CITATION	PROVISION	DRAFT COMMENTS
13.10.31.2	SCOPE: These rules apply to every: 1) health insurer as defined in Subsection H of Section 59A- 22B-2 NMSA 1978; 2) Multiple Employer Welfare Arrangement; and 3) Medicaid Managed Care Organization, that requires prior authorization as a condition to payment for a medical service, pharmaceutical, or medical supply benefit. The subject entities are referred to collectively herein as "carriers" and individually as a "carrier." [13.10.31.2 NMAC - N, 04/01/2021]	**BCBSNM Comment.** NMOSI should exercise regulatory restraint and remove Medicaid from the scope of these rules, at least at this time. Alternatively, the timeline for finalization of these rules should be substantially enlarged to ensure an exhaustive exploration and documentation of the myriad of exceptions to these rules that are needed to align them with the New Mexico Human Services Department's (HSD's) Medicaid managed care program. To BCBSNM's knowledge, the only suggestion by the Legislature that for the first time commercial and Medicaid should be regulated together by NMOSI is the Prior Authorization Act's definition of "health insurer" to include Managed Care Organizations. Respectfully, that is far too limited and subtle for NMOSI to reflexively promulgate paradigm-shifting rules that apply the same way to completely different programs, commercial/retail and Medicaid. NMOSI does not have, nor is it expected to have, the Medicaid expertise needed to regulate Medicaid managed care, arguably the most comprehensive and complex health coverage program there is. HSD has that expertise and is charged with that function. *See* NMSA 1978, Section 27-2-12.6. If the Legislature wishes for a law to apply to commercial and Medicaid, the Legislature does not express that wish so subtly. NMSA 1978, Section 59A-57-10(A) ("Except as otherwise provided in this section, the provisions of the Patient Protection Act apply to the Medicaid program operation in this state. . . . "). And, when doing so, the Legislature recognizes and acknowledges the preeminence of HSD as far as the law's application to Medicaid. In fact, that preeminence extends to prior authorization because HSD has sole authority over Medicaid eligibility criteria and limitations of Medicaid benefits. *Cf.* NMSA 1978, Section 59A-22B-2(O) (defining prior authorization as a preservice determination "regarding a covered person's eligibility for health care services") *with* NMSA 1978, Section 59A-57-10(B) ("Nothing in the Patient Protection Act shall be construed to limit the authority of [HSD] to administer the Medicaid program, as required by law. Consistent with applicable state and federal law, [HSD] shall have sole authority to determine, establish and enforce Medicaid eligibility criteria, the scope, definitions and limitations of Medicaid benefits and the minimum qualifications or standards for Medicaid service providers") (emphasis added).

		If despite the foregoing NMOSI proceeds with inclusion of Medicaid managed care in these rules, to follow is a preliminary and states very much non-exhaustive list of disconnects between the commercial/retail and Medicaid programs that need to recognized and addressed in these rules. Again, however, NMOSI should glean from these examples that these rules should not be applied to Medicaid at all. • Section 13.10.31.8(A) requires facilitation of prior authorization requests from non-participating providers. To be compensated for covered services in Medicaid, even a non-participating provider must first register with HSD. • Section 13.10.31.8(C) links prior authorizations to the "plan year" and limits changes that can be made during such year. Medicaid does not have a single, defined "plan year" because each enrollee has an individualized plan year that could start on any day of the year. Also, the New Mexico Behavioral Health Services Department prescribes the categories of behavioral health services that require prior authorization in the Medicaid program and MCOs must follow BHSD's direction. • Section 13.10.31.8(D) limits retroactive denials following prior authorization. Coordination of benefits is required to ensure that Medicaid is the payor of last resort. Third party liability by another payor may not be known at the time of Medicaid authorization. There are limitations on what Medicaid can reimburse once another payor is identified, even if an authorization was issued for Medicaid and that other payor denies or limits coverage or reimbursement. • Section 13.10.31.8(G) states that a carrier's prior authorization shall expire no sooner than 90 days from the date of approval. Benefits for certain Medicaid categories of eligibility are irreconcilably limited by design in frequency and duration to less than 90 days. • Section 13.10.31.12 states that covered services for which 90% of prior authorizations are approved shall no longer require prior authorization. Prior authorization is not an isolated, siloed process that's "just" about approving or denying coverage. It is a critical gateway for members to access other managed care benefits, such as transition of care, identification/closure of gaps in care, and timely monitoring of out-of-state placements and community reintegration, all of which are contractually required for Medicaid.

