

PART 22 MANAGED HEALTH CARE PLAN COMPLIANCE
<http://164.64.110.239/nmac/parts/title13/13.010.0022.htm>

- 13.10.22.1 ISSUING AGENCY
- 13.10.22.2 SCOPE
- 13.10.22.3 STATUTORY AUTHORITY
- 13.10.22.4 DURATION
- 13.10.22.5 EFFECTIVE DATE
- 13.10.22.6 OBJECTIVE
- 13.10.22.7 DEFINITIONS
- 13.10.22.8 ACCESS TO HEALTH CARE SERVICES
- 13.10.22.9 UTILIZATION MANAGEMENT
- 13.10.22.10 CONTINUOUS QUALITY IMPROVEMENT
- 13.10.22.11 CULTURAL AND LINGUISTIC DIVERSITY
- 13.10.22.12 CONTRACTS WITH PROVIDERS IN THE STATE OF NEW MEXICO
- 13.10.22.13 ADMINISTRATIVE COSTS AND BENEFIT DISCLOSURES
- 13.10.22.14 PENALTIES
- 13.10.22.15 SEVERABILITY

13.10.22.1 ISSUING AGENCY:

New Mexico Public Regulation Commission, Division of Insurance, Post Office Box 1269, Santa Fe, New Mexico 87504-1269.

[13.10.22.1 NMAC - Rp, 13.10.13.1 NMAC, 09/01/2009]

13.10.22.2 SCOPE:

This rule applies to health care insurers that are required to obtain a certificate of authority or licensure in this state and which provide, offer, or administer managed health care plans. This rule relates to and should be read in conjunction with 13.10.13, 13.10.16, 13.10.17, 13.10.21 and 13.10.23 NMAC.

[13.10.22.2 NMAC - Rp, 13.10.13.2 NMAC, 09/01/2009]

13.10.22.3 STATUTORY AUTHORITY:

Sections 59A-1-18, 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-16-12, 59A-16-12.1, 59A-16-13, 59A-16-22, 59A-18-17, 59A-18-27.1, 59A-22-32, 59A-22-32.1, 59A-22A-4, 59A-22A-5, 59A-23-4, 59A-44-34, 59A-44-41, 59A-46-7, 59A-46-9, 59A-46-10, 59A-46-11, 59A-46-23, 59A-46-25, 59A-46-27, 59A-46-30, 59A-46-35, 59A-46-36, 59A-47-27, 59A-47-29, 59A-47-33, 59A-57-2, 59A-57-4, 59A-57-5, 59A-57-6, 59A-57-8, and 59A-57-11 NMSA 1978.

[13.10.22.3 NMAC - Rp, 13.10.13.3 NMAC, 09/01/2009]

13.10.22.4 DURATION:

Permanent.

[13.10.22.4 NMAC - Rp, 13.10.13.4 NMAC, 09/01/2009]

13.10.22.5 EFFECTIVE DATE:

September 1, 2009, unless a later date is cited at the end of a section.

[13.10.22.5 NMAC - Rp, 13.10.13.5 NMAC, 09/01/2009]

13.10.22.6 OBJECTIVE:

The purpose of this rule is to ensure the availability, accessibility, and quality of health care services provided by health care insurers through managed health care plans, and to regulate trade practices in the insurance business and related businesses by prohibiting unfair or deceptive acts or practices.

[13.10.22.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.22.7 DEFINITIONS:

In addition to the following, this rule is subject to the definitions found in the Grievance Procedures Rule, 13.10.17 NMAC.

A. "Claim" means:

- (1) any request by an insured for indemnification by a MHCP; and
- (2) any direct services provided to an individual.

B. "Direct services" means:

- (1) services rendered to an individual by a health insurer or a health care professional, facility or other provider;
- (2) case management, disease management, health education and promotion, preventive services, quality incentive payments to providers or individuals; and

(3) any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act.

C. "Earned premium" means paid premiums for the year plus uncollected premiums minus premiums paid in advance.

D. "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.

E. "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, prepaid dental plan, a multiple employer welfare arrangement or any other person providing a plan of health insurance or a managed health care plan subject to state insurance law and regulation.

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

G. "Health care services" means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

H. "Incurred claims" means paid-on-incurred claims for the year, plus a reserve for claims incurred but not yet paid, plus the change in any other reserve held, plus expenses incurred during the year.

