EXISTING NETWORK FILING GUIDE

Plan year 2022

Office of the Superintendent of Insurance
State of New Mexico

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1. Purpose: This guide provides information about the processes and standards that govern submission and review of a proposed health plan network in New Mexico. This guide supplements and clarifies the network adequacy standards applicable to major medical managed healthcare plans, including the standards specified in Section 59A-57-4(B)(3) NMSA 1978 and 13.10.22.8 NMAC. Pursuant to those laws, the Office of Superintendent of Insurance ("OSI") has broad discretion to determine what constitutes an adequate network for a managed healthcare plan. This guide identifies minimum network adequacy standards that guide the OSI's discretion. Pursuant to Section 59A-2-8 NMSA 1978, this guide also specifies filing deadlines and processes that will facilitate and expedite OSI review of network adequacy filings and allow for the orderly processing and disposition of plan reviews approvals. Finally, pursuant to Section 59A-4-3 NMSA 1978, this guide directs managed health care plans to collect and report data and information pertinent to the OSI's development of network adequacy standards and review of network adequacy filings.

2. Contact: Please direct all questions regarding submission and review processes to Paige Duhamel, 1-505-660-7108 or Paige.Duhamel@state.nm.us. For legal questions, please contact the Life and Health Legal Counsel, Todd Baran, at 1-505-660-8172 or Todd.Baran@state.nm.us**.**

3. Deadlines. This guidance shall be implemented for the January 1, 2022, network adequacy filing deadline except for the Provider Directory Accuracy Audit (Section 7), Member Provider Directory Complaint Data (Section 7), Access and Availability Audit (Section 8), and Evidence of Attempts to Contract with Providers (Section 10). These reports are first due with the January 1, 2023, network adequacy filing submission.

4. Applicability: A major medical health insurance carrier shall follow this Existing Network Filing Guide for each approved network used in connection with a health plan for the entirety of the preceding calendar year. Each such network is considered an "existing" network. This guidance supersedes all prior guidance that addresses the same subject matter and any conflicting rule.

5. General Submission Requirements: A carrier with an existing network shall file in SERFF a network adequacy report and associated filings by January 1st of each year. A carrier with an existing large group only network shall annually file in SERFF a network adequacy report and associated filings between June 1st and September 1st. If an existing network changes by more than 40% (a "changed network"), in either provider count or number of counties covered, a carrier shall file a network adequacy report compliant with the requirements of this guide by February 15th of the first year the changed network is in service. This changed network filing shall include the most recently available enrollment numbers. If an existing network has seen its enrollment grow by more than 20% before February 1st of any given year, the carrier shall file a notice to this effect in SERFF by February 15th. OSI may request that the carrier file updated access maps and tables. A carrier shall file a notice on January 1st if it intends to file a changed network report on February 15th.

A carrier may request an extension of a filing deadline for good cause, as determined by the superintendent. This request shall be made at least 5 business days prior to the deadline. Failure to meet the filing deadline without good cause may result in disapproval of the network, a fine of $500 for each day the filing is late, or both. If a network adequacy report for an existing network or changed network associated with a QHP is not approved by April 1st of the year in which it is filed, OSI may not re-certify that QHP for the following plan year.

A network adequacy report shall comply with the directions and requirements specified in this guide. OSI may disapprove a network if the required network adequacy report does not substantially comply.

Date	Action
January 1st	Submission deadline for existing network, excluding large group-only networks.
February 15th	Submission deadline for any network that changed by more than 40% from the previously approved network. Submission deadline for notice that any existing network's enrollment increased by more than 20% over prior year.
April 1st	Deadline for compliance approval for existing network associated with a QHP.
May 15th	Deadline for compliance approval for a changed network.
June 1st – September 1st	Large group-only filing window.
Annual Rate Filing Deadline	Essential Community Provider template for all networks

Each network shall be evaluated on its own merits. Provider access analysis shall use enrollment information specific to each individual network only. For example, if a carrier has multiple networks, including an HMO, PPO, and a narrow network HMO, each network shall be accompanied by its own filing and each filing shall reflect the enrollment for that network. The HMO filing shall reflect the enrollment in the HMO product only; the PPO filing shall reflect the enrollment in the PPO product only; and the narrow network HMO shall reflect the enrollment in the narrow network product only.