13.10.31.3	STATUTORY AUTHORITY: Section 59A-2-9.8 NMSA 1978, Section 59A-15-20 NMSA 1978; Sections 59A-22B-1 through 59A-22B-7 NMSA 1978; and Sections 59A-57-1 through 59A-57-11 NMSA 1978.	**BCBSNM Comment**. Without limitation and reserving rights, much if not most of this proposed rule very well could violate the New Mexico Constitution's separation of powers provision. *See* N.M. Const. Art. III, § 1. While it is generally accepted that absolute separation of the functions of each branch is not feasible, the doctrine is an essential component of the foundation of a well-functioning government and the courts "will not be reluctant to intervene where one branch of government unduly encroaches or interferes with the authority of another branch." *See State ex rel. Taylor v. Johnson*, 1998-NMSC-015, ¶¶ 20, 23. Still, the Legislature has the power to delegate rulemaking authority to administrative agencies and such agencies have discretion to administer their duties. That discretion, however, is not unlimited. "An administrative agency has no power to create a rule or regulation that is not in harmony with its statutory authority." *Rivas v. Bd. of Cosmetologists*, 1984-NMSC-076, ¶ 3. It is well established that an agency cannot alter, modify or extend a law through a rulemaking. *See State ex rel. Taylor*, ¶ 22; *see also* NMSA 1978, § 59A-2-9(B) ("No such rule or regulation shall extend, modify or conflict with any such provision or other laws of New Mexico."). This proposed rule may exceed the rulemaking authority delegated to NMOSI via the applicable enabling statutes. There is but one express directive from the Legislature in the Prior Authorization Act to create a rule, and it is a very narrow directive about expedited requests. *See* NMSA 1978, § 59A-22B-5(H) (NMOSI "shall establish by rule" protocols and criteria pursuant to which expedited independent review of an expedited prior authorization request can be made). This proposed rule goes well beyond that directive, seeking to regulate in minute, operational detail how, and to what extent, carriers can perform prior authorization, a quintessential managed care function that has been successfully performed by those carriers for decades without the regulatory micromanagement now proposed. The Legislature has long recognized this performance by asking NMOSI to ensure that carriers have a comprehensive utilization review program with timely decisions by qualified reviewers and notice and process rights for enrollees. *See, e.g.*, NMSA 1978, § 59A-57-4(B)(5) (1998). For over two decades, NMOSI correctly interpreted and applied this authority with due restraint and without trying to prescribe minute operational details or create new mandatory exemptions from prior authorization for specific providers or specific services based on seemingly arbitrary thresholds. *See, e.g.,* § 13.10.22.9 NMAC. Had the Legislature wanted

		NMOSI to usurp the carriers' operational expertise and create "gold carding" and other novel rules in this manner, the Legislature would have said so. It did not. Perhaps NMOSI is interpreting one line from the Prior Authorization Act to give NMOSI rulemaking *carte blanche* over prior authorizations, specifically Section 59A-22B-4(A) which states that NMOSI "shall standardize and streamline the prior authorization process across all insurers." If so, NMOSI should appreciate that this provision lacks the requisite elements to survive constitutional, separation-of-powers scrutiny if NMOSI is interpreting it to allow the expansive rule as proposed. To survive such scrutiny, the Legislature must have (1) specified the end to be accomplished; (2) directed that the end be accomplished in part through the promulgation of regulations; and (3) provide specific criteria to be considered by the agency in adopting regulations. *See N.M. Petroleum Marketers Ass'n v. N.M. Env't Improvement Bd.,* 2007-NMCA-060, ¶14 (citations omitted). At most, only one of those three criteria is, without conceding the point, even arguably met by Section 59A-22B-4(A), namely the first, standardization and streamlining. Indisputably not met are the second and third. There is no direction to accomplish those ends by the promulgation of regulations, nor are there specific criteria provided for NMOSI to consider in adopting regulations. The more reasonable interpretation of Section 59A-22B-4(A) is to read it harmoniously with and limit its application to the other express provisions of the Prior Authorization Act, such as those regarding creation and use of a standardized form and timely review decisions.
13.10.31.5	DURATION: Permanent.	
13.10.31.5	OBJECTIVE: To establish and standardize oversight, reporting, transparency and confidentiality procedures for prior authorization processes.	
13.10.31.6	EFFECTIVE DATE: April 1, 2021, unless a later date is cited at the end of a section.	**BCBSNM Comment.** Implementation of these draft rules likely require system modifications that will be expensive and require many months, possibly a year, of work to accomplish. NMOSI should

