excessive or are unjust; and

(5) prepare and present a report to the forty-fifth legislature during its first session in 2001 covering:

(a) its accomplishments pursuant to this subsection;

(b) any need for additional statutory direction to achieve its duties and objectives; and

(c) the needs of health care consumers and how to better serve and educate the consumers on health care concerns.

E. It is the responsibility of an insurer to pay for the cost of any services provided by the review organization pursuant to this section.

F. The superintendent shall hold a hearing in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978 to determine if an insurer is excessively denying claims

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or denying claims unjustly. The superintendent may issue an order against an insurer that he deems necessary or appropriate to protect consumers regarding the denial of claims, including ordering the prompt delivery of appropriate care or disciplinary action that may include fines or license revocation.

G. The recommendation of the review organization to the superintendent, all supportive materials and the action taken by the superintendent shall be available to the public."

Section 7. 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 [~~OMBUDSMAN OFFICE~~]--REPORTS TO CONSUMERS--DUTIES OF THE NEW MEXICO HEALTH POLICY COMMISSION--SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS--DUTIES OF THE DEPARTMENT AND THE SUPERINTENDENT--POWERS OF THE DEPARTMENT AND THE SUPERINTENDENT.--

A. [~~Each managed health care~~] 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. [~~Each managed health care~~] A plan shall establish a consumer advisory board. The board shall meet at

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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.

[~~D.~~] C. The department shall prepare an annual report assessing the operations of [~~managed health care~~] plans subject to the department's oversight, including information about consumer complaints.

D. The commission in conjunction with the department and the department of health shall:

(1) develop standardized, quantitative performance measurements, based on a five point rating scale, of plans for use by health care consumers, purchasers and providers to assess continually the quality of clinical and service-related aspects of health care arranged for or provided by plans;

(2) encourage plans to collect on a voluntary basis the performance measurements specified in Paragraph (1) of this subsection and share that information with the commission;

(3) develop, test, refine and produce one or more managed health care performance scorecards to provide consumers with accurate, reliable and timely comparisons of plans with respect to:

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(a) organizational characteristics;

(b) clinical quality measurements;

(c) service-related quality measurements;

(d) enrollee and patient satisfaction;

(e) number and content of complaints filed with the department;

(f) punitive actions taken by the department against a plan; and

(g) reports filed showing denial of claims;

(4) carry out the activities specified in this subsection with the objective of:

(a) utilizing to the greatest extent feasible and desirable, nationally developed quality assessment tools; and

(b) minimizing duplicative quality assessment activities and associated administrative cost;

(5) prepare and present a report to the forty-fifth legislature during its first session in 2001 covering:

(a) its accomplishments pursuant to this subsection;

(b) the need for additional statutory direction to achieve its objectives; and

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(c) the needs of health care consumers and how to better serve and educate the consumers on health care concerns.

E. The department shall:

(1) enforce insurer compliance with federal and state laws or regulations protecting the rights of patients;

(2) periodically review contracts and arrangements among health care providers and plans they regulate to determine compliance with the Patient Protection Act;

(3) determine whether a provision of a contract or arrangement violates the Patient Protection Act, and if it is found to do so after a hearing by the superintendent in accordance with the provisions of Chapter 59A, Article 4 NMSA 1978, enter an order declaring it null and void and use available enforcement procedures to ensure compliance;

(4) educate and assist all managed health care consumers in exercising their rights secured pursuant to the Patient Protection Act;

(5) protect the interest of the consumer when the interest is considered to be within the rights established by the Patient Protection Act;

(6) attempt to resolve all disputes through

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advice, counseling, negotiation or other informal strategies, if possible, before proceeding to formal administrative remedies, which shall be a prerequisite to initiating litigation unless the superintendent determines in his discretion that the exhaustion of remedies limitations should not apply because in his judgment the medical or other exigencies of the case require expedited action to prevent harm to the consumer;

(7) upon the request of the consumer or the consumer's designated legal representative, pursue all available administrative, legal and other appropriate remedies on behalf of the consumer; and

(8) maintain sufficient numbers and types of staff, including employees, independent contractors and volunteers qualified by training and experience, to perform the duties imposed upon it by the provisions of this subsection.

