

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 30 NETWORK ACCESS PLANS, NETWORK ADEQUACY AND PROVIDER DIRECTORIES

13.10.30.1 ISSUING AGENCY: Office of Superintendent of Insurance (OSI), Life and Health (L&H).
[13.10.30.1 NMAC - N, 10/01/2018]

13.10.30.2 SCOPE:

A. Applicability. This rule applies to all health insurance carriers subject to the insurance laws and regulations of this state, including health insurance companies, health carriers, health maintenance organizations, hospital and health services corporations, provider service networks, non-profit health care plans, third-party administrators and any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits policies and managed health care plans in this state.

B. Limitations. Nothing contained in this rule shall be construed to:

- (1) impose any requirement on health insurance carriers as to which providers may be accepted into a carrier's network(s);
- (2) specify terms of contracts established between health insurance carriers and providers;
- (3) establish reimbursement rates by carriers to contracted or non-contracted providers for services; or
- (4) interpret terms of any contract established between a health insurance carrier and its providers.

C. Exclusions. For the purposes of this rule, a "health benefits plan" does not include the following:

- (1) an accident-only policy;
- (2) a credit-only policy;
- (3) a long- or short-term care or disability income policy;
- (4) a specified disease policy;
- (5) a medicare supplement policy;
- (6) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement policy;
- (7) a fixed indemnity policy;
- (8) a workers' compensation policy;
- (9) an automobile medical payment policy;
- (10) a short-term travel policy;
- (11) a limited-scope dental plan; or
- (12) a limited-scope vision plan.

[13.10.30.2 NMAC - N, 10/01/2018]

13.10.30.3 STATUTORY AUTHORITY: Sections 59A-1-18, 59A-2-9, 59A-4-3, 59A-16-5, 59A-22-25, 59A-22-32, 59A-22-32.1, 59A-22-35, 59A-22-36, 59A-22-39, 59A-22-47, 59A-22-49, 59A-22-49.3, 59A-22-49.4, 59A-22A-2 et seq., 59A-23-6, 59A-23-7.6, 59A-23-7.9, 59A-23-7.12, 59A-23-7.13, 59A-46-3, 59A-46-20, 59A-46-34, 59A-46-35, 59A-46-36, 59A-46-39, 59A-46-41, 59A-46-48, 59A-46-50, 59A-46-50.3, 59A-46-50.4, 59A-47-6, 59A-47-12, 59A-47-27, 59A-47-28, 59A-47-28.1, 59A-47-28.2, 59A-47-28.3, 59A-47-35, 59A-47-43, 59A-47-45, 59A-47-45.4, 59A-57-1 et seq. NMSA 1978.

[13.10.30.3 NMAC - N, 10/01/2018]

13.10.30.4 DURATION: Permanent.

[13.10.30.4 NMAC - N, 10/01/2018]

13.10.30.5 OBJECTIVE: The purpose of this rule is to establish network access plan requirements, to provide requirements for submitting network access plans to the superintendent for review and approval and to establish publication requirements for communication of provider availability and network participation to the public in a manner that is transparent, accessible and timely.

[13.10.30.5 NMAC - N, 10/01/2018]

13.10.30.6 **EFFECTIVE DATE:** January 1, 2019, unless a later date is cited at the end of a section.
[13.10.30.6 NMAC - N, 10/01/2018]

13.10.30.7 **DEFINITIONS:** For definitions of terms that are used in this rule but are not contained in this section, please refer to 13.10.30 NMAC.
[13.10.30.7 NMAC - N, 10/01/2018]

13.10.30.8 **NETWORK ACCESS PLAN SUBMISSION FOR REVIEW BY THE SUPERINTENDENT:**

A. Submission of access plans for existing products.

(1) On or before January 1, 2019, and annually thereafter, a health insurance carrier that uses a provider network for a product shall file for review and approval by the superintendent a network access plan that meets the requirements of Sections 59A-46-3, 59A-47-6 and 59A-57-4 NMSA 1978.

(2) The submitted network access plan shall be certified by an authorized representative of the health insurance carrier. The certification shall specifically state that the carrier has prepared a network access plan meeting the requirements of Sections 9 through 11 of 13.10.30 NMAC.

(3) If a single provider network is relied upon by the health insurance carrier to satisfy provider access requirements for more than one product, a single network access plan shall be prepared and a single network access plan certification of compliance shall be filed. The certification report shall identify all products and health benefits plans relying upon the common provider network to satisfy provider access requirements.