		please defer the effective date for at least 180 days after promulgation and also afford substantial enforcement grace periods to allow for development, troubleshooting and remediation of system modifications. (See prior comment for suggested delay due to proposed application of these rules to Medicaid managed care.)
13.10.31.7	DEFINITIONS: Terms used in these rules are as defined in Section 59A-22B-2 NMSA 1978, and in 13.10.29 NMAC, except as supplemented and superseded below. **A.** "Benefit" means any medical service, medical service location, medical provider selection, pharmaceutical, or medical supply that is the subject of a prior authorization request. **B.** "Utilization review organization" or "URO" means an entity engaged by a carrier to determine medical necessity for covered services. A URO includes a pharmacy benefits manager ("PBM") who determines medical necessity for a carrier's prescription drug coverage. [13.10.31.7 NMAC - N, 04/01/2021]	
13.10.31.8	GENERAL REQUIREMENTS: A carrier shall comply with the standard prior authorization processes specified in these rules. **A.** Responsibility for requesting prior authorization. A carrier shall require its participating providers to submit	**BCBSNM Comment.** **13.10.31.8(A)(3)** states that carriers accept requests from only providers. This is at odds with NCQA and CMS, both of which recognize the rights of members and their representatives to request prior authorizations, which can be especially important for coverage sought for services from out-of-network providers that might, no matter how much facilitation is furnished, refuse to submit the request for the member. Trying to cajole out-of-network providers to submit the request for members, instead of allowing members to do so, will cause

	prior authorization requests on behalf of a covered person. A carrier shall allow a non-participating provider to submit a prior authorization request on behalf of a covered person using any standard prior authorization submission process that conveys the information necessary to process the request. ~~A carrier shall only accept a prior authorization request submitted by a provider.~~ ~~(4) If a covered person directly submits, or attempts to submit, a prior authorization request, the carrier shall assist the covered person in having the authorization request submitted by a provider.~~	unnecessary delays in treatment. This provision should be stricken, as should (A)(4) to which it relates because (A)(4) depends on the consent and cooperation of an out-of-network provider over whom neither the member nor carrier have any control.
	(5)A carrier shall prohibit its participating providers from billing a covered person for a delivered benefit for which prior authorization was required if the provider failed to obtain the required authorization without the covered person's informed and documented consent. ~~(6)A carrier shall allow non-participating providers to:~~ ~~(a) request prior authorizations and~~	**BCBSNM Comment.** **13.10.31.8(A)(6)** states that nonpar providers can submit requests by all methods in these rules. This fails to recognize a crucial, fundamental distinction between in-network and out-of-network providers relative to the carrier. Platforms and systems have been built in reliance on recognition of this distinction: the carrier has a relationship with and therefore knows the in-network provider so can create the provider profile needed and justified for repeated electronic submissions of requests. There are hundreds-of-thousands of out-of-network providers for whom and which this cannot reliably be done, in part because it would depend on the consent and cooperation of out-of-network providers with whom and which the carrier has no relationship and no leverage, meaning that it will be unduly burdensome, and possibly undoable, to treat in-network providers and out-of-network providers as if they are identically situated when they are clearly not. This provision should be stricken.

	~~submit supporting documentation by all submission methods authorized by these rules; and~~ ~~(b) receive confirmations and tracking numbers as required by these rules.~~	
13.10.31.8	(B)Requests for multiple benefits. ~~1. A carrier shall allow a provider to request prior authorization for multiple, condition-related benefits for the same covered person in a single request.~~ 2. If one benefit is or may be the prerequisite to another, the carrier may make prior authorization of the later benefit contingent upon the outcome of delivery of a prior benefit, and may require supplemental documentation prior to determining the request for the later benefit. 3. A carrier shall not reject or deny a prior authorization request solely on the basis of the sequence in which the provider has listed benefits in a prior authorization request. ~~4. If a carrier does not grant prior authorization for all of the benefits in a multiple benefit request, the carrier must clearly~~	**BCBSNM Comment.** **13.10.31.8(B)(1).** This provision oversimplifies the process needed to efficiently and responsibly evaluate the broad scope of services available under the terms of a health plan. It also likely creates a problem to solve rather than solve a problem that exists. For example, providers know that it is illogical to ask for authorizations of surgery, physical therapy, drugs and DME on a single request so they do not do it. Were this to be encouraged by rule, it would be necessary for carriers to generate multiple numbers for a single request and to manually separate the request into its component parts, often from multiple unrelated provides, then for route those segregated requests to different reviewers, including external organizations, and often solicit more information about the drugs which have clinically specific criteria. All of this, if doable at all, could take years and create confusion and increased risk of errors and delays. This provision, and related (B)(4), should be stricken. BCBSNM would welcome examples from providers of concerns that led NMOSI to propose this rule so that carriers might formulate a less disruptive solution for NMOSI's consideration.