[~~E.~~] F. A person adversely affected may file a complaint with the superintendent regarding a violation of the Patient Protection Act. Prior to issuing any remedial order regarding violations of the Patient Protection Act or its [~~regulations~~] 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

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appropriate care, to protect consumers and enforce the provisions of the Patient Protection Act. The superintendent shall adopt special procedures to govern the submission of emergency appeals to him in health emergencies.

G. The superintendent shall take disciplinary action, which may include license revocation, against an insurer for refusing to provide the department, the commission or the review organization with the data required pursuant to the Patient Protection Act."

Section 8. 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 [~~managed health care~~] 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;

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(4) require an agreement or directive that prohibits a health care provider from making a recommendation regarding the suitability or desirability of an insurer for an enrollee, unless the provider has a financial conflict of interest in the enrollee's choice of insurer;

(5) require an agreement or directive that prohibits a provider from providing testimony, supporting or opposing legislation, or making any other contact with state or federal legislators or legislative staff or with state and federal executive branch officers or staff;

(6) require an agreement or directive that prohibits a health care provider from disclosing accurate information about whether services or treatment will be paid for by an enrollee's insurer or plan; or

(7) require an agreement or directive that prohibits a health care provider from informing an enrollee about the nature of the reimbursement methodology used by an enrollee's insurer to pay the provider.

B. No medical services contract may require a health care provider, as an element of the contract or as a condition of compensation for services, to agree:

(1) that in the event of alleged improper treatment of a patient, to indemnify the other party to the medical services contract for any damages, awards or liabilities, including but not limited to judgments,

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settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional act of the provider or the provider's employees;

(2) to charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person;

(3) to deny care to an enrollee because of a determination made pursuant to the medical services contract that the care is not covered or is experimental, or to deny referral of an enrollee to another provider for the provision of such care, if the enrollee is informed that the enrollee will be responsible for the payment of such noncovered, experimental or referral care and the enrollee nonetheless desires to obtain such care or referral; or

(4) that, upon the provider's withdrawal from or termination or nonrenewal of the medical services contract, not to treat or solicit a patient even at the patient's request and expense.

C. All medical services contracts shall:

(1) grant to the provider adequate notice and hearing procedures that are fair to the provider under the circumstances, prior to a termination or nonrenewal based upon issues relating to the quality of patient care rendered by the

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provider;

(2) set forth generally the criteria used by the non-provider party to the medical services contract for the termination or nonrenewal of the medical services contract;

(3) entitle the provider to an annual accounting accurately summarizing the financial transactions between the parties to the medical services contract for that year;

(4) allow the provider to withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so;

(5) provide that a doctor of medicine or osteopathy who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law shall be responsible for and have authority to make all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract;

(6) entitle the party to the medical services contract who is being reimbursed for the provision of health care services on a basis that includes financial risk withholds, or the party's representative, to a full accounting of health benefits claims data and related financial information on no less than a quarterly basis by the party to

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a medical service contract who has made reimbursement, as follows:

(a) the data shall include all pertinent information relating to the health care services provided, including related provider and patient information, reimbursements made and amounts withheld under the financial risk withhold provisions of the medical services contract for the period of time under reconciliation and settlement between the parties;

(b) a reconciliation and settlement taken pursuant to a medical services contract shall be based directly and exclusively upon data provided to the party who is being reimbursed for the provision of health care services;

(c) data, including supplemental information or documentation necessary to finalize the reconciliation and settlement provisions of a medical services contract relating to financial risk withholds, shall be provided to the party who is being reimbursed for the provision of health care services no later than thirty days prior to finalizing the reconciliation and settlement; and

(7) not contain a provision preventing the parties from mutually agreeing to alternative reconciliation and settlement policies and procedures.

D. No person may take retaliatory action against a health care provider solely on the grounds that the provider:

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(1) refused to enter into an agreement or provide services or information in a manner that is prohibited under this section or took any of the actions listed in Subsection A of this section;

(2) disclosed accurate information about whether a health care service or treatment is covered by an enrollee's insurer;

(3) expressed personal disagreement with a decision made by a person regarding treatment or coverage provided to a patient of the provider, or assisted the patient in seeking reconsideration of such a decision if the health care provider makes it clear that the provider is acting in a personal capacity and not as a representative of or on behalf of the entity that made the decision; or

(4) disclosed the provider's general financial arrangement with the insurer.

