



KATHY HOCHUL
Governor

Department of Financial Services

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Acting Superintendent

October 3, 2021

Dear Speaker Heastie and President of the Senate Andrea Stewart-Cousins:

Pursuant to the requirements of Part YY of Chapter 56 of the Laws of 2020, I hereby submit a report of the Administrative Simplification Workgroup.

Respectfully submitted,

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Acting Superintendent of Financial Services

Report of New York's Health Care

Administrative Simplification

Workgroup

October 3, 2021

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EXECUTIVE SUMMARY

Purpose of this Report

The 2020 enacted Executive budget established a Health Care Administrative Simplification Workgroup tasked with studying and evaluating mechanisms to reduce health care administrative costs and complexities and protect consumers through standardization, simplification, or technology.¹ A diverse group of health care industry leaders representing consumer groups, hospitals, physicians, behavioral health providers, health insurers, brokers, and unions participated in meetings chaired by the New York State Department of Financial Services (“DFS”), which also included the Department of Health (“DOH”), the Office of Mental Health (“OMH”), and the Office of Addiction Services and Support (“OASAS”). Workgroup discussions focused on the topics specifically identified in the law – provider credentialing, preauthorization practices, access to electronic medical records, claim submission and payment, claim attachments, and insurance eligibility verification—as well as additional topics raised by Workgroup members. The Workgroup is required to submit by October 3, 2021 a report and make recommendations to the Superintendent of Financial Services, the Commissioner of Health, the Speaker of the Assembly, and the Temporary President of the Senate. This report sets forth the findings and recommendations of the Workgroup.

DFS thanks all Workgroup members for their significant time commitment and valuable contributions. The Workgroup provided a unique opportunity for a diverse group of stakeholders to come together to discuss important areas to improve the health care payment and delivery system for the benefit of consumers, providers, and health plans. The Workgroup setting allowed the parties to reach consensus on many issues, and also identified issues where consensus could not be reached due to a lack of trust between many providers and health plans. DFS will continue to work with all stakeholders to identify solutions to the issues where consensus was not reached.

¹ Part YY of Chapter 56 of the Laws of 2020.

Summary of Recommendations

Below is a summary of the recommendations of the Workgroup. The Workgroup reached consensus on a number of the listed recommendations, and where consensus was not reached, this summary notes where continued work is needed. This report further delineates the positions of different stakeholders where consensus was not reached.

Credentialing

1. **Applicability of Credentialing Law.** The Insurance Law should be amended to expand the applicability of the credentialing timeframes and requirements to all comprehensive health insurance products with provider networks and to facilities.²
2. **Applications & Follow-Up Questions.** Health plans should use the standardized Council for Affordable Quality Healthcare (“CAQH”) credentialing application for credentialing health care professionals. Health plans should also develop a standard, simplified list of additional questions as needed, as well as identify any follow-up information requests that can be standardized or use standardized formats to obtain any follow-up information.
3. **Application Status Check.** Health plans should implement an online portal or telephone hotline to give providers real-time information and meaningful updates about their credentialing applications, including the status of an application in the health plan’s review process and any information that is missing from the application.
4. **Back & Forth Communications.** Providers should ensure that their applications are complete, that their information in the CAQH database is up to date, and that they provide timely responses to requests for additional or missing information. Health plans should not request information that will be verified during Primary Source Verification, and health plans should review their Primary Source Verification processes to ensure that duplicative information is not collected.

² Insurance Law § 4803.

5. **Centralized Credentialing Database.** Health plans and providers should collaborate to explore the feasibility of an independent, centralized credentialing database, including the scope, functions, and overall parameters of the database.
6. **Facility Credentialing.** The Workgroup should develop a standardized credentialing application for health care facilities. Health plans should pre-populate re-credentialing applications for facilities, and facilities should update any incorrect or incomplete information and provide complete and timely responses. Health plans should work with facilities to re-credential all sites at the same time, if requested by a facility.

Preauthorization Practices

1. **Disclosure of Clinical Review Criteria.** Health plans should post their clinical review criteria, including criteria used by delegated utilization review agents, in a centralized place on their websites that is readily available to the public. If any information in the clinical review criteria is considered proprietary by a third party, health plans should create an online process to request the clinical review criteria.
2. **Timeframe to Provide Clinical Review Criteria Upon Request.** Health plans (and their delegated utilization review agents) should provide clinical review criteria within five days of receiving a request for the information from an insured or their authorized representative. A shorter timeframe should apply for expedited appeals.
3. **Standard Form for Designating an Authorized Representative.** A standard form should be developed for an insured to designate an authorized representative and that form should be accepted by all health plans.
4. **Services that Require Preauthorization.** Health plans should clearly identify the services that are subject to preauthorization. At least annually, health plans should review services that are generally approved through preauthorization to identify where preauthorization requirements may

be removed. Health plans should review circumstances where repeat preauthorization requirements for the same patient/same treatment can be eliminated. Health plans should adopt evidence-based and peer reviewed clinical guidelines with the most current data informing best practices for patient care and make the guidelines available to providers. Providers should similarly order services that are consistent with the plan's evidence-based clinical guidelines, recognizing that there will be circumstances when the patient's medical condition will necessitate variation from such clinical guidelines.

5. **Peer-to-Peer Reviews.** Peer-to-peer reviews for hospital services should involve physician to physician communication, which may include the treating physician or a physician who is designated by, and either employed by or has privileges at, the hospital. The physicians discussing the case for the health plan and hospital should be knowledgeable about the patient and treatment.
6. **Transmission of Documents.** Health plans and providers are encouraged to adopt the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") standard for electronic transmission of documents for preauthorization requests.