6. Contents: A network adequacy report shall include:

a. Network description (on Provider Information Template)

b. Provider Directory Accuracy Reporting

c. Access and Availability Reporting

d. Provider Access Tables and Maps

e. Completed Exceptions Request Template

f. Provider lists

(i) In-network provider list

(ii) In-Network Hospital List

(iii) In-Network Pharmacy List

(iv) In-Network, Out-of-State List

(v) In-Network Air Ambulance List

g. Essential Community Provider Report (due with rate filing)

h. Certifications by an officer of the carrier that the carrier has reviewed its submission for compliance with this guidance (on Provider Information Template).

A carrier shall only file those supporting documents that are requested by the superintendent or are reasonably necessary to demonstrate network adequacy. A filing that contains documents not specifically requested by the OSI, referenced in this guidance, or necessary to establish compliance with network adequacy standards may be disapproved. Only relevant excerpts of larger documents shall be submitted. Relevant parts of a supporting document shall be highlighted. Provider data shall be based on fully or provisionally credentialed, in-force provider contracts for the network. Approval of a filing for network adequacy purposes does not necessarily constitute approval of supporting documents for purposes other than compliance with identified network adequacy standards. Document updates in response to OSI objections shall be redlined or highlighted to show changes.

7. Provider Directory Accuracy Reporting: A carrier shall file a provider directory accuracy report, which shall include the results of an audit performed by an independent auditor. The report shall include the following information to show how the carrier maintains an accurate provider directory:

- *Provider Directory Audit*. Using a true random sample, the carrier shall audit, at a minimum, audit the accuracy of the addresses, phone numbers, hours of operation, and panel status for at least 30% of primary care providers, 40% of behavioral health providers, and 40% of specialty care providers, or a sample of provider types as approved by the superintendent. The results shall include the number of providers removed from the directory and records updated as a part of the audit. A carrier shall also complete and file the Provider Directory Audit Template posted on the OSI Life and Health Product Filing website. The audit shall be based on provider directory data displayed as of the sixth month of the plan year. The provider directory audit may be performed at the same time as the access and availability audit.
- *Provider Directory Updates*. A carrier shall ask providers to verify their data every 90 days pursuant to the federal Consolidated Appropriations Act (CAA). If a provider's data cannot be verified 180 days after the last verification date, the provider's information shall be suppressed from the online provider directory. If the provider's data is later verified, the provider may be added back into the directory. The online provider directory display must be updated with demographic data (name, address, telephone number, and digital contact information) within five business days of the plan receiving the updated information from a provider or after investigation resulting from a member complaint. This applies to changes to any required data elements or to adding a new provider or removing a termed provider. A carrier shall track and report complaints.
- *Provider Directory Change Tracking System.* A carrier must have a process in place to recreate the information in the directory at any point in time going back in time for the prior two years. The provider directory accuracy report shall describe how the carrier maintains this information and retrieves data.
- *Screen Shots of Date Stamp*. A network adequacy filing shall include a screen shot of the online provider directory for the relevant plan showing the most current date on which the directory was last updated before the filing submission;

- *Consumer reported inaccuracies*. A carrier shall include in the EOC for each plan and in a conspicuous place on its website instructions for how a member can report provider directory errors. The first EOC in which the carrier shall include these instructions shall be for the 2023 plan year. A carrier shall maintain a log of all such member reports that will show what was corrected and the turnaround times for correcting any errors. Aggregate log data shall be reported in the Provider Information Template found on the OSI Life and Health website.
- *Consumer communication template*: A carrier shall submit for approval in SERFF any standard form used to communicate changes in the provider network to members.
- *Claims detected inaccuracies*. A carrier shall ensure that any provider directory errors detected through claims processing are eliminated from provider directories and network adequacy reporting. A carrier shall log all errors discovered. The log shall document what was corrected and the turnaround times for correcting each error. A carrier shall report aggregate log data on the Provider Directory Audit Template.
- *Emergency Care.* Carriers shall note on their provider directory(ies) that for emergency care, members shall seek care at the nearest appropriate hospital, regardless of network status.
- *Member Reliance.* A carrier shall not deny a claim or impose out of network cost-sharing if a member relied on erroneous provider directory information in selecting the carrier's health plan or making an appointment with a provider.
- *Log-in Requirements*. A carrier shall not require a member or prospective member to log-in to a specific web site to gain access to a plan's network.
- *Provider Data Verification.* The provider directory accuracy report shall state which provider data verification vendor it uses to map networks and verify data. The report shall state how often the carrier uses this vendor to verify data.