E. An insurer shall:

(1) provide sufficient numbers and types of qualified personnel and effective lines of communication at reasonable hours of service so that health care providers may obtain the necessary authorization required to provide health care services in a timely manner or may obtain an expeditious response to any question a provider may have;

(2) exhaust all available local remedies for providing necessary health care services prior to transporting

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any patient to an alternative location that provides the same health care services;

(3) provide sufficient quantities of the necessary forms that are required for approval of health care services or for referral to specialists and, if the required forms are not available, a convenient alternative shall be made available;

(4) develop and provide a standardized method for determining a clean claim and not change that method without sixty days prior notice to all participating providers; and

(5) notify all participating providers of a change in billing procedures sixty days prior to the effective date of the change.

F. No health care provider, group of providers or person providing goods or health services to a provider shall enter into a contract or subcontract with an insurer or group of providers on terms that require the provider, group of providers or person not to contract with another insurer, unless the provider or person is an employee.

G. No insurer, health care provider or group of providers may withhold from its competitors health care services that are essential for competition between health care providers.

H. No insurer may terminate or otherwise

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financially penalize a health care provider for referring a patient to another provider, whether or not that provider is under contract with the insurer. If a provider refers a patient to another provider, the referring provider shall:

(1) comply with the insurer's written policies and procedures with respect to any such referrals; and

(2) inform the patient that the referral services may not be covered by the insurer.

[~~B.~~] I. A plan that proposes to terminate a health care provider from the [~~managed health care~~] 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.

[~~C.~~] J. A [~~managed health care~~] 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

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[~~managed health care~~] plan shall adopt and implement a fair hearing [~~plan~~] 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.

K. 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.

L. A health care provider or other person that believes provisions of this section may have been violated may file a complaint with the superintendent and the attorney general's office regarding a possible violation of this section."

Section 9. A new Section 59A-57-7.1 NMSA 1978 is enacted to read:

"59A-57-7.1. [NEW MATERIAL] PENALTY FOR LATE PAYMENT FOR SERVICES.--

A. Any contract entered into between an insurer and a participating health care provider shall provide that if the insurer fails to make payment to that provider within thirty days after a clean claim has been submitted by the provider to the insurer, the insurer shall be liable for the

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amount due and unpaid with interest on that amount at the rate of one and one-half percent per month.

B. If an insurer contests a claim of a participating health care provider, that insurer 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 by the participating provider for payment is in dispute, the insurer shall pay any other portion of that claim that is clean and uncontested in accordance with provisions of Subsection A of this section.

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

Section 10. A new Section 59A-57-7.2 NMSA 1978 is enacted to read:

"59A-57-7.2. [NEW MATERIAL] PROHIBITED ACTION--GRIEVANCE PROCEDURE.--

A. As used in this section:

(1) "employee" means a health care professional who performs services for and under the control and direction of an employer for wages or other remuneration;

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(2) "employer" means a person who has one or more employees and includes an agent of an employer and a public employer, but does not include an individual health care provider;

(3) "improper quality of patient care" means any practice, procedure, action or failure to act on the part of an employer that violates any law, rule or regulation or any professional code of ethics that affects or regulates appropriate quality of care of sick or injured persons that may result in unsafe patient care.

B. An employer shall not discharge, suspend, demote, discipline, threaten, otherwise discriminate against or penalize an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because:

(1) the employee, or a person acting on behalf of an employee, in good faith, reports or threatens to report to the employer, a governmental entity or law enforcement official, a violation or suspected violation of any federal or state law or rule adopted pursuant to law or policy or practice of the employer that the employee believes to constitute improper quality of patient care;

(2) the employee is requested by a public body or office to participate in an investigation, hearing or inquiry;

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(3) the employee provides information to, or testifies before, any public body as part of an investigation, hearing or inquiry into improper quality of patient care, a violation of law or a rule promulgated pursuant to law;

(4) the employee refuses an employer's order to perform an action that the employee has an objective basis in fact to believe violates any state or federal law or rule or regulation adopted pursuant to law, and the employee informs the employer that the order is being refused for that reason; or

(5) the employee, in good faith, reports a situation in which the quality of health care services provided by a health care provider violates a standard established by federal or state law or a professionally recognized national clinical or ethical standard and potentially places the public at risk of harm."