Access to Electronic Medical Records Recommendations

1. **Requests for Medical Information.** The Insurance Law and Public Health Law should be amended to apply to HMOs the limitation on medical record requests, which provides that only records necessary to verify medical necessity may be requested.³
2. **Access to Electronic Medical Records.** Health plans and providers should continue to discuss a path forward for providing access to electronic medical records, including the feasibility of reaching individual or regional agreements to share such records, and options to streamline the exchange of medical records if access to electronic medical records is not provided.

³ Insurance Law § 4905(g) and Public Health Law § 4905(7).

Claim Submission, Payment, and Attachments

1. **Claim Submission.** Providers should submit claims electronically, where possible, instead of by paper or facsimile, and health plans should accept claims that are submitted electronically.
2. **Claim Attachments.** Providers should submit claim attachments electronically, through a web portal, where feasible. Health plans should offer assistance to providers to facilitate use of their web portals.
3. **Claim Attachment Standards.** Health plans and providers should adopt the federal claim attachments standards as soon as a national standard is adopted by the Centers for Medicare & Medicaid Services (“CMS”).

Insurance Eligibility Verification Recommendations

1. **Insurance Eligibility Verification.** Health plans should make information regarding an insured’s coverage and benefits available to providers electronically. Employers should be included in further discussions on measures to reduce the time period to notify health plans of changes to an employee’s coverage and meaningful consequences for the failure of employers or benefit managers to provide accurate and timely information to health plans. DOH should consider possible solutions to address Medicaid eligibility verification issues.
2. **Hospital Financial Assistance Forms.** Hospitals that require completion of an application to determine eligibility for financial assistance should be required to use a uniform standard financial assistance form. The income eligibility criteria should be standardized, as required by law, with flexibility permitted for hospitals to establish higher income eligibility standards to make assistance available to more consumers. The form should be easily accessible, publicly available on each hospital’s website and DOH’s website, and translated into languages other than English.
3. **Patient Financial Liability Forms.** A standard patient financial liability form and standardized financial liability language should be created, and the standard form or standardized language

should be mandated when a liability form is used. The standardized form and language should not include unlimited financial liability language when impermissible.

Topics Considered by the Workgroup in Addition to those Specifically Referenced in Law

1. **Facility Fees.** Prior to rendering services, providers charging facility fees should disclose that facility fees will be charged by that provider and in what amount. Facility fees should not be charged when an office visit is for a preventive service for which cost-sharing is prohibited.
2. **Uniform Hospital Billing.** DOH should continue discussions with stakeholders to explore ways to make billing easier for consumers to understand.
3. **Notification of Hospital Admissions.** Providers should notify health plans of hospital admissions, discharges, or transfers within 24 hours, or one business day if the admission, discharge, or transfer occurs on a weekend and health plan staff are unavailable, as a best practice in order to facilitate discharge planning and care coordination.
4. **Claim Deadlines, Duplicate Claims, and Accounts Receivable.** Health plans and hospitals should work collaboratively to develop standard terms, definitions, and methodologies to improve communication and reduce friction around claims activity.
5. **Health Care Claims Reports.** The draft template health care claims report, which must be completed by health plans and submitted to DFS starting in 2022, should be finalized in a timely manner.

INTRODUCTION

The 2020 enacted Executive budget directed DFS, in conjunction with DOH, to convene a Health Care Administrative Simplification Workgroup to study and evaluate mechanisms to reduce health care administration costs and complexities through standardization, simplification, and technology. A diverse group of health care industry leaders representing consumers, hospitals, physicians, behavioral health providers, health insurers, insurance brokers, and unions served as Workgroup members. The Workgroup was required to consider: provider credentialing; preauthorization practices; access to electronic medical records; claim submission and payment; claim attachments; and insurance eligibility verification. Additional topics were discussed, including facility fees, notification of hospital admissions, claim deadlines, health care claims reports, and utilization review. The first meeting of the Workgroup was held on November 3, 2020, and the Workgroup met regularly over a ten-month period. This report describes the discussions and recommendations of the Workgroup.

THE HEALTH CARE ADMINISTRATIVE SIMPLIFICATION WORKGROUP

DISCUSSIONS

Provider Credentialing

Background

Credentialing is the process used by health plans to assess and verify the qualifications of a health care provider (including Primary Source Verification of the provider's state licensure, board certification, education and training, residency/fellowship programs, and malpractice history) to determine whether the provider should be added to a plan's network. The Insurance Law and Public Health Law set forth requirements and timeframes for the credentialing process, which begins when a

health care professional completes a credentialing application and submits it to a health plan.⁴ Within 60 days of receipt of a complete credentialing application, the law requires a health plan to review the application and notify the health care professional whether they are credentialed or whether additional time is needed because of a failure by a third party to provide necessary documentation. A health plan must make every effort to obtain the documentation and make a final determination within 21 days of receipt of the documentation. If a health plan does not approve or deny a completed application within 60 days of receipt, a health care professional (either newly-licensed or recently relocated to New York State) in a group practice must be deemed “provisionally credentialed” and may participate in the health plan’s network. However, if the health care professional’s application is ultimately denied, the health care professional’s group practice must agree to refund any payments that were made for in-network services provided by the provisionally credentialed health care professional and only collect the in-network cost-sharing from the insured. In addition, a health plan must provisionally credential a newly-licensed physician, a physician who has recently relocated to New York State, or a physician who has changed their corporate relationship and becomes employed by a hospital or a facility upon receipt of the hospital’s and physician’s completed sections of a credentialing application, as well as notification that the physician has been granted hospital privileges. Again, if the physician is not ultimately credentialed, the health plan is not required to pay in-network benefits and the insured must be held harmless.