	~~state which benefits are approved and which are denied.~~ 5. A carrier shall permit a provider or covered person to appeal the denial of any benefits regardless of the number of benefits requested at one time.	
	(C)Changes to prior authorization requirements. 1. ~~A carrier shall not, during a plan year, expand the list of benefits for which prior authorization is required except when a new covered benefit is added to the plan, or safety or other concerns have arisen with respect to the benefit.~~ 2. A carrier shall notify its ~~enrollees and~~ [impacted enrollees and] providers at least 30-days before adding a prior authorization requirement during the plan year, unless the superintendent approves a shorter prior notice period for good cause, including patient or provider safety, public health, or other exigent circumstances. 3. A carrier may remove a prior authorization requirement at any time. A carrier who removes a prior authorization requirement during a plan year shall notify its providers of the	**BCBSNM Comment.** **13.10.31.8(C)(1).** There is no authority for this provision in the enabling Act. Additionally, it fails to recognize that different commercial groups have different renewal dates throughout the year and the plan year for a Medicaid enrollee is unique to that enrollee, making this provision unworkable. Furthermore, AMA/CMS code updates occur quarterly as do standard PA updates for drugs, the postponement of which will impair the carrier's ability to offer an evidence-based and cost-effective pharmacy benefit. This should be stricken. **13.10.31.8(C)(2).** Under these proposed rules, enrollees cannot ask for prior authorization so notification to them of prior authorization requirements seems incongruous. The reference to enrollees should be stricken or limited to those for whom the carrier's claims data shows that the change will impact the enrollee.

	change as soon as practicable, and no more than 30 days after the requirement is removed.	
	(D) Retroactive denials. Except for Medicaid, a carrier shall not retroactively deny reimbursement for a benefit provided to a covered person: **(1)** by a provider who relied upon a written prior authorization from the carrier received prior to providing the benefit, except in those cases where there was material misrepresentation or fraud by the provider; or **(2)** by a provider who relied upon a written notice from the carrier that prior authorization was not required, except in those cases where there was material misrepresentation or fraud by the provider.	**BCBSNM Comment.** **13.10.31.8(D).** This provision is especially problematic for Medicaid enrollees with other coverage when the MCO authorizes the service unaware of the other coverage but later learns of the other coverage and denies the claim pending receipt of the EOB. Also, in Medicaid, member eligibility can be retroactively updated by HSD, in which case, MCOs have the right to recoup from the provider or other person to whom MCO has made payment. *See 8.308.20.9* NMAC. Medicaid providers may report that they are registered with HSD but upon receipt of the claim the MCO discovers that the registration does not match the service. Medicaid should be removed from this provision.
	E. Retrospective Authorization Requests. A carrier shall establish written policies and guidance for the process and circumstances under which it will consider a retrospective authorization. A carrier's policies shall not unreasonably limit the ability of a provider to request or obtain a retrospective	

	authorization. F. Mental health parity. A carrier shall not apply more restrictive prior authorization requirements for covered behavioral health services than for covered medical and surgical services.	
	~~G. Expiration of prior authorization. A carrier's prior authorization shall expire no sooner than 90 days from the date of approval. A carrier shall duly consider any requests for an extension of the authorization.~~	**BCBSNM Comment.** This provision fails to distinguish between one-time and recurrent, ongoing therapies. It also fails to recognize that conditions change with time, sometimes for the better, especially in the behavioral health space. It further fails to recognize shorter, evidence-based durations for various therapies. Allowing for prolonged and potentially excessive treatment may be detrimental to the member. This provision should be stricken. Perhaps this provision could be salvaged by limiting it to one-time services and recognizing that carriers have discretion to clinically determine to which one-time services this should be applied.
	~~H.~~ Reasonable prior authorization requirements. A carrier shall not impose a prior authorization requirement that deters or unreasonably delays the delivery of medically necessary benefits warranted by prevailing standards of care. A carrier shall only require prior authorization for a benefit to the extent reasonably necessary to contain costs or implement medical management services. ~~There is a rebuttable presumption that prior authorization is not reasonably necessary if:~~ ~~1. the carrier approved more than ninety percent of the requests to deliver~~	**BCBSNM Comment.** **13.10.31.8(H).** The "rebuttable presumption" created by this provision is not contemplated in the Prior Authorization Act. Additionally, without strong epidemiological data to back up the 90% and 5% thresholds, of which BCBSNM is aware of none, the provision appears to be inherently arbitrary and capricious. Furthermore, this provision oversimplifies and misapplies the well-established dynamics of the prior authorization process and the benefits to members of it. For example, if a provider asks for a prior authorization that does not meet criteria there is often a consultation with the carrier's medical director whereby the medical director's input allows the request to satisfy criteria and result in an approval. There is no reason for an authorization approved in that fashion to substantiate a conclusion that prior authorization is not reasonably necessary; in fact, that scenario culminates in an approval that substantiates the appropriateness of prior authorization for that service. Also by way of example, this and other proposed rules assume that prior authorization is solely for cost-containment. That is not true. It is an integral part of the overall management of care, including gap identification/closure, connecting with care coordination and helping with transitions of care and community reintegration. Going on autopilot as proposed denies members those additional benefits of managed care, the engagement of and access to other managed care services. The rebuttable presumption described in this provision should be

