	Life and Health Division, NM Office of Superintendent Response to Public Comments on Proposed Amendment to 13.10.31.12			
	Section	**Commenter**	**Comment Summary**	**OSI Response**
	General	BCBSNM	BCBSNM offered the following statement in its cover letter "BCBSNM is committed to providing our members with the benefits they need to receive the right care, at the right time, from the right provider. Utilization management tools, like prior authorization, helps us deliver on that commitment. Prior authorization protects patients and prevents the overuse, misuse or unnecessary (or potentially harmful) care, helps to ensure care is consistent with evidence-based practices and can help lower a patient's out-of-pocket costs."	BCBS is one of the organizations, consisting of both health plans and health care providers, that signed onto the "Consensus Statement on Improving the Prior Authorization Process" in, which was filed into the record on October 12, 2022. These organization identified "five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform." The first of these areas is "selective application of prior authorization" based on "provider performance on quality measures and adherence to evidence-based medicine." The Blue Cross Blue Shield Association agreed to encourage the use of programs such as those proposed in this amendment.
	General	AHIP	AHIP requests a new subsection or additional language that makes "…clear that a carrier may grant, deny, or rescind a prior authorization exemption for certain covered services by initiating an evaluation if there is credible concern for patient safety, quality of care, or potential incidences of waste, fraud, or abuse."	OSI opposes the proposed addition. The rights of carriers to terminate relationships with providers for cause is preserved in 13.10.28.11 (D)(4) NMAC. Furthermore, carriers already have active internal dispute resolution processes to resolve potential unclean claims pursuant to 13.10.28.13 9(A)(4) NMAC. Contract requirements between carriers and providers are outlined in 13.10.22.12 NMAC, and include, among other requirements, that the contracts specifically address quality of care, medical necessity, credentialing, auditing, utilization management, and malpractice. OSI's proposed prior authorization amendments do not conflict with the pre-existing regulations addressing carrier's

				rights and responsibilities regarding their contracting with providers. OSI staff recommend that this proposed language not be added to the proposed regulation, as AHIPs recommendation is already addressed through existing regulation.
	General	Evicore	Evicore submitted this general comment: "While it may sound like a reasonable practice, gold carding has several serious negative impacts and is based on a false premise that it will improve care for patients and make the current prior authorization more efficient: • It would increase inappropriate care and costs, while not positively changing behavior long-term. • It would result in greater confusion and increase the administrative burden for providers. • It would eliminate several important benefits of prior authorization." Please see Evicore's submission for their full discussion supporting these assertions.	OSI staff notes that Evicore's business includes conducting prior authorization request reviews for health plans. We also note that this regulation is focused on reducing the administrative burdens on providers while still allowing for the oversight and evaluation of providers' ordering practices. We appreciate Evicore's input. OSI does not agree with Evicore's characterization of the effects of gold-carding, and further notes that this practice received broad support from providers and the health care industry, as demonstrated in the 2018 "Consensus Statement on Improving the Prior Authorization Process" which was issued by AHA, AHIP, AMA, APhA, BCBS, and MGMA. A copy of this document was filed into the record on October 12, 2022.
	General	PCMA	PCMA suggests that the Superintendent does not have the authority to mandate "gold-carding" and authorizing legislation is needed. PCMA goes on to request "… clarification on the express statutory authority of the OSI to create this new scheme for gold carding when the existing	PCMA correctly points to language in the 2019 NM Prior Authorization Act, NMSA 59A-22B-4 (A), that directs the OSI to "standardize and streamline the prior authorization process across all health insurers." The legislature mandated that the OSI address issues with prior authorization, which the OSI has chosen to do through our rulemaking authority found in NMSA 59A-2-9.

			statute mandates streamlining and standardization.	OSI elected to utilize gold carding as an industry approved means to "streamline the prior authorization process" for providers, as it was recommended in the 2018 Consensus Statement on Improving Prior Authorization Access. Gold-carding also has broad support from providers, as seen in the AMA studies which were filed into the record on October 12, 2022, and the oral comments of Dr. McAneny and Dr. Roybal made during the hearing on October 4, 2022.
	General	PCMA	PCMA asks how the proposed rule satisfies the Notice of Public Rulemaking's (NOPR) statement "2. The proposed amendments will address the section of the rule that was reserved during the previous rule promulgation and will create a more streamlined prior authorization process for carriers and health care providers"	The NOPR issued by OSI satisfied all the requirements found in 14-4-5.2 (A) NMAC. The notice included the full text of the proposed amendments, a short explanation, statutory authority for promulgation, and instructions on how participate in the rule promulgation process. OSI originally proposed a gold-carding provision in 13.10.31.12 NMAC in Case No: 20-00058-Rule-LH. The hearing officer's final recommendation included the following: "In an abundance of caution, the Hearing Officer recommends that current proposed 13.10.31.12 be removed from the proposed rule and that the section be marked as "[Reserved]" in anticipation of a notice and comment process just for 13.10.31.12 of the rule. The Hearing Officer further recommends that the Superintendent issue a NOPR for a new proposed 13.10.31.12." The Superintendent ultimately adopted that recommendation on May 24, 2021. As PCMA correctly notes in their comment, the NOPR issued for this matter references the prior order, and OSI's compliance therewith.
	General	THNM	True Health New Mexico (THNM) states: "THNM will likely be in the run-out period by the time this prior authorization alternative needs to be implemented. Any benefits to	OSI agrees with THNM's assessment that it does not make sense for THNM to implement the program.

			provider and members will not be realized. Therefore, it does not make sense for THNM to implement this program as it would require significant resources and provide no benefit."	
	General	Western Sky	Western Sky Community Care (WSCC) comments on the usefulness of prior authorizations in providing "…member access to clinically appropriate, evidenced-based care under a managed care system." WSCC adds that prior authorizations "…identify unsafe or low-value care that is inconsistent with current clinical evidence and mitigate potential harm to members. In addition, prior authorization requirements help detect, deter, and prevent insurance fraud, waste, or abuse that impact the total costs of healthcare coverage to New Mexicans." Furthermore, in its comments, WSCC encourages "…the OSI to implement and maintain an administrative regulatory framework that provides sufficient incentive and flexibility for the industry to revise, design, and maintain prior authorization exemption processes that continue to assure member safety, healthcare quality, innovative value-based care arrangements, and the mitigation of insurance fraud, waste, and abuse risks."	OSI disagrees with WSCC's comments and refers the hearing officer to the two AMA studies filed in the record, as well as the comments made on the record by Dr. McAneny and Dr. Roybal. WSCC's concerns are pure conjecture that lack support by any data, study, or other objective source of information. OSI further notes that industry partners indicated public support for gold-carding in 2018, as represented in the "Consensus Statement on Improving Prior Authorization Access," which has been filed into the record for the hearing officer's review. Despite supporting five improvements to the prior authorization process, the insurance industry has overwhelmingly failed to implement any of the proposals founding in the consensus statement over the last four years. OSI reaffirms that gold-carding is in the best interests of providers and consumers in New Mexico.