Credentialing Process

A significant issue raised by provider Workgroup members is that the credentialing timeframes and requirements in the Insurance Law and Public Health Law only apply to health maintenance organizations (HMOs) and a very narrow category of health insurance policies (managed

⁴ Insurance Law § 4803 and Public Health Law § 4406-d. A health care professional is someone who is licensed, registered, or certified pursuant to Education Law Title 8.

care products). In addition, the credentialing timeframes only apply to applications submitted by health care professionals and not to applications submitted by facilities.

The Workgroup recommends that the Insurance Law be amended to apply the credentialing timeframes and requirements to all comprehensive health insurance policies with provider networks.⁵ In addition, the Workgroup recommends that the Insurance Law and Public Health Law be amended to extend the credentialing timeframes to include facility applications.

Credentialing Application

Workgroup members representing providers expressed concern regarding credentialing applications and a lack of uniformity in related requests for information. These Workgroup members noted that health plans typically use a credentialing application provided by CAQH, which is a national, non-profit organization focused on streamlining the business of health care. However, health plans frequently ask questions and request information from providers, in addition to those in the CAQH application form, including to address state Medicaid requirements or to obtain detailed malpractice history, which may vary among the plans. Additionally, Workgroup members representing providers and facilities noted that some plans collect information with the initial application that would also be collected and verified during the Primary Source Verification process, which is unnecessary and burdensome. Workgroup members also noted that the CAQH application is designed for health care professionals and cannot be used for facility credentialing because it does not collect all necessary information such as ownership, staffing, or site inspection history.

The Workgroup recommends the continued use of the CAQH standard application for health care professional credentialing. Further, the Workgroup recommends that health plans develop a standard, simplified list of additional questions, as well as identify any follow-up information requests that can be standardized or use standardized formats to obtain any follow-up information.

⁵ Insurance Law § 4803.

Status of Credentialing Applications

Workgroup members representing providers stated that it is difficult to check on the status of a credentialing application after it is submitted to a health plan. Health plans stated that many plans currently operate dedicated telephone hotlines or online portals for providers to request status reports or have real-time communications. However, providers noted that some telephone hotlines or online portals do not provide meaningful information as to when credentialing will be completed. The Workgroup recommends that health plans implement an online portal or telephone hotline to provide effective, real-time information and meaningful status updates for providers. Specifically, the online portal or telephone hotline should be able to identify missing information from the provider's credentialing application and the status of the application in the health plan's review process.

Completion of Credentialing Applications

Workgroup members noted that the back and forth required to obtain necessary information during the credentialing process is time consuming. Workgroup members representing health plans noted that providers often submit incomplete applications, requiring the plan to reach out to the provider to obtain the necessary information for a complete application. The Workgroup recommends that providers ensure that their applications are complete, review their information recorded in the CAQH database to make sure that it is up to date, and provide timely responses to requests for additional or missing information. Additionally, Workgroup members representing providers noted that health plans frequently request information that will be verified during the Primary Source Verification process. The Workgroup recommends that health plans review their Primary Source Verification processes to ensure that the health plan is not collecting duplicative information.

Credentialing Database

Workgroup members discussed the possibility of creating a centralized credentialing database to simplify the credentialing process. The database would contain the information needed to credential a provider. Workgroup members recommend that plans and providers collaborate to explore the

feasibility of an independent, centralized credentialing database, including the scope, functions, and overall parameters of the database.

Provisional Credentialing

Workgroup members discussed whether to expand provisional credentialing, which enables a newly-licensed or recently relocated physician joining a group practice or employed by a hospital to be considered an in-network provider before being fully credentialed by a health plan. It was noted by Workgroup members representing health plans that provisional credentialing is not frequently used. Workgroup members representing providers pointed out that infrequent use of provisional credentialing may be due to the limited application of the Insurance Law provisions regarding credentialing. Workgroup members noted that if improvements on other aspects of the credentialing process reduce credentialing timeframes, expansion of provisional credentialing may be unnecessary. Workgroup members representing consumers expressed concern that a provider might have a history of malpractice or other misconduct that would not be revealed prior to provisional credentialing. The Workgroup did not reach a consensus on this issue.

Facility Credentialing

Workgroup members representing facilities noted that credentialing applications for facilities are not uniform and that the CAQH application is not workable for facility credentialing. DFS surveyed Workgroup members to obtain sample facility credentialing applications to determine the feasibility of creating a standard application for facility credentialing. DFS created a draft standard facility credentialing application and sent it to Workgroup members for feedback. The Workgroup recommends continued collaboration on creating a standardized credentialing application that will be used for facilities.

Workgroup members representing facilities also noted that during the re-credentialing process, facility credentialing applications are not pre-populated with information from a previous credentialing application. These Workgroup members found it time-consuming to re-enter this information during

re-credentialing. Facilities also expressed concern that different facility sites are credentialed at different times and suggested that health plans provide an option for all sites affiliated with the facility to be credentialed at the same time. Workgroup members representing health plans noted that some health plans currently re-credential all affiliated sites at the same time. The Workgroup recommends that health plans pre-populate re-credentialing applications for facilities, with facilities updating any incorrect or incomplete information, as opposed to facilities having to complete a new application each time the facility is re-credentialed, and that facilities provide complete and timely responses. The Workgroup also recommends that health plans work with facilities to re-credential all affiliated sites at the same time if requested by a facility.