	~~the specific benefit during a calendar year; or~~ ~~2. the carrier fails to satisfy prior authorization deadlines with respect to five percent or more of the requests to deliver a specific benefit during a calendar year.~~	stricken.
13.10.31.9	PRIOR AUTHORIZATION SUBMISSION: **A.** A carrier shall: **(1)** accept prior authorization requests submitted at any time prior to the delivery of service; **(2)** accept prior authorization requests telephonically and by facsimile; **(3)** offer one or more options for a provider to submit a prior authorization request electronically; **(4)** allow a provider to securely upload supporting documentation associated with an electronic prior authorization request, subject to reasonable limits on file type and size; **(5)** accept and consider any information from a provider that will assist in the review; **(6)** require only the information necessary to evaluate the request; **(7)** not reject a request solely on the basis of documentation or submission errors that do not prevent substantive review;	**No Comment.**

	(8) ensure that the system it operates for receiving electronic prior authorization requests and supporting documentation satisfies all applicable Health Insurance Portability and Accountability Act ("HIPAA") transaction requirements and operating rules no later than the effective date that such requirements and rules are established; **(9)** make its system available for accepting electronic prior authorization requests and supporting documentation 24-hours per day, seven-days per week. Planned maintenance or down time of the system shall be performed during historically low-utilization periods; and **(10)** notify providers of planned maintenance or downtime of the system at least 24-hours in advance. A carrier shall notify providers of any unplanned system downtime as soon as practicable.	
	B. Confirmation of receipt and tracking numbers. (1) ~~Within four hours of receipt, a carrier shall confirm receipt of a prior authorization request and any supporting documentation.~~ The carrier shall ~~also~~ assign a unique tracking number to the	**BCBSNM Comments.** **Subsection (B)(1):** Providers who use the electronic system to submit prior authorization requests receive an immediate confirmation and tracking numbers. This functionality does not exist for manual systems, such as fax, where an individual must create a request, assign a tracking number, and provide a response. A four-hour response, as contemplated in Subsection (B)(1), is administratively burdensome, arbitrary, and not in line with the

	request. The tracking number shall identify the request throughout the processing cycle, including after ~~approval or denial.~~ (2) The confirmation that includes the tracking number shall be communicated to the provider in the means most appropriate to the format in which it was submitted. ~~in the same manner that the request was submitted, and by at least one form of written confirmation (fax, e-mail or letter).~~ (3) A carrier shall provide the tracking number of a prior authorization request to the covered person upon request. (4) A carrier may assign other identifiers to a prior authorization request.]	turnaround times in the Prior Authorization Act. An non-urgent request submitted late in the day or on a weekend would require an almost emergent response, after hours or on the weekend when a provider would likely not even be in the office to receive it. **Subsection B(2):** This section provides for multiple layers of administratively burdensome communication to the providers. The Prior Authorization Act requires that health plans must provide "an electronic receipt to the health care provider and assign a tracking number to the health care provider for the health care provider's use in tracking the status of the prior authorization request, regardless of whether or not the request is tracked electronically, through a call center or by facsimile." Read in conjunction with the other sections of the Act, the intent was that health plans have available an electronic system and that would provide an immediate response to a request and assign a tracking number that could then be used to track the request throughout the process, whether by calling for an update or faxing with further documentation. This proposed section extends beyond the authority within the Act. Requiring multiples responses by different means would be a costly manual process and does nothing to incentivize the move from such processes by the provider to more streamlined and cost-effective processes like electronic prior authorization.
13.10.31.10	DOCUMENTATION AND TRANSPARENCY: A. Prior authorization forms. (1) A carrier shall accept the uniform prior authorization request form(s) developed by the superintendent and found on the superintendent's website at www.osi.state.nm.us. (2) A carrier may ask the superintendent to approve a non-uniform prior authorization request form. If the superintendent approves the non-uniform request form, the carrier shall prominently publish the form to providers on its website. B. Document retention. A carrier shall	**No comment.**

	maintain a record of each prior authorization request and its associated documentation. The carrier shall store the records in compliance with all applicable state and federal privacy and security laws and regulations. The record shall be retained for as long as required by federal and state document retention guidelines, laws and regulations.	
	C. Access to information about services requiring prior authorization. (1) A carrier shall make available on its member and provider websites a list of all benefits for which a prior authorization is required. The list shall be presented clearly and in readily understandable language appropriate for the intended audience. The list shall be updated monthly. ~~(2) Prior authorization information presented on the provider website shall include associated clinical criteria requirements and shall list all supporting documentation that must accompany the prior authorization request. A carrier shall provide a link to the clinical criteria, supporting documentation requirements and other details when applicable.~~ (3) Information on benefits requiring prior authorization, associated clinical criteria and supporting documentation may be located in an area(s) of a website(s) that is not accessible to a covered person, including the carrier's prior authorization portal.	**BCBSNM Comments.** **Subsection (C)(2):** In the review of each prior authorization request, a hierarchy of clinical criteria may be used to make an assessment based upon the member's individual case and their benefits. This may include internal medical policy, MCG clinical guidelines, CMS and Medicaid Assistance Division of HSD policies and regulations, national and local coverage guidelines. Providing this level of detailed information for each CPT-code on a provider facing website is both potentially impossible and also confusing to the provider e.g., each medical policy may be twenty to thirty pages long. Should a provider have questions on the clinical criteria that would be used to assess an individual request and member that can be provided to them upon request. We recommend removing subsection C(2). **Comment 13.10.31.10(C)(4):** BCBSNM makes available a list of services that require prior authorization on our provider website. However, if a "searchable" tool is contemplated either by procedure name or code, BCBSNM does not currently have a such a tool. Sufficient time would be needed for implementation.

