SENATE BILL 22

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

INTRODUCED BY

Gerald Ortiz y Pino

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO MANAGED HEALTH CARE; ENACTING THE HEALTH CARE PROVIDER PROTECTION ACT; PROVIDING PROTECTIONS FOR HEALTH CARE PROVIDERS WORKING WITH MANAGED HEALTH CARE PLANS; ESTABLISHING PROVIDER REIMBURSEMENT PROCEDURES FOR MANAGED HEALTH CARE PLANS; LIMITING RECOUPMENT REQUESTS BY MANAGED HEALTH CARE PLANS; REQUIRING MANAGED HEALTH CARE PLANS TO PROVIDE TECHNICAL ASSISTANCE AND TRAINING AND EDUCATIONAL PROGRAMS TO PROVIDERS; PROVIDING CREDENTIALING AND RECREDENTIALING PROCESSES FOR HEALTH CARE PROVIDERS WORKING WITH MANAGED HEALTH CARE PLANS; ENACTING THE MANAGED HEALTH CARE OMBUDSMAN ACT; CREATING A MANAGED HEALTH CARE OMBUDSMAN OFFICE; ENACTING SECTIONS OF THE NMSA 1978.

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

SECTION 1. SHORT TITLE.--Sections 1 through 7 of this act

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1 may be cited as the "Health Care Provider Protection Act".
2 **SECTION 2.** DEFINITIONS.--As used in the Health Care
3 Provider Protection Act:
4 A. "covered person" or "patient" means an
5 individual who is entitled to receive health care benefits
6 provided by a managed health care plan;
7 B. "division" means the insurance division of the
8 public regulation commission;
9 C. "health care facility" means an institution
10 providing health care services, including a hospital or other
11 licensed inpatient center; an ambulatory surgical or treatment
12 center; a skilled nursing center; a residential treatment
13 center; a home health agency; a laboratory; a diagnostic or
14 imaging center; and a rehabilitation or other therapeutic
15 health setting;
16 D. "health care insurer" means a person that has a
17 valid certificate of authority in good standing under the New
18 Mexico Insurance Code to act as an insurer, health maintenance
19 organization, nonprofit health care plan or prepaid dental
20 plan;
21 E. "health care professional" means a physician or
22 other health care practitioner, including a pharmacist, a
23 certified nurse practitioner in advanced practice as provided
24 in Sections 61-3-23.2 through 61-3-23.4 NMSA 1978 and a
25 certified nurse midwife, who is licensed, certified or

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otherwise authorized by the state to provide health care services consistent with state law;

F. "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;

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

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

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

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authority pursuant to the Provider Service Network Act;

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

K. "superintendent" means the superintendent of insurance;

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

M. "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. REIMBURSEMENT FROM A MANAGED HEALTH CARE PLAN--SERVICES RENDERED.--

A. A managed health care plan shall make a reimbursement determination in a timely manner as required by the exigencies of the situation and in accordance with sound medical principles. Such determination shall not exceed twenty-four hours for emergency care and seven days for all other determinations. If the plan is unable to make a reimbursement determination within ten days, the plan shall notify the provider in writing about the reasons for the delay

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and when a decision may be expected.

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

C. At least quarterly, a managed health care plan shall provide a report to health care providers that have submitted claims for reimbursement for services provided to covered persons during the quarter, listing any reimbursement request that did not qualify as a "clean claim", as that term is defined in Subsection A of Section 59A-16-21.1 NMSA 1978. The managed health care plan shall list the reasons that the claim did not qualify as a clean claim and provide a contact number for the provider to call to receive assistance in qualifying the claim.

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

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

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

(1) submit one reimbursement recoupment

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request per individual claim to the health care provider;

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

(3) allow the provider an opportunity to dispute the reimbursement recoupment request in accordance with the process outlined in Section 7 of this act.

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

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

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

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

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

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

B. At the managed health care plan's expense, each plan shall provide administrative and financial training and educational programs related to the plan's administrative and financial procedures to health care providers. The plan shall offer providers training and educational programs at least quarterly in several locations around the state.

C. If a dispute arises between a health care provider and a managed health care plan over the provisions of this section, either party may ask the superintendent to review the matter and issue a decision.

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

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

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

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B. Except as otherwise provided in this section, a managed health care plan shall assess and verify the qualifications of a health care provider within forty-five calendar days of receipt of a complete uniform credentialing form.

C. For all health care providers with no past or current license sanctions, as reported by the New Mexico medical board or other pertinent licensing and governing agencies, or by similar out-of-state entities for providers licensed in other states, a managed health care plan shall assess and verify the qualifications of the provider within thirty calendar days of receipt of a complete uniform credentialing form. Providers with no past or current license sanctions shall be reimbursed for all services provided to a covered person during the thirty-day verification period, unless the plan determines that the provider does not meet all of the credentialing requirements.