Preauthorization Practices

Background

Preauthorization is a review that is conducted by a health plan or its utilization review agent to determine whether a service is medically necessary before the service is provided to an insured. Preauthorization is permitted under Insurance Law and Public Health Law Articles 49, except for emergency services and certain mental health and substance use disorder treatments, and subject to certain timeframes and requirements. When conducting preauthorization, health plans and their utilization review agents typically use evidence-based and peer reviewed clinical review criteria, which are a set of standards used to determine whether a health care service or treatment is medically necessary. The Insurance Law and Public Health Law require health plans to disclose the written clinical review criteria relating to a particular condition or disease upon written request of an insured, prospective insured, or the insured's health care provider.⁶ Additionally, when a health plan or utilization review agent makes an adverse determination, it must state that the clinical review criteria

⁶ Insurance Law §§ 3217-a(b)(10) and 4324(b)(10) and Public Health Law § 4408(2)(j).

relied upon to make the determination is available upon request of the insured or the insured's designee.

Disclosure and Timeframe to Provide Clinical Review Criteria

Workgroup members representing consumers explained that access to clinical review criteria helps insureds and providers understand what information should be provided for the service to be approved and whether an appeal should be pursued, ideally leading to fewer denials and less need for appeals. Workgroup members representing consumers expressed concern that health plans and their utilization review agents do not provide timely access to their clinical review criteria and would like the clinical review criteria to be provided within one day for expedited cases. DFS reminded Workgroup members that health plans are responsible for providing clinical criteria used by their delegated utilization review agents. Workgroup members representing health plans stated that it is a common practice of health plans to post clinical review criteria on their websites. However, Workgroup members representing consumers noted that clinical review criteria are often only available in "locked" areas of a plan's website and therefore accessible only to an insured who has logged into the plan's website, making it difficult for authorized representatives and insureds who are not tech-savvy to access the information.

The Workgroup recommends that health plans post their clinical review criteria, including criteria used by delegated utilization review agents, in a centralized place on their websites that is readily available to the public. If any information in the clinical review criteria is considered proprietary by a third party, health plans should create an online process to request the clinical review criteria. In addition, the Workgroup recommends that health plans and their delegated utilization review agents provide the requested clinical review criteria within five days of receiving such requests from an insured or their authorized representative. If the request involves an expedited appeal, the health plan and their delegated utilization review agents should provide the clinical review criteria within a shorter time period.

Additionally, Workgroup members representing consumers stated that some health plans take weeks to process patient authorization forms. During this time, advocates and family members can only speak to the health plan with the insured on the call. This is not feasible for many people who are receiving inpatient treatment, where they do not have access to phones, or who are experiencing a mental health or substance use crisis. Workgroup members representing consumers recommend that health plans be required to accept a standard form for insureds to designate an authorized representative and that health plans be held to specific timeframes to process an authorization for a designated representative. Health plan Workgroup members expressed support for a standard authorization form. The Workgroup recommends that a standard form be developed for an insured to designate an authorized representative and that such form be accepted by all health plans.

Services that Require Preauthorization

Workgroup members representing providers expressed concern that each health plan has a different set of services that require preauthorization, so that providers with patients covered under different health plans have to educate themselves on the requirements of all their patients' plans. Workgroup members representing health plans noted that preauthorization requirements may be due to different regulations governing the programs they administer or reflect the varying populations served by the products they offer. Workgroup members representing consumers advocated for a portion of each health plan's website to be devoted solely to preauthorization requests, appeals, and grievances, with all related documents (e.g., clinical review criteria, insurance contracts) in one place. Health plans agreed that the services requiring preauthorization should be transparent to insureds and providers and that many health plans currently post this information on their websites.

Provider and consumer Workgroup members also expressed concern that preauthorization may act as a barrier to getting care and that the volume of services requiring preauthorization presents a significant administrative burden for providers in terms of time and costs. Provider and consumer Workgroup members expressed an overall goal of reducing the number of services that require

preauthorization. Workgroup members representing consumers stated that patients with chronic conditions (e.g., migraines, hormone insufficiency) should not be required to have their providers re-request approval for the same medication every few months. While Workgroup members representing health plans agreed that reducing the number of unnecessary preauthorization requirements is a laudable goal, they expressed concern that providers do not always adhere to commonly accepted clinical guidelines. Health plans noted that there is value in preauthorization because it ensures payment prior to the service being provided, helps ensure that a patient obtains the most appropriate health care services in accordance with clinical guidelines, and reduces unnecessary health care costs. Health plans stated that preauthorization requests would be either eliminated or be more frequently approved if providers complied with clinical guidelines when ordering services. Workgroup members representing providers disagreed that compliance with clinical guidelines is a common problem and stated that preauthorization requirements can result in needed medical care being denied or delayed. Workgroup members representing providers indicated that clinical guidelines should not be the sole basis used in determining medical necessity and that some health plans do not consider all relevant factors that the treating physician is considering. Additionally, provider Workgroup members stated that in many cases health plan clinical peer reviewers are not in the same specialty as the treating physician and considerable deference should be given to the treating physician when reviewing preauthorization requests. These Workgroup members also advocated in favor of requirements for health plans to use evidence-based and peer reviewed clinical guidelines, similar to current Public Health Law and Insurance Law requirements for step therapy protocols. Workgroup members representing health plans expressed support for evidence-based clinical guidelines and stated that such guidelines are also important to help address health inequities.

Workgroup members representing physicians also expressed concern regarding preauthorization requests being advanced unnecessarily to a physician-to-physician level review in situations when the issue could have been resolved between the health plan's staff and the provider's

staff. They raised concerns that since these requests are regularly approved at the physician level, the requests unnecessarily divert valuable time away from care delivery and exacerbate provider “burnout.” Workgroup members representing physicians advocated for additional health plan staff training to reduce the significant time and provider resources associated with navigating preauthorization requests while acknowledging that provider staff also may need to be more knowledgeable regarding the details of the preauthorization requests.