			WSCC suggests that "mandated prior authorization exemptions can reduce the attractiveness of value-based arrangement with providers and "(1) reduce standards for safe, appropriate, and affordable care that is aligned with financial and administrative incentives as spelled out in a value-based contracting arrangement; (2) reduce providers' accountability for costs and quality that may shift cost responsibility to members, employers, and taxpayers); and (3) could incentivize increased side-step of regular reviews as they may rely upon less than a high-compliance record.	
	13.10.31.12(A)	BCBSNM	BCBSNM suggests limiting applicability to "…medical services, including both physical and behavioral health services, and excluding prior authorization for prescription drugs. Prescription drugs are uniquely well managed by prior authorization as they have safety risks and cost complications that many other medical services do not share." To achieve that BCBS proposes replacing every instance of "covered benefit" in Section 12 to "covered medical benefit"	OSI receives numerous complaints from providers about problems they have with the prior authorization processes of the carriers' PBMs. While nearly 100% of the prescription they write are eventually approved, the process is administratively burdensome and delays access to the medication. In fact, in the 2018 "Consensus Statement on Improving Prior Authorization Process," which is included in the 18th docketed filing in this matter, the Blue Cross Blue Shield Association agreed to review "medical services ***and prescription drugs***" requiring prior authorization and to revise prior authorization requirements. This is contrary to BCBSNM's comment. OSI staff oppose the proposed changes, and recommend that the language in 13.10.31.12 (A) NMAC remain as suggested by OSI.
	13.10.31.12(A)	AHIP	AHIP strongly recommends "…that the scope of the regulation be limited to medical	OSI staff disagrees with this suggestion from AHIP and recommends that the proposed language in 13.10.31.12(A)

			services and specifically exclude prescription drugs." According to AHIP this is because "…can help avoid inappropriate drug use, promote evidence-based drug therapy, and assist in reducing drug costs for everyone." In addition, AHIP comments "Requiring health carriers to cover prescribed drugs during adverse determination reviews and external review processes could create challenges where therapies are initiated that may not meet clinical guidelines or nationally recognized care criteria, which could adversely impact patient care and increase costs." AHIP also brings up the danger of addiction of opioids and drug interactions with opioids.	NMAC remain. As stated above, OSI receives numerous complaints from providers about problems they have with the prior authorization process with carriers' PBMs. While nearly 100% of the prescriptions they write are eventually approved, the process is administratively burdensome and delays access to the medication. One of the goals of this regulation is to reduce the administrative burden of excessive and unnecessary prior authorization requirements. in the 2018 "Consensus Statement on Improving Prior Authorization Process," which is included in the 18th docketed filing in this matter, AHIP agreed to review "medical services ***and prescription drugs***" requiring prior authorization and to revise prior authorization requirements. This is contrary to AHIP's comment on this regulation. In the same filing, an AMA provider survey found that 91% of the respondents said prior authorizations had negative impacts to patients and 7% of respondents said the prior authorization had no impact. AHIP implies in its comments that the regulation requires carriers to "…cover prescribed drugs during adverse determination reviews…" This claim is a complete fabrication with no support in the text of the proposed amendment. The regulation is designed to be sure that "gold cards" are issued to reliable and safe prescribers. In addition, there is nothing in the regulation that requires carriers to "gold card" opioids. Gold-carding can be applied to a specific service or services, or to a specific set of services.
	13.10.31.12(A)	BCBSNM	BCBSNM also suggests creating a definition of providers for this section of 13.10.31.12 that excludes "facilities" because facilities	BCBS fails to define what a facility is. "Facility" can include psychiatric hospitals, labs and radiology facilities, ambulatory surgical centers. It is not clear what BCBSNM intends in its

			are "…are generally better resourced and staffed than professional providers, thus the administrative requirements of prior authorization are less impactful for facilities." BCBSNM adds that "…facilities support rather than drive healthcare" and "…alternate arrangements will be of greater benefit to the professional providers who are driving the delivery of health care." BCBSNM suggest language to this end	definition of facility. OSI disagrees with BCBSNM's reasoning that facilities are "better resourced" and "better staffed" than physicians and other professional providers, and therefore don't need to be gold-carded. OSI believes facilities should also benefit from being compliant prior authorization submitters. OSI suggests that well-resourced and experienced facilities, spending less administrative overhead on unnecessary prior authorization processes would help slow the growth of health care costs. The studies filed in docket item 18 in this matter support OSI's position. We note that acute-care hospital admissions and continuing stays are currently excluded from the rule. Additionally, 13.10.31.12 (C) NMAC excludes inpatient hospitals, inpatient psychiatric hospitals, rehab hospitals and DME providers from the adherence assessment for the first year, with the Superintendent having the option to exclude them in future years. OSI recommends the language in the proposed rule including facilities remain as proposed, in accordance with NMSA 59A-22B-2(G), which includes "facility" in the definition of "health care provider."
	13.10.31.12(A)	BCBSNM	BCBSNM also recommends "…clarifying the intended scope of health care plans that qualify as "fully-insured commercial coverage" and provides examples of what might or might not be included in that definition. BCBSNM points out that coverage issued under the Health Care Purchasing Act	The Prior Authorization Act, in NMSA 59A-22B-2(H) includes HMOs, non-profit health care plans, provider services networks, and **Medicaid MCOs** in the definition of "health insurer." The definition of health insurer found in the Prior Authorization Act does not include plans issued under the Health Care Purchasing Act.

			is subject to the Prior Authorization Act, and fears that the proposed language will be misconstrued about which kinds of insurance is affected.	OSI has not proposed amendments to the scope section of these regulations found in 13.10.31.2 NMAC, which are in alignment with statutory authority, and thus they cannot be amended in this matter. The proposed language in 13.10.31.12 (A) NMAC reads (emphasis ours): "**This section of the rule** shall only apply to fully-insured commercial coverages regulated by the superintendent." The specific and clear intent is to exempt Medicaid MCOs from the gold-carding provisions in the regulation as they would not qualify as a "fully insured commercial coverage." OSI finds the language clear, and in line with statutory authority.
	13.10.31.12(A)	Western Sky	Western Sky Community Care (WSCC) suggests "Clarification should be made whether the proposed rule applicability to prescription drugs."	OSI notes that the proposed regulation in 13.10.31.12 B requires carriers to include all covered benefits for which a prior authorization is required when assessing the value of requiring a prior authorization for a covered benefit. In 13.10.31.12.C the proposed regulation requires carriers to evaluate its network providers' patterns of adherence to the carrier's prior authorization criteria and policies in the preceding calendar year. Providers will be submitting prior authorization requests for any covered benefit for which the carrier requires prior authorization. If a prescription drug requires a prior authorization, then the proposed rule applies to it. OSI staff finds that additional language is not needed to clarify that the rule applies to prescription drugs and that the proposed language should remain unchanged.
	13.10.31.12(A)	UHC	UHC asks which policies the rule will apply to – only to policies issued in New Mexico	The Superintendent's jurisdiction over policies issued to New Mexico residents, regardless of the situs of the carrier, was