I. "Incurred health care expenses" means health care coverage that is provided by a health maintenance organization, as defined in Article 46 of the New Mexico Insurance Code, on a service rather than reimbursement basis.

J. "Loss Ratio" means incurred claims or incurred health care expenses to earned premiums.

K. "Managed health care plan (MHCP or plan)" means a policy, contract, certificate or agreement offered or issued by a health care insurer, provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services, except as otherwise provided in this subsection. A MHCP 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, provider service network, or plan administrator. Effective immediately, a MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies. For purposes of this section, "plan administrator" shall include and apply to an HMO or other health care insurer not required to be licensed under Section 59A-12A-2 NMSA 1978, but which is acting as a "plan administrator" as defined under the act." A MHCP includes a health benefits plan as defined under NMSA 1978 Section 59A-22A-3(D) as "the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available."

L. "Premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitation payments, recoveries from third parties or other insurers, interest and administrative fees received and claim payments made by:

- (1) an administrator or third party administrator pursuant to Chapter 59A, Article 12A NMSA 1978;
- (2) a health maintenance organization;

- (3) a nonprofit health care plan; or
- (4) an insurer.

M. "Small group health insurance market" means plans offered to small employers pursuant to Article 23C of the New Mexico Insurance Code.

N. "Usual, customary and reasonable rate" means health care services, medical supplies and payment rates for health care services provided by a health care practitioner at or near the median rate paid for similar health care services within a surrounding geographic area where the charges were incurred. Surrounding geographic area may be determined by the type of service and access to that service in the geographic area.

[13.10.22.6 NMAC - Rp, 13.10.13.6 NMAC, 09/01/2009]

13.10.22.8 ACCESS TO HEALTH CARE SERVICES:

A. Provider network adequacy: Each health care insurer through its MHCP shall maintain and have available an adequate network of licensed primary care practitioners (PCPs) to provide comprehensive basic health care services to its enrolled population at all times. Those MHCPs currently doing business in New Mexico shall submit to the superintendent for approval an access plan addressing all of the criteria of this section. A MHCP new to this state shall submit a preliminary access plan to the division as part of its application for licensure. A MHCP new to this state shall file a follow-up access plan with the superintendent within six months after it obtains a certificate of authority. The superintendent shall approve or reject an access plan submitted by a MHCP within 45 days after the access plan is submitted to the division. In considering whether to approve or reject an access plan, the superintendent shall determine whether the MHCP meets all of the following criteria; however, the superintendent may make reasonable exceptions to the criteria on a case by case basis when the MHCP demonstrates the need for such exceptions.

(1) Whether, in population areas of 50,000 or more residents, two PCPs are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, whether two PCPs are available in any county or service area within no more than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care.

(2) Whether the MHCP has a sufficient number of PCPs to meet the primary care needs of the enrolled population, using, as guidelines for calculation, the following criteria: 1) that each covered person will have four primary care visits annually, averaging a total of one hour; 2) that each PCP will see an average of four patients per hour; and 3) that one full-time equivalent PCP will be available for every 1,500 covered persons.

(3) Whether the MHCP demonstrates that the projected PCP network is sufficient to meet the primary care needs of adult, pediatric, and obstetric-gynecological patients. Each MHCP should show the adequacy of PCP availability by verifying that the PCPs committed to provide sufficient time for new patients so that projected clinic hour needs of the projected enrollment by service area are met.

(4) Whether the MHCP provides reasonable and reliable access for its covered persons to qualified health care professionals in those specialties that are covered by the MHCP. In developing its access plan, the MHCP should: 1) demonstrate that a sufficient number of licensed medical specialists are available to covered persons for specialty care when referral to such care is determined to be medically necessary by the PCP or other treating health care professional in consultation with the MHCP; and 2) attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population. A MHCP shall not restrict PCPs, in consultation with the MHCP, from referring covered persons to

providers outside the network, even when geographically distant from the covered person's residence, when access to such treatment by such provider is medically necessary and no other provider can provide comparable treatment in-network or on a more cost-effective basis.

(5) Whether the MHCP has contracts, or other arrangements acceptable to the superintendent, with institutional providers - so that: 1) the need for services covered by the MHCP is satisfied; 2) the medical needs of covered persons are met 24 hours per day, seven days per week; and 3) the institutional services are geographically accessible to covered persons. In its access plan, the MHCP should demonstrate that in population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number of residents in the county or service area and given the community's standard of care.

