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## Consensus Bill on Managed Care Reforms

### New Protections for Hospital Discharge to Home Care

- Establishes one business day and 72 hour time frames for health plan determinations involving hospital discharges to home care.
  - Provides that a health plan's utilization review (UR) agent must make a determination involving home care services following an inpatient hospital admission, and provide notice of the determination to the insured person or provider by telephone and in writing, within one business day of receipt of the necessary information for the request for home care services. This increases the prospects for quick health plan determination for home care as well as determinations prior to discharge.
  - Provides the UR agent with 72 hours for the determination and notices when the day subsequent to the request falls on a weekend or holiday. (72 hours will result in a shorter interval than the current 3 business days when the period for determination overlaps with weekends or holidays)
- Requires the health plan to cover home care services following inpatient discharge while the UR agent's determination is pending – i.e., for either the next business day or for 72 hours, as applicable.
  - Specifically prohibits denial of coverage on the basis of medical necessity or a lack of prior authorization while the UR agent's determination is pending, if the request for home care services and all necessary information has been provided prior to discharge.
  - Effectively creates the opportunity for home care agencies to secure/know the status of initial coverage prior to accepting a hospital discharge.
- Establishes an explicit right to an expedited appeal for adverse determinations involving home health care services following discharge from an inpatient hospital admission. Current law provides that expedited appeal must be processed within two days of receipt of the necessary information. This provision will help ensure that if a health plan renders an adverse determination, the home care agency will have a guarantee of immediate recourse with prompt turn-around, as well as the further recourse of appeal to an external review agent.
- Establishes the provider's right to initiate an appeal for concurrent adverse determinations, which would apply to denials of home care services following hospital discharge. (This would be effectuated through separate language in the bill; see also first bullet under subsequent "External Appeal" section on page 2).

## Hospital Discharge to Home Care Legislative Language

The legislative language for the “hospital discharge to home care” provisions follows.

Section 4903 of the Insurance Law (parallel amendments are also made to article 49 of the public health law) is amended by adding subsection (c) to read as follows:

(c) A utilization review agent shall make a determination involving continued or extended health care services, [or] additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured’s designee, which may be satisfied by notice to the insured’s health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or a holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

Subsection (b) of section 4904 of the insurance law is amended to read as follows:

(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section forty-nine hundred three of this article or

## External Appeal

- Establishes a provider’s right to appeal concurrent (as well as retrospective) adverse determinations. (Among other benefits, this ensures a home care provider’s right to directly initiate an appeal under the new home care provisions described above).
- Requires the external appeal agent to notify the provider of their determinations (currently, the agent is only required to notify the insured and the plan).
- Provides that external appeals initiated by a provider that are rendered in favor of the provider are to be paid by the plan; when rendered in favor of the plan, are paid for by the provider (except where the provider is acting as the insured’s designee, in which case the appeal is paid for by the plan); when rendered in partially in favor, payment is equally divided by the plan and provider.

- Provides that a health care provider requesting an external appeal may not pursue reimbursement from an insured person for services determined not medically necessary by the external agent, except to collect a copayment, coinsurance or deductible.
- Allows health plans and article 28 facilities (hospitals, nursing homes and clinics) to agree to an alternative dispute resolution mechanism in lieu of the external appeal process.

### **Prompt Pay**

- Reduces from 45 to 30 days the standard for prompt payment of provider claims when the claim is transmitted electronically. Also, applies prompt pay standards to Municipal Cooperative Health Benefit Plans.
- Revises the penalty provisions on insurers for prompt pay violations to distinguish between penalties for violations found based on provider complaints and those found based on Insurance Department audits or inquires not connected to such complaints, easing the sanctions in that latter instances for substantially compliant health plans.

### **Grievance and Specialty Access Applied to Insurers Utilizing Provider Networks**

- Establishes grievance procedures and requirements for access to specialty care for insurance policies that utilize a network of providers, but are not managed care contracts. (State law already provides for such procedures and requirements for managed care, but not to these types of insurance policies that use networks.)

### **Overpayment Recovery Protections**

- Provides overpayment recovery protections for health care providers (currently applicable only to physicians). Provides that a health plan shall provide 30 days written notice to health care providers before engaging in additional overpayment recovery efforts (other than recovery for duplicate payments). Requires a health plan to provide a health care provider with the opportunity to challenge an overpayment recovery. Prohibits a health plan from initiating an overpayment recovery more than 24 months after the original payment, except for cases of fraud, abuse, misconduct or in the case of a governmental program. Home care (article 36) is specifically referenced as an applicable provider.

### **Payment Protection in Coordinate of Benefit Claims**

- Prohibits (with provisos) an insurer or health plan from denying a claim on the basis that it is coordinating benefits and another insurer is liable for payment unless it has a reasonable basis to believe that the insured has other primary health coverage for that benefit.

### **Provider Requirements for Timely Filing of Claims**

- Requires providers to submit health care claims within 120 days after the date of service to be valid and enforceable against an insurer or health plan, or more favorable period for providers if the plan and providers agree. Provides that a health plan may reduce reimbursement to a

provider for an untimely claim by a penalty of no more than 25%, and also provides that providers and plans may agree to a lesser reduction or no reduction at all, that is, the "penalty" can be reduced even to "0."

### **Electronic Filings**

- Authorizes the superintendent of insurance to require filings with the Department by electronic means, with exemptions for hardship.

### **Other Protections for Hospitals, Physicians and Others**

- Prohibits an insurer from implementing an adverse reimbursement change to a contract with a health care professional otherwise permitted under the contract unless the insurer gives the professional at least 90 days written notice, and gives the professional the right to terminate the contract within 30 days of the notice.
- Prohibits managed care plans from providing that the services of a participating hospital or health care provider be covered as out-of-network solely because the referring physician is not a participating provider. (For purposes of this provision, a "health care provider" is defined as a health care professional licensed, registered or certified pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.)
- Provides protections and standards for payment of health care professionals during the period in which the professional is "provisionally credentialed" for participation in the plan.

### **Coverage of Treatments for "Rare Diseases"**

- Adds treatment for a "rare disease" to the categories qualifying for the right to an external appeal of a health plan denial.

### **Other Provisions**

- Contains various other provisions relating to consumer concerns (e.g., refund of moneys from health plans which are below medical loss ratios; filing of claims for disability, etc.)