			- NM residents with policies issued outside NM - or only New Mexico providers	established by statute in 1984 pursuant to NMSA 1978 § 59A-1-14, reinforced in subsequent legislation found in NMSA 1978 § 59A-18-1 and NMSA 1978 §59A-23-8. The proposed amendment does not have any bearing on the Superintendent's jurisdiction, which has been long since established by statute. Pursuant to NMSA 1978 § 59A-22B-2(H), and the proposed language in 13.10.31.12 (A), this rule would apply to all HMOs, non-profit health care plans, provider service networks, and third-party payers issuing coverage to a resident of New Mexico, and the OSI regulated networks affiliated with that coverage.
	13.10.31.12(A)	Desert States Physical Therapy Network, LTD	Desert States Physical Therapy Network, LTD asks how may covered lives will be affected by this regulation.	In September 2022, over 154,000 lives were covered by fully-insured commercial plans.
	13.10.31.12(B)	Evicore	Evicore recommends that this amendment (section 12) should "…only be about data collection, and the state should recommend administrative relief, if any, only after the data has been reviewed and determined a problem truly exists."	OSI appreciates the input but we disagree with this recommendation. The AMA published surveys, which can be found in docket item 18 filed in this matter, confirm the existence of a serious problem regarding prior authorization, and an industry-wide failure to implement corrective measures agreed upon over four years ago.
	13.10.31.12(B)	PCMA	PCMA notes the timeline for the implementation of the rule, and asks when all the regulations will be in effect to support the new rule and suggests that perhaps the implementation should be delayed.	The rule will be in effect on 1/1/2023. Guidance will be issued at or near the same time. The first agreements executed with providers in 2023 will go into effect on 1/1/2024. In our response to a comment on the assessment report deadline of September 30, 2023 (13.10.31.12.B(4)(a) NMAC), we recommend extending the reporting deadline to October

				31, 2023. In response to a comment on the due date of the annual report (13.10.31.12(D) NMAC) OSI did not agree to extend it beyond the original date of September 30. OSI does not find a reason to delay the implementation and recommends the implementation of 13.10.31.12 NMAC proceed as intended, taking into account the recommended change in reporting dates.
	13.10.31.12(B)(1)(a)	BCBSNM	BCBSNM suggests that should we not accept the recommendation of excluding prescription drugs from Section 12, it notes that covered benefit is not the "industry standard language for the prior authorization of prescription drugs" and that "drug classification" is used instead and they recommend that this be used in the rule "…the approval rate for each covered benefit *or drug classification* for which a prior authorization was required…"	While we understand that the industry has its standard terms, OSI staff is not convinced this differentiating language is needed if the prescribed drug is a covered benefit. There is not enough information provided by the commenter to help us understand what this term means and how it would improve the proposed rule. We believe the carriers will be able to find the best way to accurately assess approval rates for prescription drugs. OSI staff recommends leaving the language as proposed.
	13.10.31.12(B)(1)(a)	Evicore	Evicore recommends that "covered benefit" be clarified "…to be both diagnosis and procedure, not a single service code." In addition, Evicore stated "By limiting definition of "service" to a single service code you remove critical patient protections…"	OSI staff does not agree that "covered benefit" should be further defined within the rule because of the inflexibility of rules. Once we understand, through their reporting, how carriers assessed the need for prior authorizations, the Superintendent has the authority to issue more specific guidance pursuant to Section G of this rule. OSI staff notes that the proposed rule does not limit "…the definition of service to a single service code…" because the rule amendment does not have a definition for "service" or "covered benefit". Nor does the promulgated 13.10.31 NMAC rule. The definition of covered benefits found in 13.10.29.7(C)(12) NMAC does not mention a service code.

	13.10.31.12(B)(1)(a)	UHC	UnitedHealthcare (UHC) asks whether this section requires the carrier to assess every "code/service"	The language in this section reads "At a minimum, a carrier's assessment shall consider the following elements:(a)the approval rate for each covered benefit for which a prior authorization was required;" The regulation is silent on how the carrier identifies these covered benefits. The regulation requires that a carrier identifies all covered benefits for which a prior authorization is required. The carrier can choose how best to do that and will be asked to describe its methodology in its reporting.
	13.10.31.12(B)(1)(b)	BCBSNM	BCBSNM suggests the following edits: "(b) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered medical benefit protects patient safety and/or seeks to generate ~~generates~~ better health outcomes;	OSI staff notes that we do not agree with the addition of "medical" – please see our comments to BCBSNM's suggestion at 13.10.31.12(A) NMAC above. OSI's intent for the original proposed language in this section is as stated – does the prior authorization requirement ***generate*** better health outcomes, not whether it intends to or seeks to generate them. This is indicated by the prior clause which indicates that the carrier is to use "…demonstrable evidence, including claims and clinical data…" to determine whether the prior authorization requirement protect patient safety or generate better health outcomes. As for the term "and/or" – New Mexico State Records Center and Archives prohibits the use of "and/or" in regulations. See, Guide to Submitting Notice and Filing rules, Administrative Law Division, 2020. OSI recommends that this proposed language be changed from "…the prior authorization requirement for each covered benefit protects patient safety *and* generates better health outcomes, to "…the prior authorization requirement for each

				covered benefit either protects patient safety *or* generates better health outcomes, *or both.*
	13.10.31.12(B)(1)	Evicore	Evicore comments that "…payers should be allowed to report on the number of requests denied for provider's failure to submit requested clinical information."	OSI is interested in prior authorization requests that are denied due to a provider's failure to submit all required information. We are revising our annual prior authorization report to better understand the numbers of authorizations that are denied and why. We also know that a prior authorization request that is denied for lack of required information can be resubmitted and approved, so just reporting those denied requests is not the whole story. OSI staff finds, for purposes of this regulation, the number of denied requests due to lack of required information is not related to the intent of the rule.
	13.10.31.12(B)(1)(b)	Perinatal Associates of NM	Perinatal Associates of New Mexico suggests a subsection after this section with the language as follows: "If no protection of patient safety or no better health outcomes related to prior authorization of a covered benefit can be shown by the carrier, the prior authorization requirement must be eliminated for 12 months or until the carrier is able to demonstrate additional evidence to supports its position."	OSI has no objection to this amendment.
	13.10.31.12(B)(3)	UHC	UHC asks for a further definition of "benefit" and asks whether a benefit is a code or a category of service.	Benefits are the health care services, products and drug that are covered by a carrier's health plan. The carrier needs to figure out how best to identify the benefits that require prior authorization so that it can accurately identify those for which prior authorization request are approved 90% or more of the

				time. The carrier will be reporting its method of identifying these benefits.
	13.10.31.12(B) (4)(a)	BCBSNM	BCBSNM suggests that, due to the complex nature of reporting the data the rule requires, carriers should be given an extra month to produce the report in the first year, making it due no later than October 31, 2023, and each subsequent year's report due on September 30th.	Staff is not opposed to this suggestion. We recommend the date be changed to October 31, 2023, as proposed by BCBSNM
	13.10.31.12(B)(2)	AHIP	AHIP requests that implementation year be changed from 2023 to 2024	Staff disagrees with this request. This would be that the first alternative arrangement agreements would not start until January 1, 2025. The process of identifying high compliance providers and getting alternative arrangement agreements done has to start so the providers start experiencing relief in 2024. The longer providers are overly burdened by prior authorization requirements, the more New Mexico risks losing more providers.
	13.10.31.12(B) (4)(b)	BCBSNM	BCBSNM believes that the reference to subsection E is an error, and 13.10.31.12.B (4)(b) should be referring to subsection G	Staff agrees the reference to subsection E is an error, and the correct reference is to subsection G
	13.10.31.12(C)	BCBSNM	BCBSNM believes that the reference to subsection E is an error, and 13.10.31.12.B (4)(b) should be referring to subsection G	Staff agrees and the statement should be correct to reference subsection G.
	13.10.31.12(C)	AHIP	AHIP is concerned that "provider" is not well defined and urges OSI to clearly define it to mean individual providers. AHIP warns against applying the rule to provider groups or facilities, because some providers in the group or facility may be high compliance providers and others not.	"Health Care Provider" is defined at NMSA 1978 59A-22B-2(G), showing a clear legislative intent to include facilities and institutions in the Prior Authorization Act. The term provider is again defined in 13.10.29.7(P)(13) NMAC to include hospitals and facilities. OSI has no authority to change terms defined in statute, and has not proposed any amendment to 13.10.31.7 NMAC,