(4) If different provider networks are relied upon to satisfy provider access requirements for different products, then multiple corresponding network access plans shall be prepared and multiple corresponding certifications of compliance shall be filed.

B. Submission of network access plans for new products.

(1) When offering a new product, a health insurance carrier shall prepare and submit a network access plan or shall identify an existing network access plan that will be used for the product, no later than January 1 of the year immediately following commencement of sales of the product.

(2) If the number of persons covered by the new product reaches at least 5,000 lives (the "Covered Person Threshold") prior to January 1, then the network access plan or identification of an existing network access plan shall be submitted to the superintendent within the earlier of three months after the Covered Person Threshold is reached or January 1.

(3) Thereafter, health insurance carriers shall file a network access plan for the product annually on or before January 1.

(4) Health insurance carriers shall submit a new certification of compliance for each new product offered using the form available on the OSI website.

(5) If the new product will use an existing network, the health insurance carrier shall demonstrate in the network access plan how the identified network will meet access requirements for the additional covered persons.

C. Material changes to network access plans. If a health insurance carrier makes a material change to a network during the plan year, the carrier shall notify the superintendent of the change within 15 business days after its occurrence. Material changes include:

(1) a ten percent or greater reduction in the number of primary or specialty care providers available in a network;

(2) a greater than ten percent reduction in any type of provider such that a specific covered service is no longer available; or

(3) a change to tiered or multi-tiered participating provider network structure.

[13.10.30.8 NMAC - N, 10/01/2018]

13.10.30.9 **REQUIRED ELEMENTS OF THE NETWORK ACCESS PLAN:**

A. The network access plan shall plainly and comprehensively describe:

(1) Geographic access. The network access plan shall describe the product's network, including geographic accessibility, which in some circumstances may require the crossing of county or state lines or the use of telehealth services.

(2) Referral procedures. The network access plan shall include the health insurance carrier's procedures for making and authorizing referrals within and outside of its network, if applicable.

(3) Notification to covered persons. The network access plan shall include the health insurance carrier's procedures for notifying covered persons that they shall be held harmless for out-of-network emergency care pursuant to Sections 59A-57-4 and 59A-22A-5 NMSA 1978.

(4) Enrollment information. For each product offered by a health insurance carrier, the network access plan shall include the product's current enrollment in this state. The information shall be provided using a table that reports the number of covered persons by zip code of residence or employment, whichever has been specified by the covered person as the preferred point of access, the total number of covered persons statewide and the gender and age composition of the covered person population, including covered dependents and spouses.

(5) Network data. A health insurance carrier's network access plan shall include, using forms provided by the superintendent, evidence of a sufficient number of health care providers with which the carrier is contracted at the time of submission to serve covered persons:

- (a)** participating primary care practitioners (PCPs) to covered person ratios by county;
- (b)** participating specialty care practitioners to covered person ratios by county;
- (c)** access to in-network emergency and urgent care services;
- (d)** participating pharmacies accessible to covered persons;
- (e)** essential community providers (ECPs) and Indian Health Service (IHS) provider locations and access; and
- (f)** the number of participating providers who are available through telehealth services.

(6) Access to providers. The network access plan shall demonstrate access to the following contracted provider types for each county:

- (a)** a facility providing regional emergency care services;
- (b)** a facility providing perinatal services;
- (c)** a facility offering tertiary pediatric services;
- (d)** a facility offering diagnostic cardiac catheterization services;
- (e)** a facility providing inpatient psychiatric services for adults and children, if included as a covered benefit;
- (f)** a facility providing substance use treatment;
- (g)** a therapeutic radiation provider;
- (i)** a diagnostic imaging provider, including but not limited to X-ray, CT scan, ultrasound and MRI;
- (j)** a licensed renal dialysis center;
- (k)** a hospice services provider, if included as a covered benefit;
- (l)** a healing arts services provider, if included as a covered benefit;
- (l)** a home health care services provider, if included as a covered benefit;
- (m)** a skilled nursing facility;
- (n)** a provider of durable medical equipment; and
- (o)** additional provider types, as specified by the superintendent.