(6) Whether a sufficient number of health care professionals, such as registered and licensed practical nurses, are available to covered persons to ensure the delivery of covered health care services.

(7) Whether the MHCP has made surgical facilities including acute care hospitals for major surgery, hospitals for minor surgical procedures, licensed ambulatory surgical facilities, and medicare eligible surgical practices reasonably available, given the population of the service area and the institutional facilities available in or around the service area.

(8) Whether the MHCP has a policy assuring access to tertiary and specialized services as evidenced by contract or other agreement acceptable to the superintendent. In its access plan, the MHCP should describe the geographic location of and covered persons' accessibility to the following such services:

- (a) at least one hospital providing regional perinatal services, if maternity coverage is offered as a health care service;
- (b) a hospital offering tertiary pediatric services;
- (c) a hospital offering diagnostic cardiac catheterization services;
- (d) inpatient psychiatric services for adults and children, if provided as a covered health care service; and
- (e) a residential substance abuse treatment center, if provided as a covered health care service.

(9) Whether the MHCP has a policy assuring access to the specialized services listed below, as evidenced by contract or other agreement acceptable to the superintendent. The MHCP should demonstrate in its access plan the geographic location of and covered persons' accessibility to the following such services:

- (a) a therapeutic radiation provider;
- (b) magnetic resonance imaging center;
- (c) diagnostic radiology provider, including x-ray, ultrasound, and CAT scan; and
- (d) a licensed renal dialysis center.

(10) Whether the MHCP has at least one licensed home health care professional available to serve each service area where 3,000 or more covered persons reside, if home health care is provided as a covered health care service.

B. Appointment waiting times: Each MHCP shall demonstrate that the network will meet the following criteria:

(1) emergencies shall be triaged through the PCP or by a hospital emergency room through medical screening or evaluation;

(2) urgent care shall be available within 48 hours of notification to the PCP or MHCP, or sooner as required by the medical exigencies of the case;

(3) for both emergent and urgent care, the MHCP shall ensure 7 day, 24 hour access to triage services, and that each PCP will have back-up coverage by another provider;

(4) the MHCP shall have an adequate number of PCPs with admitting privileges at one or more participating hospitals within the MHCP's service area so that necessary hospital admissions are made on a timely basis consistent with generally accepted practice parameters;

(5) routine appointments shall be scheduled as soon as is practicable given the medical needs of the covered person and the nature of the health care professional's medical practice;

(6) routine physical exams shall be scheduled within 4 months;

(7) in all instances of scheduling, the MHCP or its participating health care professionals shall have guidelines to assess when an appointment should be scheduled based on the type of health care service to be provided; upon request, the MHCP shall make such guidelines available to covered persons;

(8) all appointments shall be scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice.

C. Referrals: The MHCP shall implement a system that ensures routine referrals are made to other participating health care professionals.

(1) A covered person shall not be held liable for payment of services if the MHCP health care professional mistakenly makes a referral to a non-participating health care professional, unless the MHCP has notified the covered person in writing concerning the use of non-participating health care professionals and informed the covered person that the MHCP will not be responsible for future payment to the non-participating health care professionals.

(2) The MHCP shall bear the burden of showing that the covered person has been adequately informed by specific written notice of the MHCP's future refusal to pay for future care provided by the identified non-participating health care professional.

(3) The MHCP shall ensure that a covered person is not precluded from obtaining a referral from the covered person's PCP to a specialist or other health care professional that is within the MHCP's network, if the referral is reasonable.

D. Provider lists: A MHCP must provide a list of all providers to subscribers, enrollees, covered persons or prospective enrollees upon request.

(1) The list shall include specialty health care professionals and other health care professionals providing health care services, and shall specify the locations, including addresses, of such providers.

(2) The list shall identify those health care professionals who are not currently accepting new patients.

(3) The information shall be made available and upon request be provided to enrollees in the evidence of coverage.

(4) Information should be provided through toll-free phones and electronic means, as specified in 13.10.23.7 NMAC.

(5) MHCPS are encouraged to facilitate a covered person's ability to obtain a second opinion from a participating health care professional regarding the covered person's request for a second opinion from, or referral to, a non-participating health care professional.

E. Out-of-network services: In the event medically necessary covered services are not reasonably available through participating health care professionals, the MHCP shall provide in the contract terms that the MHCP and the PCP or other participating health care professional shall refer a covered person to a non-participating health care professional and shall fully reimburse the non-participating health care professional at the usual, customary, and reasonable rate or at an agreed upon rate. The contract must further state that before a MHCP may deny such a referral to a non-participating physician or health care professional, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

F. Specialty care: Referrals to participating or non-participating specialty health care professionals must be accessible to covered persons on a timely and appropriate basis in accordance with generally accepted medical guidelines.