				specifically incorporates all terms as defined in statute and 13.10.29.7 NMAC. AHIP's recommendation would bring the regulation into conflict with statutory definitions and legislative intent. OSI opposes the change. See also our prior response to the BCBSNM comment regarding their position that facilities would not benefit from gold-carding, and subsequent response to a UHC comment
	13.10.31.12(C)	Evicore	Evicore requests that language be added "….ensuring the precertification exemption applies only to the ordering/referring physician who has evaluated the patient and determined the course of treatment, not the physician who receives the case from the referring physician and renders the service. For example, a patient with acute back pain goes to see their primary care physician for evaluation. The physician orders an MRI of the spine and sends the patient to a standalone imaging facility for the test. The radiologist at the facility oversees the MRI scan." Evicore explains that the alternative arrangement needs to be tied to the provider who examined the patient, not to the physician or facility who "…did not participate in the clinical decision."	Evicore brings up an interesting point about the many types of providers who may be involved in a service that requires a prior authorization. An MRI is a good example. The patient's direct care provider - a primary care provider (PCP) or a specialist - orders the MRI. This provider requests the prior authorization. The MRI facility bills for the actual MRI procedure – or the facility charge. The radiologist (a physician) interprets the MRI and reports the results. All three parties use the same prior authorization – the one requested by and issued to the patient's direct care provider. It is highly unlikely that the performing or interpreting provider for a service ordered by the patient's direct care provider would submit for a different prior authorization. Yet, in the case of an interventional radiology service, the patient may have been referred to the interventional radiologist by their primary physician, but the radiologist would likely be the service provider who applies for the prior authorization after examining the patient. OSI does not want to exclude these kinds of service providers from eligibility for an alternative arrangement agreement. Considering the standard practices, the gray areas, and the difficulty of covering all potential situations in a regulation,

				OSI does not agree with Evicore's recommendation to add language specifying in the regulation that eligibility for an alternative arrangement agreement should only apply "…to the ordering/referring physician", and recommend Evicore's proposed language not be added.
	13.10.31.12(C)	PCMA	PCMA thinks clarification is necessary on the "level of review" for prescription drugs, noting that prescription drugs are classified in a number of ways such as "drug level" or "drug class level". "At a minimum," says PCMA, "providers should not be exempt from prior authorization requirements for any drugs with potential abuse…"	OSI staff has responded to similar concerns below regarding the "level of review." OSI does not see this kind of direction is necessary or reasonable to put into regulation. As the industry changes, this language could tie the hands of carriers, and changing regulations is a lengthy and arduous process for all involved. We believe carriers can determine how best to evaluate a provider's success with prescription drug prior authorization requests and can choose to use the industry standards that best apply and produce actionable information. In addition, there is nothing in the regulation that requires blanket exemptions from all prior authorization requirements. Agreements can specify which drug classes will be exempted. There is nothing in the rule that requires opioids and extremely dangerous drugs to be exempted from prior authorization requests.
	13.10.31.12(C)	UHC	UnitedHealthcare requests that OSI define "providers" and comments the language suggests that the rule applies "…only to individual providers…even after the first year." UHC also asks OSI to consider that the proposed regulation could increase premiums to New Mexicans as will increase	The proposed language in this section clearly excludes from the first year's assessment of prior authorization outcomes all prior authorization requests for "…admissions to general acute care hospitals, psychiatric hospitals, and rehabilitation hospitals, and durable medical equipment, including oxygen and disposable medical supplies…" This means that, for the first year's assessment, the outcomes of all other prior authorization requests from in-network providers shall be considered.

			costs "…due to the investments carriers will need to make to technology and increased staffing in order to be compliant with these rules." UHC states "…these considerable carrier costs" will be passed on in premiums.	The section's language goes on to say that the superintendent may, through guidance, "…include these services in subsequent years." OSI staff finds this language is clear. In addition, "provider" is defined in 13.10.29.7(P)(13) NMAC, and "health care provider" is defined in NMSA 1978 59A-22B-2(G). Both of these definitions were incorporated into this regulation pursuant to 13.10.31.7 NMAC, to which no amendments have been proposed. OSI staff appreciates UHC request to consider the costs that could be incurred by carriers in order to comply with this rule and that would "inevitably" be passed on to consumers. We are not convinced that the costs of implementing will be as "considerable" as UHC suggests. In addition, we expect that any increase in costs for analytics will be offset by savings in carriers' administrative costs of supporting unnecessary prior authorization requirements and their related review processes.
	13.10.31.12(C)	THNM	True Health New Mexico (THNM) says that it "seems" that carriers need to identify high-compliance providers in the first quarter of 2023 and asks for the "look back period".	OSI staff notes that this section of the regulation does indicate the "look back" period as emphasized below: "Beginning in the first quarter of 2023, a carrier shall annually evaluate its network providers' patterns of adherence to the carrier's prior authorization criteria and policies ***in the preceding calendar year.***"
	13.10.31.12(C)	Western Sky	Western Sky Community Care (WSCC) suggests that "selective application or [sic] the criteria for a prior authorization exemption process should be narrowly defined to limit legally defined exemption eligibility to only the highest compliant providers. WSCC goes on to suggest 4 categories of criteria that it thinks would be	OSI staff notes that this section has the following language that limits the assessment of high-performing providers to a carrier's "…network providers." OSI objects to the proposed changes.

			more selective – "(1) track record of high prior authorization approval rates; (2) ordering and prescribing patterns that align with evidence-based guidelines; (3) trends of claims volume for specific services; and (4) projected enrollee or provider impact." WSCC also suggests a pilot program starting with a "limited number of services" available for exemption. WSCC suggests that "the rule should specify that any prior authorization exemption process is reserved for in network providers only."	
	13.10.31.12(C)	Desert States Physical Therapy Network, LTD	Desert States Physical Therapy Network, LTD, notes that "pattern of adherence" is not defined and that sometimes prior authorizations are denied due to carrier error.	OSI appreciates this point about denials that are not the fault of the submitter. We will address this concern in subregulatory guidance pursuant to Section G of this proposed regulation. OSI notes that the proposed language in this section describes a provider's "pattern of adherence "…as evidenced by prior authorization approval rates of 90 percent or greater …"
	13.10.31.12(C)(1)	Evicore	Evicore asks for a definition of "covered services". Then goes on to recommend that the regulation require "…payers to review no less than 30 cases of the same service when determining eligibility for an exemption." Evicore points out the 30 is "…is a common number of completed same procedures for a hospital to grant privileges for a physician to perform it independently	In an earlier comment, Evicore asked for a definition of "covered benefits". Upon a search of the proposed rule amendment, the term "covered services" is not used. OSI staff believes this is an inadvertent "typo" and the commentor intended to use "covered benefits". OSI staff appreciates the recommendation of a minimum threshold of having 30 prior authorization request reviews for the same service to be eligible for consideration of being a