(7) Counties lacking provider availability. If one or more of the above services is not available in a county or counties, the health insurance carrier shall note the unavailability of providers in its network access plan submission. The carrier shall describe the process by which it facilitates timely access to services for covered persons residing in counties without provider availability, including only providers and facilities that are under contract with the carrier at the time the network access plan is submitted to the superintendent.

(8) Monitoring and expansion procedures. The network access plan shall describe the health insurance carrier's ongoing process for monitoring and ensuring the sufficiency of the network to meet the health care needs of covered persons, including expansion of the network as required by changes in the population served that may occur during the reporting period.

(9) Criteria for contracting with providers. The network access plan shall describe the factors relied on by the health insurance carrier to build its provider network, including a description of the network and the criteria used, if applicable, to select and tier providers. These factors may include facility quality rating standards, density of covered person populations or disciplinary complaint review.

(10) Diversity and special considerations. A health insurance carrier shall describe in its network access plan its ongoing efforts to contract with providers that meet the accessibility requirements of the

Americans with Disabilities Act (ADA) and to address the needs of all covered persons regardless of age, including those:

- (a) with limited English proficiency or other literacy issues;
- (b) from diverse cultural or ethnic backgrounds;
- (c) with physical or mental disabilities; and
- (d) with serious, chronic or complex medical conditions pursuant to Section 11 of

13.10.22 NMAC.

(11) Covered medications. The network access plan shall describe the health insurance carrier's method of informing covered persons of changes to the drug formulary and coverage of prescription medications pursuant to Sections 59A-46-50.4, 59A-47-45.4, 59A-23-7.13 and 59A-22-49.4 NMSA 1978.

(12) Continuity of care. The network access plan shall describe the health insurance carrier's proposed plan for providing continuity of care in compliance with Section 14 of 13.10.23 NMAC.

(13) Provider directory audit. The network access plan shall include a report for the prior calendar year on the outcomes of the health insurance carrier's provider directory audit(s), as described in Subsections F and G of Section 12 of this rule.

(14) Other information. The network access plan shall include all other information that the superintendent determines is necessary to confirm compliance with the provisions of this rule and the insurance code.

B. Corrective action. The superintendent may order corrective action if, after review and opportunities to correct deficiencies have been provided, the network access plan is determined not to meet the requirements of this subsection pursuant to Sections 59A-1-18, 59A-46-20, 59A-47-12 and 59A-57-11 NMSA 1978. [13.10.30.9 NMAC - N, 10/01/2018]

13.10.30.10 PUBLIC ACCESS TO NETWORK ACCESS PLANS:

A. A health benefits plan shall disclose the existence and availability of its network access plan. However, all rights and responsibilities of a covered person under the health benefits plan shall be included in the contract provisions, regardless of whether such provisions are specified in the network access plan.

B. A health insurance carrier shall make its network access plan available to any interested party:
(1) electronically and free of charge upon request; and
(2) printed upon request, for which the carrier may require reimbursement of reasonable production and, if applicable, delivery costs.

[13.10.30.10 NMAC - N, 10/01/2018]

13.10.30.11 NETWORK ACCESS PLAN MINIMUM REQUIREMENTS:

A. Standards for timely access to scheduled care.

(1) Network capacity and provider availability. A health insurance carrier shall take reasonable steps to ensure, based on an adequate sample of surveyed participating providers and covered persons, that at least ninety percent of covered persons' appointments meet the following timeliness requirements:

(a) for an initial visit to establish a relationship with a participating PCP, an appointment date shall be available within 30 days of a covered person's request or sooner, if medically necessary, or so that a covered person can receive an on-schedule immunization;

(b) for routine-care services from a participating PCP, an appointment date shall be available within 15 days of a covered person's request to the PCP, or sooner if medically necessary or so that a covered person can receive an on-schedule immunization;

(c) non-urgent appointments with a specialty provider shall be available within 45 business days of a covered person's request for an appointment;

(d) non-urgent appointments with a non-physician behavioral health care provider shall be available within 15 business days of a covered person's request for an appointment; and

(e) non-urgent appointments for ancillary services, such as magnetic resonance imaging, diagnostic radiology services or echocardiogram, for the diagnosis or treatment of injury, illness or other health condition, shall be available within 15 business days of a covered person's request for appointment.

(2) Provisions for provider shortages. A health insurance carrier operating in a county that has a shortage of one or more types of required providers shall make reasonable efforts to provide timely access to covered health care services as set forth in this section, including applicable timeliness standards. This may include referring covered persons to, or, in the case of a preferred provider network, by assisting covered persons to locate available and accessible contracted providers in neighboring or nearby counties.