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

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person who will serve as the contact person for the provider.

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

F. Any dispute between a health care provider and managed health care plan regarding credentialing or recredentialing shall be governed by the process set forth in Section 7 of this act.

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

A. A managed health care plan shall adopt and implement a process pursuant to which a health care provider may raise with the plan concerns regarding the credentialing and recredentialing process, the provider's reimbursement request or the plan's reimbursement recoupment request. The process shall include, at a minimum, the right of the provider to present the provider's concerns to a plan committee responsible for the substantive area addressed by the concern and the assurance that the concern will be conveyed to the plan's governing body. In addition, a plan shall adopt and implement a fair hearing procedure that permits a provider to dispute the existence of adequate cause to terminate the provider's participation with the plan due to conflicts over

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

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

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

SECTION 8. SHORT TITLE.--Sections 8 through 16 of this act may be cited as the "Managed Health Care Ombudsman Act".

SECTION 9. DEFINITIONS.--As used in the Managed Health Care Ombudsman Act:

A. "division" means the insurance division of the public regulation commission;

B. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a laboratory; a diagnostic or imaging center; and a rehabilitation or other therapeutic health setting;

C. "health care insurer" means a person that has a

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valid certificate of authority in good standing pursuant to the New Mexico Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan;

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

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

F. "managed health care plan" or "plan" means a health care insurer or a provider service network that, when offering a benefit, either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with or employed by the health care insurer or provider service network, including networks offering medicaid services. "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

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benefit that covers only short-term travel, accident-only, limited benefit or specified disease policies; or student health plans;

G. "ombudsman program" means the ombudsman program created by the Managed Health Care Ombudsman Act or any authorized representative of that program;

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

I. "serious mental illness" means a diagnosable disorder of a person's emotional process, thoughts or cognition resulting in functional impairment that substantially interferes with or limits one or more major life activities, but "serious mental illness" does not mean a developmental disability; and

J. "superintendent" means the superintendent of insurance.

SECTION 10. MANAGED HEALTH CARE OMBUDSMAN OFFICE.--

A. The division shall establish and operate a "managed health care ombudsman office".

B. The superintendent shall designate the managed health care ombudsman.

C. The ombudsman shall serve on a full-time basis and shall, personally or through representatives of the office:

(1) identify, investigate and resolve

complaints by patients and health care providers as they relate to the patients' and health care providers' rights as set forth in the Patient Protection Act and the Health Care Provider Protection Act;

(2) work with each managed health care plan's consumer assistance office, evaluate the effectiveness of the plan's consumer assistance office and require the plan's consumer assistance office to adopt measures to ensure that the plan operates effectively to protect both patients' and health care providers' rights under the Patient Protection Act and the Health Care Provider Protection Act;

(3) attempt to resolve disputes through advice, counseling, negotiation or other informal strategies, if possible, before proceeding to formal administrative remedies. Formal administrative remedies shall be pursued before litigation is initiated, but the requirements of this paragraph do not apply when, in the judgment of the ombudsman, the medical or other exigencies of the case require expedited action to prevent harm to the patient;

(4) research and identify ways to improve treatment of persons who are covered by a managed health care plan and are diagnosed with serious mental illness, including providing ongoing training, education and support to health care providers who provide health care services to such persons; and

(5) prepare an annual report that:

(a) describes the activities carried out by the office in the year for which the report is prepared;

(b) contains and analyzes data collected;

(c) evaluates the problems experienced by and the complaints made by or on behalf of patients and health care providers; and

(d) provides policy, regulatory and legislative recommendations to solve identified problems, to resolve complaints, to improve the quality of care of patients and to ensure that a managed health care plan's administrative practices do not unduly burden health care providers.

D. The ombudsman program shall maintain sufficient numbers of staff, qualified by training and experience, to perform the functions of the ombudsman program. Staff may include employees, independent contractors performing services pursuant to contract and volunteers.

SECTION 11. OPERATIONS OF THE OMBUDSMAN PROGRAM THROUGH CONTRACTUAL RELATIONSHIP.--

A. The division shall contract with one or more independent organizations or consortia of organizations to operate the ombudsman program. The contractor has authority to enter into subcontracts for performance of any part of the duties required by the contract. The ombudsman program shall

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operate independently of any state agency or health care plan.

B. The criteria used in selecting a contractor or contractors to operate the ombudsman program shall include preference for:

(1) private, not-for-profit organizations representing a broad spectrum of consumer interests in New Mexico; and

(2) organizations that have, or whose principals have, demonstrated interest and expertise in health care issues and a background in consumer advocacy.

C. A person contracting to perform ombudsman program functions shall not:

(1) be directly involved in the licensing, certification or accreditation of health care facilities, health care plans or health care providers;

(2) have a direct ownership or investment interest in a health care facility, health care plan or health care provider;

(3) be employed by or participate in the management of a health care facility, health care plan or health care provider; or

(4) have the right to receive remuneration under a compensation arrangement with an owner or operator of a health care facility, health care plan or health care provider.