			without supervision." Finally, Evicore recommends that the threshold for a high compliance provider be higher than the 90% approval rate.	high compliance provider. But is it 30 requests in what time period? A year? 2 years? 5 years? Reviewing any more than the prior year would be burdensome for carriers. OSI staff finds that the proposed requirement that the carriers identify their most frequent prior authorization submitters who have a high rate of success submitting prior authorizations is reasonable. In addition, carriers have the option of offering agreements for a specific service or a specific set of services. These agreements are not intended to be blanket waivers of all prior authorization requirements, nor does the rule say they are. As for Evicore's 90% approval rate, please see OSI staff response to Evicore's comments to 13.10.31.12 (C)(2) NMAC. In summary, OSI staff does not agree with Evicore's 30-case threshold approach for the reasons stated above. We recommend keeping the proposed language in 13.10.31.12(C)(1) NMAC.
	13.10.31.12(C)(1)	UHC	In this comment, UnitedHealthcare (UHC) asks for a definitions of "adherence" and "frequent submitters". UHC also asks whether "this is by procedure or for all services for a particular provider." Finally, UHC asks if there is "…a minimum number of claims required to be reviewed?"	OSI notes that proposed language in this section describes a provider's "pattern of adherence" as "…evidenced by prior authorization approval rates of 90 percent or greater …" OSI has deliberately not specified what a "frequent submitter" is as this can change by provider type. OSI is interested in how carriers identify frequent submitters, which will be reported pursuant to 13.10.31.12(D)(1) NMAC. For the same reason, OSI did not specify whether a provider's adherence to a carrier's prior authorization requirements and criteria is measured "by procedure or for all services for a particular provider." OSI staff notes that the Superintendent

				may issue guidance concerning selection criteria for subsequent years pursuant to subsection G of this rule. Finally, in response to UHC's final question, if a carrier finds it helpful to review a provider's claims as part of its process to identify high compliance providers in addition the results of the provider's prior authorization requests, the carrier is free to review any number of claims it feels is appropriate. We look forward to reviewing carriers' reports on the criteria and processes they used to identify their high compliance, in-network providers.
	13.10.31.12(C)(1)	Desert States Physical Therapy Network LTD	Desert States Physical Therapy Network LTD again makes the point that some prior authorization requests are denied due to carrier error and is concerned these will be counted against providers when determining "adherence".	OSI staff finds this to be a valid concern and will address this in guidance issued pursuant to Section G in this proposed regulation.
	13.10.31.12(C) (2)	Evicore	Evicore is concerned that 90% approval rate is too low. In Evicore's words: "Gold carding as proposed here also asks patients to accept that providers can provide the wrong care up to 10% of the time and remain unchecked."	OSI staff does not agree with Evicore's characterization of the 90% threshold as the acceptance of "…wrong care up to 10% of the time" Studies show that prior authorization does not guarantee a patient gets the right care. Item 18 in this case's docket includes an AMA survey of physicians that shows that prior authorization requirements actually threaten patient safety and health. Providers reported that prior authorizations delay treatment for a significant percentage of their patients and can sometimes lead to "abandonment" of treatment, and that prior authorization requirements frequently lead to patient harm, including hospitalizations, permanent disabilities, and life-threatening events.

				In addition, the providers in alternative arrangement agreements will not "remain unchecked". They will be monitored by the carriers and the agreements will include how a provider's performance will be monitored and measured. OSI further notes that Texas passed its "Gold Card Act" in 2021, which also uses a 90% threshold to determine prior authorization exemption. See, TX INS 4201.653. We recommend that the threshold percentage remain for high compliance providers remain at 90%.
	13.10.31.12(C) (2)	PCMA	PCMA makes a number of points in this comment. Like other commenters, PCMA makes the point that the term "negotiate" puts the carriers in a bad position because it doesn't obligate the providers to negotiate. In addition, PCMA views the minimum of offering 30% of high compliance providers an alternative arrangement as discriminatory to other providers and doesn't protect carriers from those providers who meet the high compliance provider criteria but are not selected for participation. PCMA points out that PBMs don't enter into contracts with providers.	OSI has responded to commenters' concerns about the term "negotiate" in comments under 13.10.31.12(C)(2)(a) NMAC, recommending the term "enter into an agreement with…" to replace "negotiate." OSI is unclear what further protection the carriers will need in addition to being compliant with the regulation, as well as any subregulatory guidance the Superintendent may choose to issue. Keep in mind that the 30% threshold is a minimum. The language in the proposed rule says "…no less than 30%..." Carriers can certainly choose to enter into alternative arrangement agreements with more than 30% of its high compliance providers. The intent of the 30% was to gradually implement this new process. The regulation also provides for increasing participation in subsequent years. The proposed language in 13.10.31.12(A) NMAC specifically exempts Medicaid MCOs from compliance with this section. However, the Prior Authorization Act itself applies not only to health insurers, but also their third-party payers and agents. See, NMSA 1978 59A-22B-2(H). Though PCMA is correct that

				the carrier would be the entity entering into agreements with providers, and submitting the necessary reports to OSI, contracted PBMs would be obligated to track and provide the necessary information to their carriers. PBMs and carriers will have to work together to identify high compliance prescribers.
	13.10.31.12(C) (2)	UHC	In its comments for this subsection, UnitedHealthcare (UHC) asks if the alternative arrangements are by TIN (tax identification number), pointing that multiple providers in group share the same TIN, but not all of them are necessarily high compliance providers. In a subsequent question concerning this section, UHC asks whether the "gold card" can apply only to the individual provider or to all providers sharing the same TIN must be gold-carded. UHC asks OSI to "…clarify that a carrier is not required to "gold card" all providers meeting the 90% threshold" and that just 30% of the carrier's high compliance providers have to be selected.	OSI is aware that many providers, probably a majority, are part of provider groups. Since individual providers request prior authorizations, the proposed regulation was written with an individual provider in mind. There is nothing in the proposed language that restricts alternative arrangements to individual providers, or prevents an agreement from being made with an individual provider who is a member of a provider group. Finally, there is also nothing in the proposed regulation that prevents a carrier from entering into an agreement with an entire provider group. How a carrier identifies the high compliance provider for purposes of its own internal operations is up to the carrier. This is not something OSI would regulate. OSI recognizes that provider groups can complicate entering into an agreement with a single provider within the group. The proposed rule leaves the mechanics of this up to the carriers and their participating providers. The proposed rule is clear that, in the first year, alternative arrangements shall be entered into with "no less than 30%" of high compliance providers. There is no language that would prevent a carrier from selecting more than 30% of its high compliance providers for alternative arrangements.
	13.10.31.12(C) (2)	BCBSNM	BCBSNM is concerned with the language in this section because it "… does not account	Staff agrees that it is possible that a carrier and provider may not come to an agreement "despite good faith efforts by both