(3) Scheduling guidelines. In all instances of scheduling, a health insurance carrier or its participating providers shall maintain guidelines to determine how quickly an appointment shall be scheduled based on the type of health care services to be provided. The carrier shall make the guidelines available to covered persons upon request and free of charge.

(4) Provider backup coverage. A health insurance carrier shall ensure that each participating PCP has back-up coverage provided by another practitioner who offers primary care services.

B. Standards for timely access to urgent and emergent care. A health insurance carrier shall ensure that its provider network has adequate capacity and availability of licensed urgent and emergent care providers to offer 100 percent of covered persons access to urgent and emergent care that meets the following timeliness requirements based on an adequate sample of surveyed participating providers and covered persons:

(1) Urgent care access at the in-network level of benefits. Access to urgent care services shall be available from a participating provider seven days per week during, at minimum, standard business hours.

(2) Emergency care access at the in-network level of benefits. Covered persons shall have access to emergency care from a participating provider 24 hours a day, seven days a week.

(3) Triage of services. Contracts with providers shall require that the providers' triage or screening services be provided in a timely manner appropriate for the covered person's condition and that the triage or screening waiting time shall not exceed standards established by the providers' licensing or accreditation agency or board.

C. Permitted deviations from timely access to care standards.

(1) Extension of waiting times. Contracts with participating providers shall permit the extension of waiting times for appointments if the referring or treating health care professional providing triage or screening services has determined and included in the relevant record(s) that the longer waiting time will not have a detrimental impact on the health of the covered person.

(2) Advance scheduling. Contracts with participating providers shall allow advanced scheduling of appointments for routine care and periodic follow-up care, including but not limited to:

(a) standing referrals to specialists for chronic conditions;

(b) periodic office visits to monitor and treat pregnancy;

(c) cardiac or behavioral health conditions;

(d) laboratory and radiological monitoring for recurrence of disease; and

(e) physical and occupational therapy.

D. Access to care in special circumstances. Health insurance carriers shall arrange for the accessibility of covered specialty services from non-participating specialists when the services are not available from a participating specialist and such services are medically necessary.

(1) Payment level. Cost-sharing for covered services furnished by nonparticipating providers to whom a covered person was referred by the health insurance carrier or its participating provider under this subsection shall be no higher than the participating provider level.

(2) Charges from non-participating specialists. A health insurance carrier shall make a good faith effort to ensure that non-participating specialists to whom a covered person is referred charge covered persons applicable in-network cost-sharing amounts at the time of service.

(3) Covered person's preference. This requirement does not prohibit a health insurance carrier or one of its participating providers from accommodating a covered person's preference to wait for a later appointment from a specific contracted provider.

E. Geographic accessibility requirements. For the purposes of meeting geographic accessibility requirements, a participating provider may be located outside the physical boundaries of the county being assessed if the provider's location meets the time and distance standards for at least one covered person in that county as required by this rule.

(1) County population. Geographic access to health care providers shall be based on the population of the county in which the covered person resides.

(2) County type designations. Network access shall be measured for county types based on their designations as metropolitan, micropolitan, rural or counties with extreme access considerations (CEAC) as established by the Centers for Medicare & Medicaid Services (CMS) as of the prior September 1. A table of county-size designations is available on the OSI website.

(3) Maximum travel time and distance requirements. Geographic access shall be determined as follows, with all distances defined as driving distances:

(a) Metropolitan areas. At least ninety percent of covered persons residing in a metropolitan area shall have access to:

(i) primary care services from at least two participating PCPs that are accepting new patients and located within 10 miles or 20 minutes from the covered person's preferred point of service.

(ii) specialty care services from participating specialty care providers located within 20 miles or 40 minutes from the covered person's preferred point of service; and

(iii) inpatient care in a participating acute care or specialty hospital located within 20 miles or 40 minutes from the covered person's preferred point of service.

(b) Micropolitan areas. At least ninety percent of covered persons residing in micropolitan areas shall have access to:

(i) primary care services from at least two participating PCPs that are accepting new patients and located within 35 miles or 70 minutes from a covered person's preferred point of service;

(ii) specialty care services from participating specialty care providers located within 50 miles or 90 minutes from the covered person's preferred point of service; and

(iii) inpatient care in a participating acute care or specialty hospital located within 50 miles or 90 minutes from the covered person's preferred point of service.