D. The ombudsman program shall exercise its powers

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and duties independently of any state agency or health care plan. To assure the independence of the ombudsman program, the contract to operate the ombudsman program shall be awarded as a multi-term contract for three-year terms. The contract shall not be terminated by the division before its scheduled expiration date except for lack of available funds or for significant deficiencies in contract performance. Before the contract may be terminated by the division on the basis of deficiencies in contract performance, the division shall:

(1) give the contractor notice of the proposed termination and a detailed written statement of deficiencies in contract performance;

(2) give the contractor a reasonable opportunity to respond to and correct the identified deficiencies; and

(3) give timely public notice and an opportunity for public comment on the proposed termination.

SECTION 12. ACCESS TO INFORMATION.--

A. When the assistance of the ombudsman program has been requested on behalf of a patient or health care provider, the ombudsman program shall be granted access to the medical and administrative records relevant to the issue presented; provided that the ombudsman program has the permission of the patient involved or the patient's designated representative.

B. The ombudsman program shall have access to the

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administrative records, policies and documents of health care plans to the extent that the materials are not proprietary or privileged.

C. The ombudsman program shall have access to licensing and data reporting records with respect to health care plans reported to the state, the federal government or private accrediting agencies, to the extent that the information is not proprietary or privileged.

D. State agencies, health care plans and health care providers shall provide cooperation, assistance, data and access to records necessary to enable the ombudsman program to perform its duties under the Managed Health Care Ombudsman Act and other applicable federal and state law. Charges for copies of documents provided to the ombudsman program by a state agency, plan or provider shall be the lesser of actual costs, not to exceed the prevailing community market rates for photocopying, or fifty cents ($.50) a page.

E. Communications between the ombudsman program and a person requesting the assistance of the ombudsman program are privileged. The case files and records of the ombudsman program are confidential and may be disclosed only as provided in this subsection for purposes of fulfilling the duties of the ombudsman program. Those files and records are not subject to subpoena and are exempt from disclosure under the Inspection of Public Records Act. The ombudsman program shall not disclose

1 the identity of or any confidential information regarding any
2 individual who has requested the assistance of the ombudsman
3 program, unless:
4 (1) the patient, health care provider or the
5 patient or provider's designated representative consents to the
6 disclosure; or
7 (2) disclosure is ordered by a court of
8 competent jurisdiction.
9 F. Reports by the ombudsman program on operations
10 of the ombudsman program or systemic issues in managed health
11 care shall be prepared in a manner to ensure that the
12 identities of individuals served by the ombudsman program are
13 not disclosed and information shall be presented in a report in
14 such a way as to prevent identification of individuals served
15 by the ombudsman program.
16 **SECTION 13.** PROHIBITION ON INTERFERENCE WITH OMBUDSMAN
17 PROGRAM OR RETALIATION.--
18 A. No person shall willfully interfere with the
19 lawful actions of the ombudsman program.
20 B. No person shall engage in discriminatory,
21 disciplinary, retaliatory or other adverse action against any
22 person for contacting the managed health care ombudsman office,
23 requesting the assistance of the ombudsman program, providing
24 information to the ombudsman program or otherwise cooperating
25 with the ombudsman program.

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SECTION 14. IMMUNITY FROM LIABILITY.--No representative of the ombudsman program is liable for the good-faith performance of the functions of the ombudsman program pursuant to the Managed Health Care Ombudsman Act.

SECTION 15. AUTHORITY NOT EXCLUSIVE.--The authority granted the ombudsman program under the Managed Health Care Ombudsman Act is in addition to the authority granted under the provisions of any other statute or rule. The authority granted to the ombudsman program does not limit or affect any rights or remedies of managed health care plan enrollees.

SECTION 16. SURCHARGE--MANAGED HEALTH CARE OMBUDSMAN FUND--CREATED.--

A. To ensure adequate funding for the operations of the ombudsman program, a surcharge is assessed on premiums received by insurers offering health care plans. The surcharge is in the amount of one-tenth of one percent of the dollar amount of premiums collected by the insurer for coverage of enrollees in the insurer's health plans, whether for privately paid insurance or for publicly funded programs, including the medicaid program.

B. There is created in the state treasury a "managed health care ombudsman fund". All money collected pursuant to the provisions of subsection A of this section shall be deposited in the managed health care ombudsman fund. Balances in the fund and interest earned on money in the fund

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are appropriated to the division for the purpose of administering and contracting for the ombudsman program as provided in the Managed Health Care Ombudsman Act. Any unexpended or unencumbered balance remaining at the end of a fiscal year shall not revert.

SECTION 17. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2011.