			for the possibility that, despite good faith efforts by both sides, a carrier and a high-compliance provider may be unable to reach an agreement." Furthermore, BCBSNM finds that the language here puts an "administrative mandate" only on the carrier, which would create an "…an artificial negotiation imbalance that is likely to impair rather than facilitate achievement of the rule's overall objective." BCBSNM recommends the following language changes: (a) ~~negotiate~~ offer an agreement ~~with~~ to each selected high-compliance provider ..."	sides." OSI cannot force the provider to agree with the offer made by the carrier and vice versa. Disputes between provider and carrier regarding gold-carding would be subject to 13.10.16 NMAC, which goes into effect on January 1, 2023. That said, OSI staff agrees that the word "negotiate" can be improved on, but we do not agree with the term "offer" because that is one-sided, too. "Offer" can sound like it's a take-it-or-leave-it arrangement, which is not the intent of the proposed rule. It also causes concerns that that these "offers" will be boilerplate approaches rather than customized to the circumstances of the individual provider. OSI staff expects the alternative arrangement agreement to be acceptable to both sides, which may require some discussion between the parties, and suggests the language "enter into an agreement with" in lieu of "negotiate" in 13.10.31.12(C)(2)(a) NMAC. OSI staff notes that if the hearing officer proposes new language in place of "negotiate" in 13.10.31.12(C)(2)(a), then "negotiated" in (C)(2)(b) should be struck. In addition, staff found that the word "describes" in (C)(2)(b) should be "describe", as shown below: "**(b)** the ~~negotiated~~ agreement with each provider shall clearly describe~~s~~ the terms of the alternate arrangement…"
	13.10.31.12(C) (2)	AHIP	AHIP requests Subsection C (2)(a) be revised to clarify that health insurance providers are required to make *offers* to qualifying high compliance providers, but health insurance providers are not required to *negotiate*	This concern is similar to the concern expressed by BCBSNM above. Please see our response and recommendation above.

			agreements with 30% (and 50%) of high compliance providers.	
	13.10.31.12(C) (2)	Evicore	Evicore suggests revising language to read "…offer to negotiate an agreement". Like prior commentors, Evicore finds the language as proposed does not require the provider to negotiate and puts the carrier at a disadvantage.	Please see OSI's response to this concern in our response to BCBSNM's comments above.
	13.10.31.12(C) (2)	Desert States Physical Therapy Network LTD	Desert States Physical Therapy Network LTD asks for a definition of a "…discreet service or set of services."	The intent of the proposed language is to allow the carrier to exempt a provider from prior authorization requirements for one service or a set of services (which could mean all services the provider requests.) Because carriers do differ in how they identify the services they prior authorize, although the use of procedure codes is the most common way, OSI did not want to specifically prescribe in the regulation how a carrier is to identify services in their prior authorization procedures and processes. In the reporting section, carriers are required to describe how they identified the services in prior authorization.
	13.10.31.12(C) (2)	BCBSBNM	BCBS suggests that "in furtherance of patient safety" the agreements in 2(a) above be limited to 6 months instead of 12 with the option to renew for another 6 months if no notice of termination has been issued by either party.	OSI strongly disagrees with BCBSNM's suggestion to shorten the length of the agreement to 6 months. OSI recommends the length of the agreement remain at 12 months. Shortening the length of the agreement is not in the interest of patient safety, as suggested by BCBSNM. An AMA physician survey, which can be found in docket item 18 filed in this matter, shows that prior authorization requirements threaten patient safety and health. Providers reported that prior authorizations delay treatment for a significant percentage of their patients and can sometimes lead to "abandonment" of treatment, and that prior authorization requirements frequently lead to patient harm, including hospitalizations,

				permanent disabilities, and life-threatening events. In addition, nothing in the proposed rule prevents the parties to the agreement to assess performance during the 12-month agreement period. OSI recommends keeping the proposed language that provides for a minimum length of 12 months for these agreements.
	13.10.31.12(C) (2)	Evicore	Evicore recommends that alternative arrangement agreements should be limited to 6-months, rather than 12 months. Evicore supports this recommendation because "…medical knowledge is doubling every 73 days."	OSI staff disagrees with this recommendation. Carriers are free to add caveats to the agreement to allow for things such as a substantial change in the standard of care for a condition or disease. Carriers can issue new clinical guidelines that providers must adhere to. Nothing in the proposed amendment precludes any of this. We recommend keeping the proposed language that provides for a minimum length of 12 months for these agreements.
	13.10.31.12(C) (2)	PCMA	PCMA finds that the requirement that agreements include "…under what conditions the agreement can be terminated…" is problematic because new warnings for drugs come out, new drugs in class are approved for use, and new clinical guidelines about the drug/class may be issued." PCMA explains the regulation fails to provide for these kinds of changes. Finally, PCMA states that the regulation "… fails to settle whether the gold carding status can be changed or revoked if changes are warranted by new medical evidence."	OSI strongly disagrees with PCMA in its assessment. There is nothing in the proposed regulation that prevents carriers from including in their agreements with high compliance providers necessary caveats about changes in clinical guidelines for services or drugs, or the introduction of a new drug within a class, and what the parties to the agreement can expect when that happens. We disagree with that the changes described by PCMA should be considered reasons to terminate an agreement, as we don't think these are valid reasons to terminate an agreement and that there are less drastic approaches to deal with these events.

				Therefore, OSI staff suggests the following additional language in section 13.10.31.12(C)(2)(b): **(b)** the ~~negotiated~~ agreement with each provider shall clearly describe~~s~~ the terms of the alternate arrangement, including under what conditions the agreement can be terminated by a carrier or a provider. Changes in clinical guidelines, the addition of a new drug, new warnings for medical services or drugs, and similar events shall not be valid causes for termination. The agreement shall include how the provider's ordering and prescribing performance during the course of the alternative arrangement will be monitored and evaluated, how changes in clinical guidelines or the introduction of a new drug and other such events will be handled, how results will be communicated, and how the agreement can be extended beyond the base period of the agreement. At a minimum, the agreement will be effective for 12 months.
	13.10.31.12(C) (2)	UHC	In its comment, UnitedHealthcare (UHC) also brings up the word "negotiate", noting that negotiations can be lengthy. In lieu of negotiating the agreement, UHC asks whether it can simply "…notify the providers that they qualify instead of putting it in a contract", similar to the Texas law. UHC notes that Texas provides for open ended agreements, rather than time limited. UHC asks whether the terms of the agreements must be the same across all high-performing providers.	OSI's proposed regulation reflects OSI's intent to allow providers to have a say in the terms of their "gold carding" arrangement. Our proposed regulation also recognizes that carriers all have different processes and procedures, and it is hard to standardize them. In response to multiple concerns about the term "negotiate", we have proposed to drop "negotiate" and use "enter into an agreement with". Please see our comments in response to BCBSNM's concerns. We note that there is nothing in the regulation that precludes a carrier from starting with a basic, boilerplate agreement that can, if necessary, be customized to reflect a provider's particular circumstances. There is nothing in the proposed regulation that prevents a carrier from entering into an agreement with a high-compliance provider that waives all prior authorization requirements for the provider.