	(4) By January 1, 2021, A carrier shall provide an on-line search tool for any provider to use to search the list of benefits that require prior authorization.	
13.10.31.11	AUTO-ADJUDICATION: A. No later than January 1, 2021, a carrier shall implement a process to auto-adjudicate electronically submitted prior authorization requests. (1) A carrier shall comply with all statutory timelines applicable to prior authorization review. A list of all statutory prior authorization review timelines is posted on the OSI website at www.osi.state.nm.us. (2) A carrier may reject for correction an auto-adjudicated prior authorization request for reasons other than medical necessity as long as the rejection is completed within statutory timelines. (3) A carrier may pend an auto-adjudicated prior authorization request if it requires manual review, as long as the review is completed within statutory timelines. (4) A carrier shall not automatically deny an auto-adjudicated prior authorization request. A carrier shall only deny a prior authorization request based on a live review.	**No comment.**

	B. Incomplete information. If a provider fails to supply sufficient information to evaluate a prior authorization request, the carrier shall allow the provider a reasonable amount of time, taking into account the circumstances of the covered person, but not less than two days, to provide the specified information. C. Notice. A carrier shall provide written notice to the provider and covered person of a determination to approve or deny authorization. The Notice shall contain the reasons for a denial. D. Delegation. A carrier may delegate one or more of the obligations mandated by these rules to a qualified third party, including a URO. A carrier who delegates any obligation mandated by these rules remains responsible for compliance with the delegated obligation. E. Reporting. At least annually, a carrier shall report to the superintendent data and information about the auto-adjudication process, when and as directed by the superintendent.	**BCBSNM Comment.** **13.10.31.12(B).** This provision is unclear and potentially presents carriers with a Hobson's Choice, risk offending the regulation or accreditation requirements. In terms of clarity, this provision does not identify the event or activity that starts the two-day clock for the provider to furnish more information. If the intent is that a request for information from the carrier start's the provider's two-day clock, this provision virtually guarantees that carriers will not be able to comply with accreditation requirements for some urgent requests. The Prior Authorization Act affords 24 hours after receipt of necessary information to make a decision. In other words, the clock does not start until the carrier has the information needed to make a decision. NCQA affords 72 hours after receipt of the request, regardless of supporting information, to make a decision. In other words, the clock starts even if the carrier does not have the information needed to make a decision. Upon receipt of the request, the carrier must therefore start the NCQA clock. If the carrier asks for more information during or by the end of the first day after receipt of the request and must then wait two days to receive it, the 72-hour clock from NCQA will be near expiration or expired. And, if the provider waits until the second day to furnish the information, the carrier will have less than 24 hours to make a decision as contemplated by the Prior Authorization Act. Similar challenges may exist for standard requests depending on the circumstances. This provision should be stricken or a more reasonable approach substituted that acknowledges the competing and potentially irreconcilable obligations to which carriers are being subjected.
13.10.31.12	EVALUATIONS OF PRIOR AUTHORIZATIONS AND PROVIDER PERFORMANCE: A. Review of covered benefits that require prior authorizations. Annually, a carrier shall review and audit its requirements for prior authorizations for all covered benefits, except for inpatient admissions to acute-care	**BCBSNM Comments:** **13.10.31.12(A)(1)(d).** Carriers do not have an objective methodology to quantify and measure the providers' experience with a PA requirement. BCBSNM recommends that this language be stricken. **13.10.31.12(A)(2).** Specifying the quarter in which a carrier must complete its annual review is overly prescriptive and would restrict a carrier's judgment to resource manage the timing of an annual, resource-intensive administrative responsibility. As such, BCBSNM recommends that language be stricken. If NMOSI does not accept BCBSNM's proposal to