(1) If the MHCP requires covered persons to obtain prior authorization before referral to specialty care, the MHCP must provide covered persons the following information in the evidence of coverage:

- (a) procedures a covered person must follow to obtain prior authorization for specialty referrals, including whether a covered person's PCP, the MHCP's medical director, or a committee must first authorize the specialty referral;
- (b) the necessity, if any, of repeating prior authorization if the specialist care is to be ongoing; and
- (c) procedures to obtain a second medical opinion.
- (d) if a PCP referral is required under the MHCP, the MHCP must inform PCPs of their responsibility to provide written referrals; of any specific procedures that must be followed in providing such referrals; and that the PCP must refer patients to those participating health care professionals who are qualified to address the covered person's health care needs as determined by the PCP in consultation with the MHCP.

(2) The MHCP shall make determinations on requests for referrals in accordance with Subsection D of 13.10.13.19 NMAC.

(3) Covered persons denied referral to specialty care may initiate a grievance through the MHCP's grievance procedures pursuant to 13.10.17 NMAC.

G. Ongoing specialty care: If, in the best medical judgment of the covered person's PCP, the covered person's health condition requires ongoing specialty care, such as for chronic illnesses requiring medical supervision beyond the capability or training of the PCP, the PCP may, after consultation with the specialist and the MHCP, refer the covered person to the appropriate specialist for ongoing care as the severity of the condition warrants.

(1) The ultimate determination, however, of whether the covered person should have ongoing care from the specialist shall remain with the PCP.

(2) In such cases, neither the PCP nor the covered person will be required to obtain a prior authorization from the MHCP for subsequent specialist visits.

(3) The MHCP may review such referrals to specialist care on an annual basis to determine whether ongoing specialist care continues to be medically necessary. In conducting such a review, the MHCP shall consult with the covered person's primary care physician and the specialist to whom the covered person has been referred.

(4) Nothing in Subsection G of 13.10.22.8 NMAC prohibits a MHCP from requiring that covered persons receive ongoing specialist care from those specialists who are considered "participating health care professionals" by the MHCP, unless there are no participating specialists of the type required to manage the patient's condition. In such instances, the MHCP shall make indemnity or other payment

arrangements for the patient's care, and covered persons will not be assessed higher or additional co-payments as a result of such arrangements.

(5) A MHCP must allow qualified health care professionals who are specialists to act as PCPs for patients with chronic medical conditions of sufficient severity to require primary coordination of care by a specialist as determined by the covered person, the covered person's current treating health care professional, the covered person's PCP if different than the treating health care professional, and the MHCP, provided that:

(a) the specialist offers all basic health care services that are required of them by the MHCP; and

(b) the specialist meets the MHCP's eligibility criteria for health care professionals who provide primary care.

H. Out of state providers: A MHCP is encouraged to enter into contracts or other arrangements with out of state providers in order to meet the access requirements of this rule.

I. Access to non-allopathic health care services: In order to maximize covered persons' access to all types of health care services, the division affirmatively encourages each health care insurer or MHCP to enter into appropriate contracts with qualified health care professionals, including but not limited to, doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives to provide both allopathic and non-allopathic health care services.

J. Reliance on nationally recognized accreditation standards to meet access standards: If the MHCP utilizes an open network pursuant to NMSA 1978, Section 59A-22A-5, then in lieu of the provisions of 13.10.22.8 NMAC, Subsections A-I, the MHCP shall present to the superintendent written verification either that the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission/URAC (URAC) determined that the MHCP has achieved one of the two highest ratings for all factors regarding availability of health care professionals and accessibility of services, under contemporaneous NCQA or URAC standards.

(1) In lieu of the above, the plan shall present evidence to the superintendent that it would achieve these ratings if evaluated by the NCQA or URAC, in addition to member survey results.

(2) Plans shall also take into account that the division will utilize the standards described in Subsections D, H and I of 13.10.22.8 NMAC, and the "medical necessity" and "usual, customary, and reasonable rate" standards found in Subsection E of 13.10.22.8 NMAC.

[13.10.22.8 NMAC - Rp, 13.10.13.11 NMAC, 09/01/2009]