Section 11. Section 59A-57-8 NMSA 1978 (being Laws 1998, Chapter 107, Section 8) is amended to read:

"59A-57-8. ADMINISTRATIVE COSTS AND BENEFIT COSTS DISCLOSURES--DISCLOSURE OF EXECUTIVE COMPENSATION.--

A. The department shall adopt [~~regulations~~] rules to ensure that both the administrative costs and the direct costs of providing health care services of each [~~managed health care~~] plan are fully and fairly disclosed to consumers in a uniform manner that allows meaningful cost comparisons

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among plans.

B. Each insurer shall file annually with the department and the department shall make public:

(1) a copy of the insurer's form 990 filed with the federal internal revenue service; or

(2) if the insurer did not file a form 990 with the federal internal revenue service, a list of the amount and recipients of the insurer's five highest salaries, including all types of compensation, in excess of fifty thousand dollars ($50,000)."

Section 12. A new Section 59A-57-12 NMSA 1978 is enacted to read:

"59A-57-12. [NEW MATERIAL] NON-PREEMPTION.--Nothing in the Patient Protection Act preempts or replaces requirements related to patient protections that are more protective of patient rights than the requirements established by the Patient Protection Act."

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

"59A-57-13. [NEW MATERIAL] CONFIDENTIALITY.--

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

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FORTY-FOURTH LEGISLATURE

FIRST SESSION, 1999

March 10, 1999

Mr. President:

Your PUBLIC AFFAIRS COMMITTEE, to whom has been referred

SENATE BILL 511

has had it under consideration and reports same with recommendation that it DO NOT PASS, but that

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR SENATE BILL 511

DO PASS, and thence referred to the JUDICIARY COMMITTEE.

Respectfully submitted,

.126182.1

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_____

Shannon Robinson, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 5 For 0 Against

Yes: 5

No: 0

Excused: Feldman, Ingle, Stockard, Smith

Absent: None

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SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 511

44TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1999

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.--[~~Sections 1 through 11 of this act~~] 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

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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;

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

[~~B. "covered person"~~] D. "enrollee" [~~"patient" or "consumer"~~] means an individual who is entitled to receive health care benefits provided by a [~~managed health care~~] plan;

[~~C.~~] E. "department" means the insurance [~~department~~] division;

[~~D.~~] 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

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person;

[~~E.~~] 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;

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

~~G.~~] 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;

[~~H.~~] 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;

[~~I.~~] J. "health care services" includes, to the extent offered by the plan, physical health or [~~community-based mental~~] behavioral health or developmental disability services, including services for developmental delay;

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[~~J. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that 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, student health plan or specified disease policies~~]

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;

[~~K.~~] 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

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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;

[~~L.~~] N. "point-of-service plan" or "open plan" means a [~~managed health care~~] 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;

[~~M.~~] 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;

[~~N.~~] P. "superintendent" means the superintendent of insurance; and

[~~O.~~] 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--

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UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM.--

A. Each [~~covered person enrolled~~] enrollee in a [~~managed health care~~] plan has the right to be treated fairly. A [~~managed health care~~] 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 [~~regulations~~] rules to implement the provisions of the Patient Protection Act and shall monitor and oversee a [~~managed health care~~] plan to ensure that each [~~covered person enrolled~~] enrollee in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting [~~regulations~~] rules to implement the provisions of Subparagraphs (a) and (b) of Paragraph [~~(3)~~] (5) and Paragraphs [~~(5)~~] (7) and [~~(6)~~] (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 [~~regulations~~] rules adopted by the department to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment, a [~~managed health care~~] plan shall provide [~~a summary of benefits and exclusions, premium information and a provider listing. Within a reasonable time after enrollment and at subsequent periodic times as appropriate, a managed health~~

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~~care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons~~] 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

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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;

[~~(2)~~] (4) a [~~managed health care~~] plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

[~~(3)~~] (5) in providing reasonably accessible health care services that are available in a timely manner, a [~~managed health care~~] 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 [~~managed health care~~] plan;

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(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; [~~and~~]

(e) reimbursement for emergency care or ambulance services shall not be contingent upon time constraints of less than fifteen days for notification by the enrollee to the insurer or any other entity that the care or services have been used; and

[~~(e) the plan~~] (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;

[~~(4)~~] (6) a [~~managed health care~~] plan [~~shall~~] adopt and implement a prompt and fair grievance procedure for resolving [~~patient~~] enrollee complaints and addressing [~~patient~~] 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

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procedure shall [~~notify patients~~] 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;

[~~(5)~~] (7) a [~~managed health care~~] plan [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be subject to the plan's grievance procedure and appeal to the superintendent; and

[~~(6)~~] (10) a [~~managed health care~~] plan [~~shall~~] 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

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to read:

"59A-57-4.1. [NEW MATERIAL] 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:

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

A. [~~Each managed health care~~] 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. [~~Each managed health care~~] 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.