8. Access and availability: A carrier shall file an access and availability report and complete the access and availability template available on the OSI Life and Health website. A carrier's network shall reasonably comply with the following access and availability standards:

a. For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than thirty (30) calendar days, unless the member requests a later time;

b. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical care, the request-to-appointment time shall be no more than fourteen (14) calendar days, unless the member requests a later time;

c. For non-urgent behavioral health care, the request-to-appointment time shall be no more than fourteen (14) calendar days, unless a member requests a later time;

d. Primary medical and behavioral health care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours;

e. For specialty outpatient referral and consultation appointments, excluding behavioral health, the request to appointment time shall be consistent with the clinical urgency, but no more than twenty- one (21) calendar days, unless the member requests a later time;

f. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the member requests a later time;

g. For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need;

h. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours;

i. For Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours.

A carrier's Access and Availability Report shall be based on an independent, and statistically valid survey. The statistical validity shall be based on the number of responses received. The surveyor shall have a background in survey science with a demonstrated capability conducting health insurance coverage access surveys. A carrier shall note the number of providers that the surveyor failed to reach while conducting the survey, and the number who were not taking new patients.

The survey may be conducted by internal sources if the carrier can demonstrate that the survey was conducted independently and scientifically. Any internal surveying entity must meet the required standards for experience.

This survey shall be conducted anytime during the last six months of the plan year and submitted with the network adequacy filing. If the survey has plans with more than one plan year, the last six months of the calendar year is acceptable. The survey must be conducted on each network offered by a carrier. The survey does not need to be conducted in a secret shopper format. A carrier shall submit to the superintendent the name and qualifications of the intended surveyor within one month of the survey's commencement. This name should be sent to paige.duhamel@state.nm.us.

The survey report shall include:

- the name and qualifications of the surveyor;
- the dates the survey was conducted;
- the survey methodology.

The survey shall encompass a sample of the following provider types:

- PCPs: To include only Family, General, Internal Medicine Practitioners, Nurse Practitioners and Physician Assistants
- Women's PCPs: To include only OB/GYNs, Certified Nurse Midwives, Midwives, OB/GYN Nurse Practitioners and Physician Assistants
- Behavioral Health (Social Workers)
- Behavioral Health (Psychologists)
- Psychiatrists
- Allergist/Immunologist
- Cardiology

- Dermatology
- Endocrinology/Diabetes
- Oncology
- Orthopedics
- Otolaryngology
- Physical Therapy/Rehabilitation
- Urology

A survey report shall identify any changes to access and availability by provider type from a prior survey.

9. Provider Access Maps and Tables:

a. *Tables.* A carrier shall submit tables for each provider or facility type listed below showing:

(i) The number of members per county as of no earlier than November 1st of the prior year for January 1st filing submissions (i.e. for the January 2022 filing, enrollment as of no earlier than November 1st 2021), no earlier than December 1st for February 15th filings, and no more than two months prior for large-group only submissions;

(ii) The number of providers or facilities in-network by county as of no earlier than November 1st of the prior year (i.e. for the January 2022 filing, number as of no earlier than November 1st 2021), no earlier than December 1st for February 15th filings, and no more than two months prior for large-group only submissions;

(iii) The number of members with and without access per county based on drive distance standards as described below. For provider types that typically serve only one demographic, report based on the number of members that use that provider. For example, pediatricians primarily serve children, accordingly, report based on the number of children in each county. Report the pediatric population as from the age at birth to 18. Report the geriatric population as 65 and older.