	hospitals, and assess the continued utility of each requirement. (1) At a minimum, a carrier's evaluation and audit shall consider the following: (a) the approval rate for each covered benefit for which a prior authorization was required; (b) whether the prior authorization requirement for a covered benefit enhances patient safety and generates better health outcomes; (c) whether the prior authorization requirement for a covered benefit generates cost savings; (d) whether the costs and other administrative burdens associated with the prior authorization requirement for a covered benefit, considering both the providers' and the carrier's experience, outweigh the demonstrated benefits of the requirement, including any actual cost savings; and (e) whether the prior authorization requirement for a covered benefit contributed to unreasonable or unnecessary delays in treatment or adverse health outcomes for a covered person. (2) A carrier shall conduct and complete the review annually ~~in the first quarter of each calendar year, beginning in 2022,~~ and shall evaluate the prior authorizations issued during the prior calendar year.	strike the language requiring review during the first quarter of each calendar year, BCBSNM alternatively recommends that the second quarter of each calendar year be substituted instead. A first quarter review would be undesirable from a data accuracy standpoint. Not all of the prior calendar year's data will be available for review by the first quarter of the following year due to claims run out, thus causing the results of a first quarter review to be unreliable. **13.10.31.12(A)(3).** Neither the Prior Authorization Act nor the Patient Protection Act provide for—explicitly or implicitly—a prohibition of certain PAs based on a single metric. Pursuant to the Prior Authorization Act, the Legislature entrusted carriers with the responsibility to "validate that [their] prior authorization requirements advance the principles of lower cost and improved quality, safety and service." This subsection would frustrate carriers' ability to advance those principals as the Legislature intended. Under the proposed provision, up to ten percent of patients would receive a service for which a PA previously would have been denied as clinically inappropriate or for other reasons. While ten percent would appear to be a small minority, it equates to a large number of patients and services given how many PAs are requested annually across all carriers. It would be inconsistent with the principles identified by the legislature to accept that patients will receive inappropriate (clinically or otherwise) services when a process that can prevent that is readily available. Additionally, certain high-cost prescription drugs have a high approval rate. Losing the ability to verify the appropriateness of those drugs through the PA process could significantly impact cost even if the increase in claims received for those drugs is relatively small. Moreover, the provision does not account for the nuances of PA. For example, the clinical appropriateness of certain services is managed via frequency and duration of treatment (e.g., ABA therapy) rather than a black-and-white determination of appropriateness. The PA approval rate for such services may be very high, but the approval rate does not reflect the care management conversations that take place between the providers and the carrier's medical directors prior to approval. Please also see BCBSNM's comment on 13.10.31.8(H). Accordingly, BCBSNM recommends that this subsection be stricken.

	(3) ~~A carrier shall identify those covered benefits, with the exception of inpatient admissions to acute care hospitals, for which ninety percent of the prior authorization requests for that benefit are approved, and shall not require a prior authorization for those covered benefits, effective no later than 60 days after completion of its evaluation.~~	
	B. Assessment of prior authorization request outcomes. Annually~~, during the first quarter of each year beginning in 2022,~~ a carrier shall evaluate each provider's ordering and prescribing patterns for adherence to the carrier's prior authorization criteria and policies over the preceding calendar year. Inpatient prior authorization requests shall be excluded from this evaluation. (1) A carrier shall identify those providers who are in the top fifty percent of prior authorization request submitters and who have a consistent pattern of adherence to prior authorization requirements and criteria as evidenced by prior authorization approval rates of ~~eighty percent~~ ninety-five percent or greater (a "high compliance provider"). (a) The carrier shall offer to every high compliance provider an exemption or other alternative	**BCBSNM Comment:** **13.10.31.12(B)(1)-(3).** Neither the Prior Authorization Act nor the Patient Protection Act provide for—explicitly or implicitly—a regulatorily required gold carding system. As previously noted in regard to other provisions, given the lack of statutory support for a proposal that does not appear to be contemplated by the authorizing statutes, these provisions may impermissibly encroach on the exclusive powers of the legislative branch. While BCBSNM understands that NMOSI has been tasked with standardizing and streamlining the PA process pursuant to 59A-22B-4(A), that should be confined to administrative implementation of the provisions of the Prior Authorization Act, not gold carding by rule making, which goes well beyond that. It is a hardline restriction on a carrier's ability to utilize its own PA process—a process that presumably would be sufficiently standardized and streamlined for the majority of providers in accordance with the Prior Authorization Act and this regulation. Further, creating a system that allows for similarly situated providers to be treated three different ways ("high compliance," average or "low compliance") by each carrier with respect to the PA process appears inconsistent with 59A-22B-4(A)'s direction to standardize and streamline the PA process. Additionally, PA is an individualized process. The outcome of any PA review depends on the unique factors of the patient, their clinical history, and the requested benefit. Exemptions from that individualized review process could lead to a downward trend in cost-effective therapies if not carefully managed. For example, in the context of prescription drug benefits, a PA exemption could lead to increased first-line usage of more expensive medications (i.e., brand, non-formulary, etc.) than would otherwise be approved through the PA process after reviewing the patient's clinical history. Furthermore, the proposed imposition of a regulatory gold card system would be resource intensive and administratively burdensome for carriers. BCBSNM, and presumably other