(c) Rural areas. At least ninety percent of covered persons residing in rural areas shall have access to:

(i) primary care services from at least one participating PCP that is accepting new patients and located within 30 miles or 60 minutes from the covered person's preferred point of service;

(ii) specialty care services from participating specialty care providers located within 60 miles or 100 minutes from the covered person's preferred point of service; and

(iii) inpatient care in a participating acute care or specialty hospital located within 60 miles or 100 minutes from the covered person's preferred point of service.

(d) CEAC areas. At least ninety percent of covered persons residing in CEAC areas shall have access to:

(i) primary care services from at least one participating PCP that is accepting new patients and located within 60 miles or 90 minutes from the covered person's preferred point of service;

(ii) specialty care services from participating specialty care providers located within 100 miles or two hours from the covered person's preferred point of service; and

(iii) inpatient care in a participating acute care or specialty hospital located within 100 miles or two hours from the covered person's preferred point of service.

(4) Requests for exceptions. A health insurance carrier may seek exceptions to the above standards based on one or more of the following factors:

(a) the county-type designation is rural or CEAC or, for specialty care, micropolitan;

(b) the availability and distribution of PCPs;

(c) the availability and distribution of other types of providers; or

(d) the existence of exclusive contracts in the local provider community or other barriers to entry.

(5) A health insurance carrier shall make a good faith effort to contract with providers closest in proximity to populations of covered persons. A carrier shall not unduly burden covered persons by requiring them to travel to reach participating providers where local, qualified providers are available and willing to contract with the carrier to provide services.

F. Minimum ratios and standards.

(1) Provider-to-covered-person ratio. A health insurance carrier's provider network shall meet the following provider-to-covered-person ratios. For each county there shall be at least one full-time-equivalent (FTE):

(a) primary care practitioner, including but not limited to family and general practitioners, pediatricians and internists, for each 1,000 covered persons;

(b) obstetrician-gynecologist for each 1,000 female-bodied covered persons;

(c) general surgeon for each 2,000 covered persons;

(d) orthopedic surgeon for each 7,000 covered persons;

(e) neurologist for each 10,000 covered persons;

(f) cardiologist for each 2,000 covered persons; and

(g) psychiatrist for each 2,000 covered persons.

(2) Home health care. If home health care is a covered benefit, a network shall include at least one state-licensed home health care professional available to serve each county in which 3,000 or more covered persons reside.

(3) Medically required services. Delineated provider-to-covered-person ratios notwithstanding and with due regard to the availability and distribution of providers within a county and to other providers who may furnish telehealth services; a health insurance carrier shall provide access to medically necessary primary, acute and specialty care for covered services, as clinically appropriate.

(4) Proximity of providers. A carrier's network shall include a participating provider located within the maximum travel time and distance of at least one covered person who resides in the county being assessed in order for the provider to be counted toward the minimum requirements of this subsection.

G. Community-based provider access.

(1) Essential community providers (ECPs). A health insurance carrier shall have a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECP providers for low-income, medically underserved individuals. Sufficient number and geographic distribution is defined as at least 20 percent of available ECPs in the rating area participating in the carrier's provider network.

(2) Indian Health Service (IHS) providers. A health insurance carrier is not responsible for credentialing providers and facilities that are a part of the IHS. A carrier may use the HHS Standard Indian Addendum when contracting with IHS providers. Regarding IHS providers, a health insurance carrier:

(a) shall offer contracts in good faith to providers that are a part of the IHS System;

(b) shall ensure that covered persons may obtain covered services from IHS providers at no greater cost to the covered person than if the service were obtained from participating providers; and

(c) may use the HHS Standard Indian Addendum when contracting with Indian providers.

H. Nothing in this section shall prohibit a health insurance carrier from limiting its coverage based on plan benefit eligibility, medical necessity determinations or other approved utilization review determinations.

[13.10.30.11 NMAC - N, 10/01/2018]

13.10.30.12 PROVIDER DIRECTORIES:

A. Purpose. Commencing January 1, 2019, health insurance carriers shall publish and maintain a provider directory or directories with information on participating providers that deliver health care services to covered persons. Each provider entry shall clearly indicate whether the provider is currently accepting new patients. A provider directory shall not list or include information about a provider with which it does not currently contract. The provider directory's format, content, publication schedule and accessibility requirements are set forth in this section.