			UHC asks whether if a provider terminates an alternative arrangement agreement because the provider wants higher reimbursement rates, does the carrier have to keep the provider in the carrier's network. UHC thinks the 12-month minimum agreement length is too long and suggests the 6-month agreements that Texas allows. UHC suggests that 12-month agreements "…open the door to fraud and abuse."	Staff also notes that there is nothing in the proposed regulation that would prevent an alternative arrangement agreement from being open-ended. We add that the regulation does require the agreement to "… under what conditions the agreement can be terminated by a carrier or provider" and how the provider's performance will be monitored. There is nothing in the proposed regulation that requires the terms of the agreements to be the same across all high-performing providers. We also note that there is no language in the proposed regulation concerning decisions on either party's part about a provider's ongoing participation in a carrier's network. OSI staff disagrees with UHC's suggestion that a minimum 12-month agreement would "…open the door to fraud and abuse" but a 6-month renewable agreement would not. Other commenters have suggested this but none have not provided any supporting evidence. OSI staff notes that the proposed regulation requires monitoring of provider performance during the course of the agreement. Therefore, staff recommends that the minimum 12-month length of the agreement remain as proposed.
	13.10.31.12(C)(3)	PCMA	PCMA finds that the requirement that carriers to select "…various eligible provider types within a carrier's network, and the spectrum of covered benefits." does not adequately take into account the differences between specialties and their prescribing. PCMA adds "Allowing plans and PBMs to continue to use evidence based prior	OSI finds that PCMA is not fully understanding the proposed regulation. There is nothing in the regulation that precludes carriers and PBMs from using "evidence-based prior authorization requirements." The intent of this subsection is to assure that carriers enter into alternative arrangement agreements with a variety of high compliance provider types and specialties, for a range of services and drugs. OSI staff

			authorization requirements will provide the highest level of protection for patients rather than setting arbitrary thresholds based on "various eligible providers."	sees no reason to change this language and recommends it remain as proposed.
	13.10.31.12(C)(3)	UHC	UnitedHealthcare (UHC) asks for clarification of "provider type". UHC notes that high performing providers may not be representative of a full cross section of the carrier's network or of benefits.	The intention of the use of "provider types" in the proposed regulation was inclusive of various kinds of providers such as physicians, psychologists, labs and radiology facilities, etc. However, while considering this question, OSI staff found that the language needed some clarification, and we propose the following clarification for 13.10.31.12.C(3)(b): **(3)** The high compliance providers selected for alternate arrangements shall be representative of the various eligible types of providers, including specialists, ~~provider types~~ that participate in a carrier's network, and the spectrum of covered benefits. OSI staff realizes that not all types of providers and all benefits will be represented among the high-compliance providers in a carrier's network. However, the intent of the proposed language is to require carriers to vary its selection of high-compliance providers so that as wide a variety of provider types and specialists are participating in an alternative arrangement.
	13.10.31.12(C)(3)	Desert States Physical Therapy Network LTD	Desert States Physical Therapy Network LTD asks "…how will multiple providers be considered?"	OSI is aware that many providers, probably a majority, are part of provider groups. Since individual providers request prior authorizations, the proposed regulation was written with an individual provider in mind. There is nothing in the proposed language that restricts an alternative arrangement with individual providers, or prevents an agreement from being made with an individual provider who is a member of a provider group. Finally, there is also nothing in the proposed

				regulation that prevents a carrier from entering into an agreement with an entire provider group.
	13.10.31.12(C)(4)	BCBSNM	BCBSNM questions the intent of the proposed rule in terms of how much to increase the number of high compliance providers and whether that is a year-over-year increase or something else. BCBSNM states that if "…it is intended to be a year-over-year increase, a carrier would be required to enter into alternate arrangements with 100% of its high-compliance providers in year four." BCBSNM goes on to say this would limit carriers' flexibility and discretion, and make it difficult to negotiate agreements ("untenable" was the word used.)	OSI wants all high compliance providers to eventually have a "gold-carding" agreement of some kind. We note that there is nothing in this rule that requires the agreements to cover every service for which a specific provider submits a prior authorization request (see 13.10.31.12(C)(2)(a) NMAC) Also, the alternative arrangement agreements entered into must specify how the provider's performance will be monitored and evaluated, how the results are communicated and how the agreement can be extended (see 13.10.31.12(C)(2)(b) NMAC) That said, the intent of the language was that carriers enter into agreement with 50% more providers than the prior year. So, if a carrier has identified a total of 1000 high compliance providers, the first year 300 would have alternative arrangements in place. The next year, the carriers would increase the number of high compliance providers entering into alternative arrangement agreements by 50%, which would be an additional 150 (50% of 300) high compliance providers. Note also that 13.10.31.12.C.(5) states "After the second year, a carrier shall comply with specific performance requirements identified in guidance issued pursuant to subsection ~~E~~G of this rule." To improve the clarity of the intent of these section of the proposed rule, OSI staff proposes the following revisions: 13.10.31.12(C) (4) The first year's alternative arrangements shall go into effect on January 1, 2024 and all subsequent

				years' agreements shall go into effect on the first day of the calendar year. 13.10.31.12(C) (5) After the first year, a carrier shall increase the number of high compliance providers with which it enters into alternate arrangements by at least fifty percent of the number of providers who had alternative arrangements in ~~compared to~~ the first year. If a carrier is not able to increase the number of providers with alternate arrangements by at least fifty percent compared to the prior year, the carrier shall request an exception according to guidance issued by the superintendent. The exception request will be subject to the approval of the superintendent. With the numbering of subsequent subsections in 13.10.31.12(C) changing accordingly
	13.10.31.12(C)(4)	AHIP	AHIP asks that Subsection C (4) be revised to clarify that the intention is not for health insurance providers to be required to increase the alternative arrangements for high compliance providers by **50% every year**. This language could lead to the unintended consequence that nearly all network providers are in an alternative arrangement and contradicts the intention of this regulation that high compliance providers must earn and maintain a minimum exemption threshold of 90% every year for certain covered benefits.	OSI disagrees with how AHIP's members are interpreting this section. Only high compliance providers can enter into alternative arrangement agreements with carriers. This means that unless a carrier's network providers are all high compliance providers, the idea that "nearly all network providers" will be in alternative arrangements. And if there is a service or a set of services where nearly all network providers ordering that service are high compliance, perhaps the carrier should reassess whether that service, or services, needs to be prior authorized. Finally, please see our response to a similar concern from BCBSNM above for clarification of intent and some suggested clarifying language.
	13.10.31.12(C)(4)	PCMA	PCMA points out that the original language in this section is not clear in its intent as	OSI has proposed clearer language above. OSI also points out that 13.10.31.12(C)(5) as proposed states that after the second year, the Superintendent will issue performance

			whether it applies to the second year or year-over-year, and requests clarity.	requirements in guidance pursuant to Section G of the proposed rule.
	13.10.31.12(C)(4)	UHC	UnitedHealthcare asks OSI to explain how "…this would be merit-based if there are specific quota [sic] to be met."	OSI staff is not sure we understand the context of UHC's request. Both the first year requirement of entering into agreements with 30% of high-compliance providers, and the subsequent year's increase provided for in the proposed regulation are minimums. A carrier can enter into alternative arrangement agreements with all of its high-compliance providers in the first year if it wants to do so. The intent of starting at these levels is to gradually implement this new process. We note that the regulation also provides for increasing participation in subsequent years.
	13.10.31.12(C)(5)	BCBSNM	BCBSNM notes that this section references the wrong section – should be G, not E	Please change the following reference to subsection G, as indicated: (5) After the second year, a carrier shall comply with specific performance requirements identified in guidance issued pursuant to subsection ~~E~~G of this rule.
	13.10.31.12(C) (6)	UHC	UnitedHealthcare (UHC) asks whether a carrier may add new codes to the prior auth list.	Nothing in this section (13.10.31.12 NMAC) prevents a carrier from adding a new code to the prior authorization list. Staff refers UHC to 13.10.31.8(C) NMAC for provisions concerning adding new benefits to the prior authorization list.
	13.10.31.12(D)	BCBSNM	BCBSNM suggests moving the due date of the annual report to December 31 so that a full year of experience can be captured.	OSI staff selected the September 30 deadline in order to have sufficient time to review the reports and if the Superintendent finds it necessary, develop guidance for the following year. OSI staff wants to be able to issue the guidance sufficiently in advance of the following year, so we recommend the due date for the report required in this section remain September 30. However, we recommend the following additional language:

				13.1031.12.(D)(4) (a) The report shall be submitted to the superintendent no later than September 30th of every year, beginning in 2023. The superintendent may revise this date in guidance pursuant to subsection G of this rule.
	13.10.31.12(D)	THNM	TrueHealth New Mexico (THNM) requests for more details on the "specific elements" that will be required in the assessment report due September 30, 2023	Guidance will be issued with the specific elements and information carriers will be required to include in the assessment report, including templates, if needed.
	13.10.31.12(D)(2)	BCBSNM	BCBSNM states it is unclear as to them "… whether the annual report deadline also serves as a deadline whereby the carriers must complete contractual negotiations with high compliance providers pursuant to Subsection C."	It is not the intent of OSI that the proposed reporting deadline of September 30 is also the deadline for entering into alternative arrangement agreements. OSI finds the language in this subsection to be clear and focused solely on reporting. However, we are in agreement with the suggested additional language and proposes that the language at 13.10.31.12(D)(2) be revised in the following manner: (2) lists the providers identified, ~~and~~ the providers with whom an alternate arrangement was made, and the providers with whom negotiations are ongoing; and
	13.10.31.12 (D)(3)	UHC	UnitedHealthcare (UHC) refers OSI to its comments about notifying a provider they qualify for a gold card vs entering into an agreement, stating that a "letter" would be easier and maybe less costly for carriers.	This subsection of the proposed regulation describes the information a carrier must include in its annual report. Since OSI staff has not recommended changing the approach from agreements to notifications or "letters", a carrier will need to report the information as described in this proposed subsection, and in accordance with any guidance issued pursuant to Section G of this rule.
	13.10.31.12 (D)(5)	PCMA	PCMA questions what mental health parity laws the regulation is referring to and how	OSI agrees with PCMA that this requirement will be problematic to implement as written, and recommends striking it from the recommendations.

			they are supposed to comply with the terms of MHPAEA with the gold carding agreement	Guidance issued pursuant to Section G will address the OSI's concern that behavioral health providers to be fairly represented in alternative arrangements
	13.10.31.12(E)	THNM	True Health New Mexico (THNM) suggests there also be a section for carriers exiting the New Mexico market	OSI appreciates this suggestion. The Life and Health Division has identified numerous areas for which guidance for exiting carriers is needed. We will address all topics in a single guidance document.
	13.10.31.12(F)	BCBSNM	BCBSNM expresses the following : "Certain information reported to the superintendent pursuant to subsection (B)(4) and subsection (D) may contain a carrier's confidential data, the release of which could harm the carrier or facilitate anti-competitive practices among New Mexico carriers. BCBSNM recommends that any reported information that is not deemed confidential be aggregated prior to publication by the superintendent. Further, as the prior authorization assessment and evaluation process created by the proposed rule would be new to New Mexico, BCBSNM suggests omitting the development and promulgation of rules as a delineated regulatory purpose. The complexity of this rule will require carriers to adjust and refine their internal processes as they gain experience with assessing for and entering into alternate arrangements. Information reported in the first or second year following promulgation of the rule may not accurately reflect the forward impact of these adjustments and refinements. Relying on	OSI staff does not agree to remove the language regarding using information from carriers' reporting to inform future rulemaking. The language is necessary for transparency. Should OSI choose to promulgate regulations based on data that is considered too "new", interested parties will have opportunities for input, both formal and informal. The changes recommended by BCBS are overbroad and would place this regulation in conflict with statutory requirements under the Inspection of Public Records Act, which states that it is the "public policy of this state, that all persons are entitled to the greatest possible information regarding the affairs of government and the official acts of public officers." See, NMSA 1978, 14-2-5. There is not a legal basis for OSI to support confidentiality of information that is utilized to develop and promulgate regulation. In fact, OSI has an obligation under IPRA to make such information public. OSI has a pre-exiting confidentiality request process, outlined in Bulletin 2022-001, through which entities can request information submitted to the OSI be deemed confidential. This process would apply to any information collected under this rule, and allow carriers the opportunity to ensure trade secrets remain protected.

			that information for rulemaking purposes may lead to the promulgation of a rule to address a perceived issue that has already been resolved. BCBSNM recommends the following revisions: **"Data confidentiality and use.** Information reported to the superintendent concerning a specific, identifiable, provider shall be deemed confidential pursuant to Subsection B of Section 59A-2-12 NMSA 1978. The superintendent may publish and use any other reported information for any regulatory purpose, including development and promulgation of rules to specify minimum prior authorization incentive and corrective action programs, provided that any such reported information shall be aggregated prior to publication so that it cannot be traced to a specific carrier."	
	13.10.31.12(F)	PCMA	PCMA requests that PBMs be added to the confidentiality provisions in Section F	Pharmacy Benefit Managers and Third Party Administrators have no direct reporting requirements under this regulation. They are not considered providers eligible for gold-carding. If a carrier believes their annual report, which is required under 13.10.31.12(D) NMAC, contains trade secrets or other information eligible for confidentiality, they will have the opportunity to request a confidentiality determination in accordance with Bulletin 2022-001.

				OSI notes that carriers are extremely familiar with this process, and submit requests throughout the year, on a wide range of topics. Though PBMs and TPAs are not required to submit information directly to the OSI under this regulation, they have the same opportunity as any other entity to request information they file with the OSI be deemed confidential. OSI opposes this change.
	13.10.31.12(F)	UHC	UHC asks that provider names not be published.	OSI drafted this section to ensure compliance with IPRA, NMSA 1978, 14-2-1 et seq, and proposed maintaining the confidentiality of information regarding specific identifiable providers. Full names and NPIs are two means by which information could be attached to a specific identifiable provider, and would thus be deemed confidential under the regulation as written. OSI disagrees with UHC's comment that this is overbroad, and opposes any changes. OSI notes that no providers who commented on this regulation objected to this measure to ensure their privacy.
	13.10.31.12(G)	Evicore	Evicore requests the timing of guidance as allowed for in this section.	Guidance will always be provided sufficiently in advance of the time period to which it applies.
	13.10.31.12(G)	UHC	UHC asks when OSI will "issue further guidance"	OSI staff expects to issue initial guidance for 2023 at the turn of the year.