(iv) The percentage of members with and without access per county based on drive distance standards described below. For provider types that typically serve only one demographic, report based on the number of members that use that provider. For example, pediatricians primarily serve children, accordingly, report based on the number of children in each county. Family practice provider counts may include adults and children.

(v) Average drive distance for a member by county. These tables may be sorted by urban, rural, and frontier county status. A network adequacy report shall not include out-of-state providers unless they meet the drive distance standards for a county.

b. *Maps.* A carrier shall submit service-area-wide maps for each provider or facility type listed below showing:

(i) Location of single and multiple provider practices in each county and members without access noted (in a different color). Members without access is defined as members outside of the provider type's drive distance standards;

(ii) Location of enrolled members on a statewide map;

Separate maps for urban, rural, and frontier counties is not necessary. If access for all three county types is reported on one map, the carrier shall designate each county type using a different color.

c. Maps and tables shall be generated to show access for each of the following provider and facility types:

(i) Primary Care Providers: Adult PCPs (to include only Family, General, Internal Medicine Practitioners); Pediatricians; OB-GYNs only; Women's PCPs to include OB-GYNs, Certified Nurse Midwives, Certified Professional Midwives, and OB/GYN Physician Assistants and Nurse Practitioners; Geriatricians; Other PCPs: To include only Physician Assistants, Nurse Practitioners, Practitioners of the Healing Arts, e.g.).

(ii) Facilities: Level 1 Trauma Centers; acute care hospitals; hospitals offering perinatal services (maternity care); inpatient psychiatric hospitals for adults and children, therapeutic radiation providers, pharmacies, Diagnostic radiology provider(s) (X-ray, CT scan, mammography, and ultrasound), laboratory services, rehabilitation centers; renal dialysis centers, substance use treatment centers; urgent care centers.

(iii) Specialists: Allergy/Immunology; Anesthesiology; Cardiology; Dermatology; Endocrinology; Gastroenterology; Infectious Diseases; Hematology; Home Health Care; Nephrology; Neurology; Oncology; Orthopedics, Otolaryngology; Plastic/Reconstructive Surgery; Podiatry; Psychiatry (behavioral health); Psychology (behavioral health); Pulmonology; Physical Therapy; Mid-Level Behavioral Health Providers (excluding psychologists) (behavioral health); Psychologists (behavioral health); Rheumatology; Urology.

d. A county shall be designated Urban, Rural, or Frontier in the following manner:

(i) Urban: Bernalillo, Doña Ana, Los Alamos , and Santa Fe. .

(ii)Rural: Chaves, Curry, Eddy, Grant, Lea, Luna, McKinley, Otero, Rio Arriba, Roosevelt, Sandoval, San Juan, Socorro, Taos, Valencia.

(iii) Frontier: Catron, Cibola, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Lincoln, Mora, Quay, San Miguel, Sierra, Torrance, Union.

e. Provider to Member ratios and drive distances shall be calculated for each county in the following manner:

(i) For PCPs, including Women's PCPs, behavioral health providers, and pharmacies, including 24/7 pharmacies where one is available, the following standards shall apply:

(a) Ninety percent (90%) of Urban members shall travel no farther than (30 miles);

(b) Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles; and

(c) Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles.

(ii) For the Licensed Medical Specialists listed paragraph (c)(iii) above, except for individual behavioral health providers, and facilities, except for pharmacies: :

(a) Ninety percent (90%) of Urban members shall travel no farther than (30 miles);

(b) Ninety percent (90%) of Rural members shall travel no farther than sixty (60) miles; and

(c) Ninety percent (90%) of Frontier members shall travel no farther than ninety (90) miles.

(iii) For Licensed Medical Facilities listed in paragraph (c)(ii) above, the following standards shall apply.

(a) Ninety percent (90%) of Urban members shall travel no farther than (30 miles);

(b) Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles; and

(c) Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles.