B. Use of multiple directories. If a health insurance carrier does not employ a common network of providers across all of its products, then it shall provide a directory or directories, as appropriate, for each specific network offered for each product using a consistent method of network and product naming, numbering or other classification method that ensures that the public, covered persons, potential covered persons, the superintendent and other state or federal agencies can easily identify the networks and products in which each provider participates.

C. Directory accessibility and transparency. Health insurance carriers shall ensure accuracy, accessibility and transparency of their provider directories in the following manner:

(1) Online access. An online provider directory or directories shall be available free of charge on a health insurance carrier's website to the public, potential covered persons, covered persons and providers without restrictions or limitations. The directory or directories shall be accessible with no requirement that an individual seeking the directory information demonstrate coverage with the carrier, indicate interest in obtaining coverage, provide a member or group identification or policy number, provide other identifying information or create an account for access.

(2) Printed and bound directory. A health insurance carrier shall accept and, within a reasonable timeframe, fulfill requests from covered persons, potential covered persons, providers and members of the public for a printed and bound copy of the provider directory or directories via the carrier's toll-free telephone number, electronically, in writing or in person.

(3) Report to superintendent. On the fifteenth day of every month, a health insurance carrier shall submit provider directory information for its network(s) to the superintendent in a format specified by the superintendent on the OSI website.

(a) The information submitted to the superintendent shall be updated prior to each submission to include all corrections, updates, additions to and deletions from the carrier's network(s) that have occurred since the previous month's submission.

(b) The superintendent will use the information to create and maintain user-friendly, searchable, aggregated information sources available to the public on the OSI website.

D. Provider directory content. A health insurance carrier shall include in its online and printed provider directory or directories for each product the following:

(1) For health care professionals:
(a) name;
(b) gender (required in online directories only);
(c) the name of each affiliated provider group currently under contract with the plan and through which the provider serves covered persons;
(d) contact information, including physical address and telephone number;
(e) specialty or specialties, including board certification, if applicable;
(f) languages spoken fluently other than English by provider, if applicable (required in online directories only);

(g) whether accepting new patients (required in online directories only); and
(h) website hyperlink or URL, if applicable.

(2) For hospitals:
(a) name;
(b) type (e.g. acute, rehabilitation, specialty);
(c) location(s) and contact information, including address and telephone number;

and

(d) website hyperlink or URL, if applicable.
(3) For facilities, other than hospitals, by type:
(a) name;
(b) type, including whether it is a federally qualified health center;
(c) types of services performed;
(d) location and contact information, including address and telephone number; and
(e) website hyperlink or URL, if applicable.

(4) For the purposes of this subsection, website hyperlinks and URLs shall be limited to 20 characters and to the subdomain, domain, top-level domain and one path or folder (www.domain.org/path, e.g.). A URL shortened through an online service may be used.

(5) By no later than July 1, 2019, a health insurance carrier's online provider directory shall include a method by which enrollees can search for specific providers and facilities by name, location, or practice or service type, and by which enrollees can determine providers' network participation status.

(6) A health insurance carrier shall include a disclosure in its printed provider directory or directories that the information required by Paragraphs 1 through 3 of this subsection and included in the directory(ies) is accurate as of [date of printing] and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service telephone number] to obtain the most up-to-date provider directory information.

E. Explanation of provider directory construction.

For each product, a health insurance carrier shall include in plain language in the online and print versions of the associated provider directory or directories the following general information:

(1) a description of the criteria the carrier has used to build the provider network;
(2) if the carrier assigns providers to tiers or levels, then:
(a) a concise description of the criteria the carrier has used to assign providers to the tiers or levels;

(b) a concise explanation of the carrier's criteria for including providers in the tiers or levels; and

(c) for each provider, a clear indication of the tier or level assigned, using a name, symbol, grouping or other designation.

(3) if applicable, a statement that prior authorization or referral may be required to access some providers;

(4) a statement that providers may be added to or removed from the network within the coverage year;

(5) a statement that covered persons may choose obstetrician-gynecologists as primary care practitioners or see obstetrician-gynecologists for primary care without a referral; and

(6) a statement that unless the carrier has notified a covered person in writing that the carrier will not be responsible for future payments to a specific, non-participating provider, the covered person shall not be held liable for payment for services except for cost-sharing at the in-network level of benefit if:

(a) the health insurance carrier's online provider directory erroneously lists a non-participating provider as in-network on the date the provider furnished the service; and

(b) the covered person notifies the carrier of reliance on the erroneous listing within 180 days of issuance of the explanation of benefits.