The Workgroup recommends that health plans clearly identify the services that are subject to preauthorization. In addition, at least annually, health plans should review services that are generally approved through preauthorization to identify where preauthorization requirements may be removed. Health plans should also review circumstances where repeat preauthorization requirements for the same patient/same treatment can be eliminated. Health plans should adopt evidence-based and peer reviewed clinical guidelines, with the most current data informing best practices for patient care and make the guidelines available to providers. Providers should similarly order services that are consistent with the plan’s evidence-based clinical guidelines, recognizing that there will be circumstances when the patient’s condition will necessitate variation from such clinical guidelines.

Peer-to-Peer Reviews

Workgroup members representing hospitals expressed concern about peer-to-peer reviews with health plans, which are conversations between a hospital and health plan to discuss a patient’s care. Hospitals expressed concern that some health plans will not allow them to choose the hospital physician to participate in the peer-to-peer discussion and instead will only engage in discussions with the patient’s attending physician. Hospital Workgroup members stated that hospitals are in the best position to determine which physician should participate in the peer-to-peer review on their behalf and expressed concern that some health plan physicians frequently lack knowledge of the specialty area involved in the patient’s care. Workgroup members representing health plans expressed concern that some hospitals designate hospitalists or other providers who lack knowledge of the patient’s case or

appropriate course of treatment. It was noted that the law does not specify who may be a clinical peer on behalf of a hospital. However, the law does provide that a health plan's "clinical peer reviewer" must be either a physician who possesses a current and valid non-restricted license to practice medicine; or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession, and is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review.⁷ The Workgroup recommends that for hospital services, peer-to-peer reviews involve physician to physician communication, which may include the treating physician or a physician who is designated by and either employed by, or has privileges at the hospital. The physician discussing the case for both the health plan and hospital should be knowledgeable about the patient and treatment.

Transmission of Documents

Workgroup members representing providers expressed concern regarding the transmission of documents for preauthorization requests, which is still primarily done by mail or facsimile.

Workgroup members representing hospitals expressed concern that some health plans require submission of faxed documents and that these are frequently lost, requiring multiple resubmissions. As a result, responses to some preauthorization requests may be delayed, which means that the care itself may be delayed. Workgroup members representing health plans stated that many plans have adopted, or will be adopting, electronic processes to accept preauthorization requests, but expressed concern that providers do not always use these electronic processes. Workgroup members confirmed that a HIPAA standard transaction for preauthorization requests exists but has not been widely

⁷ Insurance Law § 4900(b) and Public Health Law § 4900(2). For reviews of mental health and substance disorder treatment, a clinical peer reviewer must specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment.

adopted. The Workgroup recommends that health plans and providers adopt the HIPAA standard for the electronic transmission of documents for preauthorization requests.

Access to Electronic Medical Records

Background

The Insurance Law and Public Health Law set forth the parameters for health plans and their utilization review agents to request medical records from providers when conducting medical necessity reviews.⁸ During preauthorization or concurrent review, health plans and their utilization review agents may request copies of medical records only when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record may be requested. However, HMOs are specifically exempted from these requirements. Additionally, the law permits utilization review agents to request copies of partial or complete medical records retrospectively. Also, during these medical necessity reviews, many health plans and providers exchange information primarily by means of paper or facsimile communication. This method of communication is rife with inefficiencies that lead to numerous back-and-forth, unwieldy exchanges between health plans and providers with a large volume of requests for medical records and short timeframes for submission. There is growing frustration regarding lost information requests and disputes about whether necessary information has been received due to reliance on paper communication when better technology is available.

Discussion

Workgroup members discussed the need and feasibility of granting health plans structured access to providers' electronic medical records ("EMRs") to address problems inherent in the exchange of information during medical necessity reviews. EMRs are essentially digital versions of the paper charts in the provider's office.

⁸ Insurance Law § 4905(g) and Public Health Law § 4905(7).

Workgroup members representing providers expressed concern that entire medical records are often requested when only a portion would be necessary to review the service. Some provider and consumer Workgroup members also voiced concern about the security of information and privacy issues when electronic medical records are shared. Several provider Workgroup members expressed concern that granting access to EMRs will increase claim denials and that EMR access is sought mainly for this purpose. In fact, some hospital Workgroup members indicated that their hospitals had previously entered into agreements with certain health plans to share EMRs and saw claim denials increase. Hospital Workgroup members indicated that the increasing volume of claims denials and payment delays have resulted in a great deal of mistrust of health plan behavior. Due to this unresolved issue, hospital Workgroup members indicated that it will be difficult to grant health plans access to providers' EMRs.

Health plan Workgroup members view access to EMRs as a solution to many administrative burdens that currently exist and a significant driver toward achieving administrative simplification. Health plan Workgroup members stated that where access to EMRs has been implemented, providers see a reduction in denials based on lack of information to determine coverage, without any material increase in overall denials. Specifically, they stated that access to EMRs would ease many administrative burdens and would address several concerns raised by providers, including easier peer-to-peer reviews, simplifying the submission of claims and claims attachments, and potentially reducing the amount of back and forth between providers and plans. Health plan Workgroup members mentioned that their experience in other states has shown that an electronic data exchange can enable better care and reduce adverse outcomes (e.g., readmission and avoidable emergency room visits). Some health plans reported having EMR arrangements in place with some hospitals in New York and that both parties were satisfied with the resulting efficiencies and privacy protections. Health plan Workgroup members also support implementing health plan developed guiding principles for sharing

of EMRs and implementing additional requirements as necessary to ensure patient privacy. These principles include the following guardrails:

- EMR access is used exclusively for individual claim/care review and adjudication and will not be used for any auditing function or to detect any historical patterns of billing or abuse.
- Limit access to admission, discharge, and treatment data to better support an insured’s health needs.
- Health plans will not separately request additional information to support a coverage determination if the information is otherwise available in an EMR.
- Health plans will not seek information that they are not already permitted to receive.
- Health plans will prioritize the safeguarding of their insureds’ data, including their protected health information and personally identifiable information.
- To the extent feasible and necessary, health plans will also seek to be HITRUST certified, which requires demonstrating and following global standards for data security and privacy compliance.