[~~D.~~] 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

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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.

[~~E.~~] 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 [~~regulations~~] 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,

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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 [~~managed health care~~] 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.

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[~~B.~~] D. A plan that proposes to terminate a health care provider from the [~~managed health care~~] 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.

[~~C.~~] E. A [~~managed health care~~] 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 [~~managed health care~~] plan shall adopt and implement a fair hearing [~~plan~~] 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,

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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. [NEW MATERIAL] 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 with interest on that amount at the rate of one and one-half percent per month.

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

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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 [~~managed health care~~] 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 [~~managed health care~~] 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

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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. [~~Notwithstanding other provisions of the Patient Protection Act, a medicaid recipient or applicant who files an appeal to the human services department pursuant to the Public Assistance Appeals Act may not file an appeal on the same issue to the superintendent pursuant to the Patient Protection Act, unless the human services department refuses to hear the appeal.~~] 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 [~~the effective date of the Patient Protection Act~~] July 1, 1998 and that is in compliance

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with contractual and regulatory requirements applicable to that program shall be deemed to comply with any requirements established in accordance with [~~that~~] the Patient Protection Act until July 1, 1999. [~~provided that, from the effective date of that act, any rights established under that act beyond those under requirements of the human services department shall apply to enrollees in medicaid managed health care plans~~] 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. [NEW MATERIAL] CONFIDENTIALITY.--Nothing in the Patient Protection Act requires disclosure of information that is otherwise privileged or confidential under any other provision of law."

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FORTY-FOURTH LEGISLATURE

FIRST SESSION, 1999

March 12, 1999

Mr. President:

Your JUDICIARY COMMITTEE, to whom has been referred

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR

SENATE BILL 511

has had it under consideration and reports same with recommendation that it DO PASS.

Respectfully submitted,

_____

Michael S. Sanchez, Chairman

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 6 For 0 Against

Yes: 6

No: None

Excused: Payne, Stockard

Absent: None

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SENATE BILL 511

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR

44TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1999

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.--[~~Sections 1 through 11 of this act~~] 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

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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;

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

[~~B. "covered person"~~] D. "enrollee" [~~"patient" or "consumer"~~] means an individual who is entitled to receive health care benefits provided by a [~~managed health care~~] plan;

[~~C.~~] E. "department" means the insurance [~~department~~] division;

[~~D.~~] 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

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person;

[~~E.~~] 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;

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

~~G.~~] 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;

[~~H.~~] 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;

[~~I.~~] J. "health care services" includes, to the extent offered by the plan, physical health or [~~community-based mental~~] behavioral health or developmental disability services, including services for developmental delay;

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[~~J. "managed health care plan" or "plan" means a health care insurer or a provider service network when offering a benefit that 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, student health plan or specified disease policies~~]

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;

[~~K.~~] 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

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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;

[~~L.~~] N. "point-of-service plan" or "open plan" means a [~~managed health care~~] 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;

[~~M.~~] 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;

[~~N.~~] P. "superintendent" means the superintendent of insurance; and

[~~O.~~] 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--

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UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM.--

A. Each [~~covered person enrolled~~] enrollee in a [~~managed health care~~] plan has the right to be treated fairly. A [~~managed health care~~] 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 [~~regulations~~] rules to implement the provisions of the Patient Protection Act and shall monitor and oversee a [~~managed health care~~] plan to ensure that each [~~covered person enrolled~~] enrollee in a plan is treated fairly and in accordance with the requirements of the Patient Protection Act. In adopting [~~regulations~~] rules to implement the provisions of Subparagraphs (a) and (b) of Paragraph [~~(3)~~] (5) and Paragraphs [~~(5)~~] (7) and [~~(6)~~] (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 [~~regulations~~] rules adopted by the department to protect patient rights shall provide at a minimum that:

(1) prior to or at the time of enrollment, a [~~managed health care~~] plan shall provide [~~a summary of benefits and exclusions, premium information and a provider listing. Within a reasonable time after enrollment and at subsequent periodic times as appropriate, a managed health~~

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~~care plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, enrollee financial responsibility for payments, grievance procedures, appeal rights and the patients' rights generally available to all covered persons~~] 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

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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;

[~~(2)~~] (4) a [~~managed health care~~] plan shall provide health care services that are reasonably accessible and available in a timely manner to each covered person;

[~~(3)~~] (5) in providing reasonably accessible health care services that are available in a timely manner, a [~~managed health care~~] 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 [~~managed health care~~] plan;

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(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; [~~and~~]

(e) reimbursement for emergency care or ambulance services shall not be contingent upon time constraints of less than fifteen days for notification by the enrollee to the insurer or any other entity that the care or services have been used; and

[~~(e) the plan~~] (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;

[~~(4)~~] (6) a [~~managed health care~~] plan [~~shall~~] adopt and implement a prompt and fair grievance procedure for resolving [~~patient~~] enrollee complaints and addressing [~~patient~~] 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

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procedure shall [~~notify patients~~] 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;

[~~(5)~~] (7) a [~~managed health care~~] plan [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be subject to the plan's grievance procedure and appeal to the superintendent; and

[~~(6)~~] (10) a [~~managed health care~~] plan [~~shall~~] 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

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to read:

"59A-57-4.1. [NEW MATERIAL] 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 [~~OMBUDSMAN OFFICE~~]--REPORTS TO CONSUMERS--SUPERINTENDENT'S ORDERS TO PROTECT CONSUMERS--DUTIES OF THE DEPARTMENT AND THE SUPERINTENDENT--POWERS OF THE DEPARTMENT AND THE SUPERINTENDENT.--

A. [~~Each managed health care~~] 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. [~~Each managed health care~~] 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.

[~~D.~~] 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

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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.

[~~E.~~] 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 [~~regulations~~] 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,

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Chapter 107, Section 6) is amended to read:

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A. No [~~managed health care~~] 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.

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[~~B.~~] D. A plan that proposes to terminate a health care provider from the [~~managed health care~~] 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.

[~~C.~~] E. A [~~managed health care~~] 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 [~~managed health care~~] plan shall adopt and implement a fair hearing [~~plan~~] 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,

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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 with interest on that amount at the rate of one and one-half percent per month.

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

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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:

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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 [~~managed health care~~] 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 [~~managed health care~~] 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. [~~Notwithstanding other provisions of the Patient Protection Act, a medicaid recipient or applicant who files an appeal to the human services department pursuant to the Public Assistance Appeals Act may not file an appeal on the same issue to the superintendent pursuant to the Patient Protection Act, unless the human services department refuses to hear the appeal.~~] 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 [~~the effective date of the Patient Protection Act~~] July 1, 1998 and that is in compliance

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with contractual and regulatory requirements applicable to that program shall be deemed to comply with any requirements established in accordance with [~~that~~] the Patient Protection Act until July 1, 1999. [~~provided that, from the effective date of that act, any rights established under that act beyond those under requirements of the human services department shall apply to enrollees in medicaid managed health care plans~~] 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:

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FORTY-FOURTH LEGISLATURE

FIRST SESSION, 1999

March 16, 1999

Mr. Speaker:

Your CONSUMER AND PUBLIC AFFAIRS COMMITTEE, to whom has been referred

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE
FOR SENATE BILL 511

has had it under consideration and reports same with recommendation that it DO PASS, amended as follows:

1. On page 7, line 2, after "enrollment" insert "and at subsequent periodic times as appropriate".

2. On page 9, line 18, strike "fifteen" and insert in lieu thereof "seven".

3. On page 16, line 20, strike "with" and insert in lieu thereof "plus".

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underscored material = new
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4. On page 16, line 21, before the period insert ", computed on a daily basis".

Respectfully submitted,

_____

Patsy Trujillo Knauer, Chairwoman

Adopted _____ Not Adopted _____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 7 For 0 Against

Yes: 7

Excused: None

Absent: None

.129227.2

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underscored material = new
[~~bracketed material~~] = delete

FORTY-FOURTH LEGISLATURE
FIRST SESSION, 1999

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