F. Notification of network limitations.

(1) If a product utilizes provider tiered, regional or other network limitations, the health insurance carrier shall include in plain language in the associated online and print directories the following:

(a) the network tier to which a provider is assigned, if applicable; and

(b) if a product uses a limited, regional or tiered provider network, a statement displayed in a clear and conspicuous manner that is substantially similar to the following:

(i) Limited/regional provider network. "This plan provides access to a network that is smaller than [name of health insurance carrier]'s [general provider network name] provider network. With this plan, members have access to covered benefits only from the providers in [name of limited or regional network]. Please consult the [name of limited or regional network] provider directory or visit the provider search tool at [website address] to determine which providers are included."

(ii) Tiered provider network. "This plan includes the tiered provider network called [name of network]. Under this plan, members pay different levels of [copayments, co-insurance, deductibles] depending on the tier of the provider delivering a health care service, equipment or supply. The plan may change a provider's tier annually on [month/date/year]. Please consult the [name of network] provider directory or visit the provider search tool at [website address] to determine the tier of a provider in [name of network]."

(2) A Preferred Provider Plan (PPO) shall not be deemed to have tiered networks for the purposes of this subsection unless it has established tiered levels of access to participating providers.

(3) Nothing in this subsection shall be construed to require the use of network tiers other than contracting and non-contracting tiers.

G. Language assistance. Provider directories shall include in their directories clear, concise written statements in the top 15 languages spoken in New Mexico explaining how a covered person may access assistance in their language.

H. Directory update requirements. A health insurance carrier shall ensure a process is in place to allow participating providers to promptly and securely verify or submit changes to their directory information. The process shall include, at a minimum, an online interface through which participating providers may submit verification or changes and which shall generate an acknowledgement of receipt from the health insurance carrier. A health insurance carrier shall update its provider directories as follows:

(1) Scheduled updates. Health insurance carriers shall regularly update provider directories as follows:

(a) Online directories. Health insurance carriers shall update online directories monthly unless a more frequent update schedule is required by the superintendent.

(b) Printed directories. Health insurance carriers shall update printed provider directories at least semi-annually unless a more frequent update schedule is required by the superintendent.

(2) Special updates. A health insurance carrier shall update its provider directory or directories upon its knowledge that:

(a) a participating provider or provider group is either:

(i) no longer accepting new patients or is otherwise unavailable; or

(ii) now accepting new patients or has otherwise become available;

(b) a participating provider or provider group's practice location or other contact information is listed incorrectly or has changed;

(c) a provider or provider group has been added to a product's network;

(d) a provider or provider group has been removed from the network due to retirement or practice cessation, expiration or termination of the provider's contract with the health insurance carrier, or a provider is no longer associated with a provider group;

(e) there is a future contract termination date for a provider or provider group, within 15 days of its knowledge of which the carrier shall add the expected termination date to the affected online directory entry or entries; or

(f) when the health insurance carrier knows of any other information that affects the content or accuracy of the provider directory or directories.

(3) A health insurance carrier is deemed to know of the addition, expiration or termination of a provider or provider group from the carrier's network, of a change in a provider's hospital or group affiliation when the carrier:

(i) receives notification of such a change or changes from a provider;

(ii) takes any action with respect to the provider, such as adjudicating or processing claims, that demonstrates there is a change in the provider's network status or location; or

(iii) receives and verifies a complaint from a covered person or potential covered person that the provider's contact information or network status has changed.

(4) Last update date displayed. A health insurance carrier shall ensure that the date of a provider directory's most recent update is conspicuously displayed thereon or therein.

I. Consumer complaints. A health insurance carrier shall prominently display in its provider directory or directories and on the carrier's website an email address and a telephone number that members of the public, covered persons and providers may use to notify the health insurance carrier if provider information contained in a directory appears to be inaccurate.

(1) Acknowledgement of receipt. The health insurance carrier shall acknowledge receipt of the complaint to the complainant within one business day of its filing.