Workgroup members representing hospitals indicated that these principles are not sufficient for many hospitals to agree to share EMRs and that many of these principles simply re-state what is already required by law. These Workgroup members indicated that they would need to see considerable progress in reducing inappropriate claim denials before allowing health plans to access EMRs.

Workgroup members representing consumers recommend that insureds be given access to their own EMRs to facilitate authorized representatives in assisting insureds with their appeals as they believe that providers do not always provide adequate patient access to records.

Workgroup discussions affirmed the need for more integrated electronic interactions between providers and plans. Nonetheless, a common theme raised by Workgroup members is that there is a lack of trust between many providers and health plans and that this barrier would need to be overcome

for some providers to agree to EMR arrangements with health plans. Workgroup members recommend that health plans and providers continue discussions to determine if individual or regional agreements to share EMRs can be reached. However, the Workgroup could not reach a consensus on whether providers should be required to permit health plans to access their EMRs. Workgroup members recommend that health plans and providers discuss options to streamline the exchange of medical records if access to EMRs is not provided. Workgroup members also recommend, with respect to the issue of scope and volume of medical record requests, that the Insurance Law and Public Health Law be amended to remove the exception for HMOs.⁹

The Workgroup also discussed whether the Statewide Health Information Network for New York (“SHIN-NY”) is an option for health plans to access EMRs. SHIN-NY allows the electronic exchange of clinical information and connects health care professionals statewide. Specifically, SHIN-NY connects regional networks, which allows participating health care providers, with patient consent, to quickly access electronic health information and securely exchange data statewide. However, discussions with SHIN-NY representatives revealed that SHIN-NY does not have all the information a health plan would likely need to make a medical necessity decision, nor is it presently configured in a way that would facilitate medical necessity reviews. Further, the information in SHIN-NY is not currently permitted to be used for utilization review purposes without obtaining level 2 written consent from each patient. However, over the next several years, the minimum dataset is being expanded pursuant to federal requirements, and consent policy and permitted purposes are being re-evaluated, which could make SHIN-NY a more viable potential solution for the future. Workgroup members representing health plans stated that SHIN-NY is a trusted source that health plans believe could be better used to facilitate information transmission between plans and providers if it is enabled to collect the necessary data.

⁹ Insurance Law § 4905(g) and Public Health Law § 4905(7).

Claim Submission, Payment, and Attachments

Background

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) was enacted to modernize the flow of health care information. Title II of HIPAA, known as the Administrative Simplification provisions, requires national standards to be established for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.¹⁰ HIPAA rules standardize medical codes used by coders and billers to identify diagnoses and procedures. The HIPAA Electronic Data Interchange (“EDI”) rule specifies the types of transactions that are covered under HIPAA. It also requires a specific format for each transaction type, including claims, claim status, eligibility verifications, referrals, and authorizations. HIPAA requires all providers and billers covered by HIPAA to submit claims electronically, using the requisite format.

Electronic Claim Submissions

One of the issues related to claims submission identified by Workgroup members involves the use of paper claims instead of electronic claims. Workgroup members stated that the use of paper claims is time-consuming when better technology is available. Discussion among Workgroup members revealed that electronic claims processes are already widely used by providers, health plans and their vendors (such as clearinghouses). Workgroup members also pointed out that HIPAA requires the use of electronic claims, as noted above. However, some provider Workgroup members raised concerns that some health plans are requiring paper claims to process secondary claims. Secondary claims are claims submitted to a secondary payor after primary responsibility for payment was determined to be with a different health plan. In such instances, it was stated that providers’ electronic secondary claims were rejected by some health plans, and providers were instructed to resubmit using paper claims. Workgroup members representing consumers stated that standardized

¹⁰ <https://www.cms.gov/regulations-and-guidance/administrative-simplification/hipaa-aca>.

and publicly available standards for submitting claims are useful for consumers, advocates, and providers and that claims for out-of-network care are often denied on the basis that the claims submitted did not include all the required information. The Workgroup recommends that providers submit claims electronically, where possible, instead of by paper or facsimile, and that health plans accept claims that are submitted electronically.

Claim Attachments

Another claim submission issue identified by Workgroup members involves claim attachments being lost or separated from the claim because the attachments are submitted via facsimile or mail. This results in additional time spent by billing staff and delays in claims processing and payment. During discussions, it was discovered that many, if not most, health plans have developed web portals for use by providers. However, some provider Workgroup members stated that some health plans either continue to ask providers to mail medical records in support of claims or do not make web portal information widely available. Moreover, it appears that not all providers prefer to use web portals in all instances. For example, where a provider does not have many patients covered by a particular health plan, the provider may be hesitant to learn how to use that health plan's portal, instead relying on other methods to submit attachments. The Workgroup recommends the use of electronic submission of claim attachments where feasible, such as the use of a web portal. The Workgroup also recommends that health plans offer assistance to providers to facilitate the use of their web portals.