	to prior authorization requirements for a period of time of no less than 12 months if the provider is also willing to accept upside and downside risk. The exemption or other alternative may be applied to all benefits that require a prior authorization, or to a subset of such benefits. (b) A carrier shall, in writing, clearly describe the terms of the prior authorization alternative arrangement offered to each high compliance provider including the duration of the alternative and how the provider's ordering and prescribing performance during the course of the alternative arrangement will be evaluated. (c) A carrier may offer any provider an exemption from prior authorization or an alternative to prior authorization requests based on the frequency or type of benefits provided. (d) A carrier shall reevaluate each high compliance provider's prior authorization request patterns on an annual basis and reevaluate the provider's qualification for prior authorization exemptions or alternatives to prior	carriers, would have to develop an entirely new program to administer this gold card system. The program would require hiring of new staff and significant funding for: (1) implementation of the program; (2) administration once implemented; (3) executing the annual audit/review process as well as ongoing data analytics; and (4) potentially re-contracting providers to allow for applying non-uniform PA standards. BCBSNM questions whether theoretically improved efficiency for a select group of providers (that fails to recognize the ancillary benefits of the prior authorization process, such as closing gaps in care) outweighs the high cost and ongoing administrative burden on carriers to administer such a system. Therefore, BCBSNM generally recommends that 13.10.31.12(B)(1)-(3) be stricken. If, however, the proposed gold card system is tailored to address specific concerns that NMOSI has received from the provider community, BCBSNM recommends that these provisions be stricken **and** that NMOSI schedule and hold a series of work sessions with carrier and provider stakeholders so that all parties can discuss the proposal together. With the current proposed system to inform the discussion, NMOSI and stakeholders may be able to substantially agree upon a system that could then be proposed in a subsequent rulemaking. --- Subject to and without waiving the foregoing comment on subsections 13.10.31.12(B)(1)-(3), BCBSNM submits the following additional and/or alternative comments: **13.10.31.12(B).** Specifying the quarter in which a carrier must complete its provider evaluations is overly prescriptive and would restrict a carrier's judgment to resource manage the timing of an annual, resource-intensive administrative responsibility. As such, BCBSNM recommends that language be stricken. If NMOSI does not accept BCBSNM's proposal to strike the language requiring evaluations during the first quarter of each calendar year, BCBSNM alternatively recommends that the second quarter of each calendar year be substituted instead. First quarter evaluations would be undesirable from a data accuracy standpoint. Not all of the prior calendar year's data will be available by the first quarter of the following year due to claims run out, thus causing the results of first quarter evaluations to be unreliable. **13.10.31.12(B)(1).** Based on current analytics of our PA programs, BCBSNM considers a provider who has eighty percent of their PA requests approved to be of average performance. If the intent is to incentivize high performance and to lessen administrative

	authorization requirements. A carrier shall reevaluate a provider sooner due to patient safety concerns or other exigent circumstances. (e~~) Beginning July 1, 2022, any provider may request, at any time, a prior authorization exemption or alternative to prior authorization requirements. A carrier shall develop and publish to providers a straightforward process through which a provider may submit such request, and specify the criteria the carrier will consider in determining whether to grant the request~~.	burden on high performing providers, BCBSNM recommends that the threshold for a "high compliance provider" be raised to at least a ninety-five percent approval rate. Additionally, limiting this evaluation to the top fifty percent of requesters is not enough of a control because for some provider types, there are very few of them in New Mexico, such as ABA providers. In addition to being in the top fifty percent, there should be a minimum number of requests that likely will need vary by type of service because some are more common than others. Finally, to maintain reasonable cost and quality controls when select providers are offered exemptions from the PA requirement, such exemptions should be limited to those providers willing to accept financial downside risk inclusive of quality metrics. **13.10.31.12(B)(1)(d).** BCBSNM agrees that routine reevaluation would be integral to the viability of the system and to improve safety and quality of services. However, BCBSNM observes that if a high-compliance provider is granted an exemption or alternative PA requirements, there will be a limited amount of data to evaluate that provider's PA request patterns and approval rates when compared to other providers. **13.10.31.12(B)(1)(e).** Similar to one of the concerns raised in BCBSNM's comment on 13.10.31.12(B)(1)-(3), permitting any provider to request a PA exemption or alternative would be resource intensive and administratively burdensome for carriers. BCBSNM recommends that this provision be stricken.
	(2) A carrier shall identify those providers who are in the top fifty percent of prior authorization request submitters and who have low rates of adherence to prior authorization requirements and criteria as evidenced by high rates of prior authorization denials due to incomplete documentation or failure to meet required criteria required for approval (a "low	

	compliance provider"). A carrier shall identify at least ten percent of low compliance providers and offer each such provider a corrective action plan to improve the provider's prior authorization request success rates. (3) At the request and direction of the superintendent, a carrier shall report its evaluation process for identifying high and low compliance providers, the corrective action plans offered to low compliance providers and the prior authorization adjustments offered to high compliance providers.	
13.10.31.13	PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any violation of this rule may be imposed against an insurer in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978. [13.10.31.13 NMAC - N, 04/01/2021]	**No Comment.**
13.10.31.14	SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.	**No Comment.**