Where a county is adjacent to a more populated county with higher numbers of providers, a carrier may rely on contracts with providers in the more populated county to meet time and distance standards for members in the less populated county. Carriers are encouraged, however, to contract with available providers in the less populated county to meet members' health care access needs.

f. Provider counts. A carrier shall only include on its maps and tables providers that are fully or provisionally credentialed and PAR-activated. Mid-level providers shall not be counted in the carrier's provider count unless independently credentialed. Where a carrier counts a specialist with a subspeciality, that specialist shall be counted for only one category of provider. For example, if a pediatric neurologist is counted as a neurologist, this provider should not then also be counted in an additional category, i.e., pediatrics. A provider shall not be counted more than once for services performed at a unique address. Telemedicine providers shall not be included in the provider count for any county in which they do not physically practice. The provider count shall not include Indian Health Services only providers. The provider list shall indicate, to the best of a carrier's knowledge, if a provider works at a facility part-time and for what number of days each month. An estimate will be accepted in this field.

A carrier shall verify its county-level provider counts. OSI may disapprove a network adequacy filing that includes erroneous or inflated provider counts. If, in the process of developing the network access report, a carrier discovers incorrect provider data, the carrier shall make parallel changes to its provider list.

g. Tiered Networks: A carrier's network adequacy shall be determined by the access available at the lowest-level cost-sharing tier.

h. PPO networks shall meet time and distance standards at the in-network level.

10. Exceptions Requests: For counties where the plan does not meet the access standards described in Section 8 and the carrier has not contracted with available providers in that county, the carrier shall file an exceptions request. This exception request shall demonstrate that the carrier has made a good faith effort to contract with available providers, including evidence of attempts to contract. Single case agreements with available providers will not suffice as evidence of attempts to contract. Do not report on counties without available providers of a specific type. OSI will verify which counties are without an available provider type using New Mexico Health Care Provider Workforce data reporting, Medicare databases, HSD databases, and other investigation tools. A carrier who is disproportionately unable to contract with available providers may have its network disapproved. A carrier shall also use

the exceptions request template to report decreases in its network, by provider type, of greater than 20%, unless that decrease does not impact the carrier's ability to meet access standards. The template for reporting is available on the OSI Life and Health web page.

11. Provider List: A carrier shall submit a provider list that is accurate as of the date it was created but shall be generated no earlier than November 1st. The provider list shall include the types of providers reported in the carrier's network adequacy provider maps and tables. The Provider List shall be in excel format using the template available on the OSI Life and Health website. These lists shall be used to generate the data reported in the carrier's network adequacy tables and maps. The template includes a required cover letter in which the carrier shall describe the structure of the network. The template also includes a tab where a carrier shall report telemedicine-only providers, where available. On the out-of-state provider tab, OSI requests that carriers report only data for providers that meet OSI drive distance standards or providers within 100 miles of the nearest border town or city, whichever is greater. OSI encourages inclusion of in-network providers in Lubbock, Odessa, and Tucson. Carriers shall also submit hospital-only, facility, air ambulance, and pharmacy provider lists.

12. Essential Community Providers: A carrier shall file an Essential Community Provider template with their form and rate submissions. A proposed network must include 50% or more ECPs and at least 60% of FQHC's in each county in the network service area. These filings shall be filed pursuant to the binder filing schedule established by OSI's forms and rates submissions deadlines. Large group-only plans shall also submit this template with any rate filing.

13. Same or Substantially Similar Networks: OSI may disapprove a proposed network that is the same or substantially like another approved network used by the same carrier. OSI defines same or substantially similar network as networks that cover the same service area, are the same network type (HMO, PPO, EPO, etc.) contain 95% of the same providers and facilities, and do not have reimbursement differentials that will result in more than 10% premium cost differences for consumers.

14. Non-compliance: The OSI will disapprove a network access plan, or mandate corrective action, if the network does not meet standards. Absent good cause, failure to comply with submission requirements, including full and accurate responses to data requests, after two rounds of objections will also result in disapproval. A carrier may refile a disapproved network access plan only if its new filing cures deficiencies identified in to the OSI's prior objections. A carrier may be ordered to treat out-of-network care as in network for cost-sharing purposes for an enrollee who relies on misinformation in a provider directory in selecting the carrier's plan.