Claim Attachment Standards

Workgroup members identified the slow acceptance of the use of electronic claim attachments across the industry as an issue. Many Workgroup members acknowledged the lack of a national standard as being the primary cause. Without a national standard, health plans and providers are reluctant to invest in systems and technology to send or accept electronic claim attachments. CMS has indicated that they will be adopting a national standard for electronic claim attachments and that

parties will have two years for implementation. The Workgroup recommends that once the federal standards are adopted, providers and health plans adopt those standards as soon as possible.

Insurance Eligibility and Overpayment Recovery

Background

Overpayment recovery occurs when a health plan pays a provider's claim for health care services and subsequently seeks recovery of all or a portion of that payment. In some cases, the health plan may have conducted a preauthorization review and approved the health care services as medically necessary. Reasons for overpayment recovery include the appropriateness of the application of a particular coding to the services, the insured's coverage was not in effect when services were provided, or suspected fraud. The Insurance Law requires health plans to provide 30 days' advance written notice to providers before engaging in overpayment recovery efforts, and the notice must include the patient's name, service date, payment amount, proposed adjustment, and a specific explanation of the proposed adjustment.¹¹ The health plan must give the provider an opportunity to challenge an overpayment recovery, including the sharing of claims information, and have written policies and procedures in place for providers to follow. Overpayment recovery is limited to 24 months after the original payment was received by the provider; however, this time limit does not apply to overpayment recovery efforts that are: based on a reasonable belief of fraud or other intentional misconduct, or abusive billing; required by a self-insured plan; or required or authorized by a state or federal government program or coverage that is provided by New York State or a municipality to its employees, retirees, or members. With respect to overpayment recovery for services that have been preauthorized, the Insurance Law requires a health plan to pay a claim for a health care service for which preauthorization was required and received, unless the insured was not a covered person at the

¹¹ Insurance Law § 3224-b(b).

time the service was rendered.¹² However, the Insurance Law does not permit a health plan to deny a claim if the insured's coverage was retroactively terminated more than 120 days after the date of the service (if the claim was submitted within 90 days after the date of service).¹³ If the claim is submitted more than 90 days after the date of service, the health plan has 30 days after the claim is received to deny the claim on the basis that the insured was not covered at the time of service. In addition, with respect to services for which preauthorization was required and received, the Insurance Law requires a health plan to pay a claim for a health care service unless the preauthorization was based on materially inaccurate or incomplete information provided by the insured or the insured's provider such that preauthorization would not have been granted had complete information been provided.¹⁴

Insurance Eligibility

Workgroup members discussed issues surrounding insurance eligibility verification and expressed concern with being unable to rely on coverage information obtained on a real-time basis. In these instances, providers confirm an insured's health insurance coverage with a health plan at the time services are rendered, only to have payment recouped months later because coverage was not actually in effect at the time of treatment. Providers stated that overpayment recovery is unfair in this instance because they rendered services and relied on coverage information given to them by the health plan. Health plans stated that they must rely on information from employers regarding changes to an employee's coverage status. Additionally, premium grace periods may result in retroactive termination when premiums are not ultimately paid. Workgroup members representing health plans noted that, while health plans typically make information regarding an insured's coverage and benefits available to providers electronically, employers should be included in further discussions on measures to reduce the time period to notify health plans of changes to an employee's coverage. Workgroup members representing providers also expressed concern regarding Medicaid delays in updating eligibility

¹² Insurance Law § 3238(a)(1)(i).

¹³ Insurance Law § 3238(a)(1)(ii).

¹⁴ Insurance Law § 3238(a)(4).

information, although health plans noted that there may be valid reasons to delay terminating an individual on Medicaid.

The Workgroup recommends that health plans make information regarding an insured's coverage and benefits available to providers electronically. The Workgroup recommends engaging employers in further discussions on measures to reduce the time period to notify health plans of changes to an employee's coverage and meaningful consequences for the failure of employers to provide accurate and timely information to health plans. The Workgroup also recommends that DOH consider possible solutions to address the Medicaid eligibility verification issue.

Other Overpayment Recoveries

Workgroup members representing hospitals expressed concern with health plan overpayment recovery efforts, particularly related to medical necessity (including level of care) and the appropriateness of the application of a particular coding to the services after a claim has been paid. These Workgroup members stated that, in many cases, medical necessity and coding reviews were conducted at the time the claim was paid and that a second review of the same services is unfair and, sometimes, impermissible. Workgroup members representing health plans stated that overpayment recovery efforts are necessary to ensure that upcoding does not occur and that health care services are paid at the correct level. Some hospital Workgroup members stated that, if the health plan already determined that the services were medically necessary and coded appropriately, it should not get a "second bite at the apple" and be able to reverse that determination. They also expressed concern with their ability to obtain information to which they are entitled from some health plan third party vendors during overpayment recovery. DFS encouraged Workgroup members to provide DFS with specific examples of impermissible overpayment recovery practices. The Workgroup did not reach a consensus recommendation on this overpayment recovery issue.

Hospital Financial Assistance Forms

Background

The Public Health Law establishes requirements regarding hospital financial assistance programs.¹⁵ Financial assistance application forms must be printed in the “primary languages” of patients served by the hospital. “Primary languages” include any language that is either: used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers; or spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Patients must be permitted to apply for assistance within at least 90 days of the date of discharge or date of service and be provided at least 20 days to submit a completed application. Minimum standards for eligibility are established in the Public Health Law, and DOH guidance states that for patients whose income is equal to or less than 300% of the federal poverty level, hospitals should assume that patients are eligible for financial assistance through the hospital’s program for emergency services for New York State residents, and for all other services, if the patients reside within the hospital’s primary service area.¹⁶ Determinations of eligibility must be made in writing within 30 days of receipt of a completed application. The hospital must have a process, detailed in its financial policies and procedures, for appealing a denial.