(2) Investigation required. Upon receipt of a complaint alleging that a provider is included in a directory but does not participate in the applicable network, a health insurance carrier shall investigate the complaint within 30 days as follows:

(a) The carrier shall send a request to the provider for verification of the provider's network participation status. The request shall include notice that the provider will be removed from the associated provider directory or directories if the carrier does not receive a response within 30-days.

(b) A carrier shall not remove a provider from a directory if a response is received before the end of the 30-day notice period and participation in the carrier's network is confirmed.

(c) If a provider does not respond to the carrier's request for verification within 30 days, the carrier shall remove the provider from the associated provider directory or directories.

(3) Directory update required.

(a) A health insurance carrier shall update the affected online provider directory or directories to reflect changes to a provider's network participation status within 15 days after completion of its investigation or at the next scheduled update, whichever period is longer.

(b) A carrier shall update affected printed provider directory or directories at the next scheduled update.

(4) Notification of resolution required. A health insurance carrier shall notify a complainant of the outcome of the carrier's investigation within 30 days of its completion.

J. Annual directory audit--no claims filed. At least once annually a health insurance carrier shall send a notice to its participating providers and provider groups that have not filed a claim for payment for health care services within the preceding six months.

(1) Form of notice. The health insurance carrier shall send the notice by U.S. mail, email or other online interface or by facsimile, whichever will provide the promptest notice and timeliest response.

(2) Contents of notice. The notice shall include:

(a) a recitation of the provider's information in the carrier's directory, including a list of the networks and products in which the provider participates;

(b) a statement that failure to respond to the notice within 30 days may result in the delay of payment or reimbursement for services or termination of the provider's contract with the carrier; and

(c) instructions regarding how the provider may respond to the notice and submit updated directory information via U.S. mail, email or other on-line interface or by facsimile.

(3) Response required. The health insurance carrier shall require an affirmative response from the provider acknowledging receipt of the notice and stating whether the provider is currently accepting new patients.

(4) Failure to respond.

(a) If the health insurance carrier does not receive a response to the notice from a provider within 30 days, the carrier shall take no more than an additional 30 days to verify whether the provider's information is correct or requires update as follows:

(i) the carrier shall attempt to verify the provider's network status by phone, email, facsimile or U.S. mail; and

(ii) the carrier shall document the transmission, receipt and outcome of each attempt to verify the provider's directory information.

(b) If the carrier is unable to verify within the permitted timeframe whether a provider's information is correct or requires update, the carrier shall notify the provider that it will be removed from the provider directory or directories after 30 days. A provider shall not be removed from the provider directory or directories if the provider responds before the end of the initial 30-day period following notice.

(c) A health insurance carrier may terminate a provider's contract for a pattern of repeated failure to timely verify or update required provider directory information

(5) Acute care hospitals shall be exempt from the requirements of this subsection.

K. Annual directory audit--claims filed. At least once annually a health insurance carrier shall send a notice to its participating providers and provider groups from whom they have received a claim for payment for health care services within the preceding six months.

(1) Form of notice. A health insurance carrier shall send the notice by U.S. mail, email or other online interface or by facsimile, whichever will provide the promptest notice and timeliest response.

(2) Contents of notice. The notice shall include the following:

(a) a recitation of the provider's information in the carrier's directory, including a list of the networks and products in which the provider participates;

(b) a request for verification of the provider's directory information including whether the individual provider is accepting new patients; and

(c) instructions regarding how the provider may respond to the notice and submit updated directory information via U.S. mail, email or other on-line interface or by facsimile.

(3) Response required. The health insurance carrier shall require an affirmative response from the provider acknowledging receipt of the notice and stating whether the provider is currently accepting new patients.

(4) Failure to respond. If the health insurance carrier does not receive a response from a provider within 30 days, the carrier shall update the relevant provider directory or directories during the next update cycle or within 15 days, whichever is longer, to indicate that the provider's information is unverified.

(5) Acute care hospitals shall be exempt from the requirements of this subsection.

L. Subscriber liability. Unless the carrier has notified a covered person in writing that the carrier will not be responsible for future payments to a specific, non-participating provider, the covered person shall not be held liable for payment for services except for cost-sharing at the in-network level of benefit if:

(1) the health insurance carrier's online provider directory erroneously lists a non-participating provider as in-network on the date the provider furnished the service; and

(2) the covered person notifies the carrier of reliance on the erroneous listing within 180 days of issuance of the explanation of benefits.

[13.10.30.12 NMAC - N, 10/01/2018]