Discussion

Workgroup members that represent consumers raised hospital financial assistance forms as an issue for the Workgroup to address. These Workgroup members stated that hospital financial

¹⁵ Public Health Law § 2807-k(9-a).

¹⁶ Public Health Law § 2807-k(9-a) and DOH Patient Financial Assistance Letter, May 11, 2009, available at https://www.health.ny.gov/facilities/hospital/financial_assist/letters/05-11-2009_financial_aid_legislation_feedback_letter.htm.

assistance forms are not standardized, with each hospital having a different form, and the forms are often difficult for consumers to understand and sometimes fail to comply with state law and guidelines. Hospitals also have different eligibility criteria for determining financial assistance. Additionally, these Workgroup members reported that it can be difficult for consumers to access the hospital financial assistance forms. For example, consumer advocates noted that these forms are not always accessible on a hospital's website and a consumer must go to the hospital to obtain the form. Workgroup members representing consumers also stated that hospital financial assistance forms are not always available in languages other than English, making applying for assistance difficult for consumers who speak or read languages other than English.

The Workgroup recommends the creation of a uniform standard hospital financial assistance form that must be used when hospitals require completion of an application to determine eligibility for financial assistance. The eligibility criteria for hospital financial assistance should be standardized, as required by law, with flexibility permitted for hospitals to establish higher income eligibility standards to make assistance available to more consumers. Workgroup members will be providing suggested changes to DOH on an older model form for consideration, so that work on a standardized hospital financial assistance form may continue. The Workgroup acknowledges that work on this standard form will continue after the issuance of this report. Additionally, the Workgroup recommends that the uniform standard hospital financial assistance form be posted on each hospital's website and on DOH's website. The form should be publicly available, easily accessible, and translated into languages other than English.

Patient Financial Liability Forms

Background

Workgroup members that represent consumers raised patient financial liability forms as an issue for the Workgroup to address. Patient financial liability forms are used by health care providers

to obligate patients to pay for health care services. These forms typically provide that if a patient opts to receive a particular health care service, the patient agrees to be financially liable for the service if coverage is denied by the patient's health plan. The Insurance Law and Public Health Law include protections that hold insureds harmless when they receive certain services from participating providers, so that they should only be charged their in-network cost-sharing. These protections also apply when insureds receive emergency services or surprise bills from out-of-network providers.¹⁷ In addition, the federal No Surprises Act imposes limitations on patient financial liability forms, effective January 1, 2022.¹⁸

Discussion

Workgroup members representing consumers expressed concern that no standardized patient financial liability form currently exists and that providers use different forms, including some that require insureds to agree to be financially responsible for services that go beyond what is permitted by law. For example, some insureds must agree to unlimited financial liability to receive services from providers in their health plan's network, even when their health plan is required to cover the services and the participating provider is prohibited from balance billing the insured. Some Workgroup members provided sample patient financial liability forms to be considered, and the Workgroup recognizes that the federal No Surprises Act will likely impact the content of the forms.

The Workgroup recommends that a standard patient financial liability form be created and use of the standard form or standardized language be mandated when a liability form is used. Additionally, the Workgroup recommends that unlimited financial liability language should not be included when impermissible. The Workgroup acknowledges that work on this standard form or language will continue after the issuance of this report.

¹⁷ Financial Services Law Article 6.

¹⁸ The No Surprises Act was enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

Facility Fees

Background

Workgroup members representing consumers raised the issue of facility fees for discussion. Facility fees are fees charged for an ambulatory surgical center, office-based surgery, or office visits when the physician's office is owned by or affiliated with a hospital. A facility fee is charged in addition to the charges for the physician's professional services and is not uniformly covered by health plans. This means that, in addition to the consumer's in-network cost-sharing, the consumer may also pay the full cost of any non-covered facility fee.

Discussion

Workgroup members representing consumers stated that these facility fees are similar to a surprise bill, where an insured has done everything possible to stay in-network but receives an unexpected bill after the services are provided. They also noted that facility fees have been charged even in instances where an insured received preventive services that are statutorily required to be covered without any cost-sharing. Consumer Workgroup members propose that facility fees be disclosed on a provider's website and at the time a patient makes an appointment because, once a patient has arrived at a doctor's office for a scheduled appointment, it is difficult to seek care elsewhere to avoid the fee. These Workgroup members also recommend that facility fees should not be charged for physician office visits taking place at practices owned by or affiliated with a hospital. Additionally, these Workgroup members recommend that if a consumer was not notified of a facility fee at the time they made an appointment, they should be held harmless for the fee. Finally, Workgroup members representing consumers stated that facility fees should never be charged for preventive services for which cost-sharing is prohibited under the Affordable Care Act.¹⁹

The Workgroup recognizes that the federal No Surprises Act requires enhanced disclosure of provider charges, including facility fees, before services are rendered beginning in 2022. The

¹⁹ 42 U.S.C. § 300gg-13.

Workgroup recommends that providers disclose when facility fees will be charged by that provider, and the amount of the fee, before services are rendered to allow the consumer to make an informed decision about whether to proceed with the services. The Workgroup also recommends that facility fees not be charged when the office visit is for a preventive service for which cost-sharing is prohibited.

Uniform Hospital Billing

Background

Workgroup members representing consumers raised the topic of hospital bills for the Workgroup to discuss. During a hospital stay, services are often provided by multiple providers, including physicians not employed by the hospital. Consumers typically receive multiple bills from different providers following a hospital stay, including separate bills from the hospital and physicians.

Discussion

Workgroup members representing consumers stated that hospital billing is confusing and that consumers often receive multiple bills for a single hospital stay. They suggested that hospitals send a single, consolidated bill that clearly explains the services and charges shortly after discharge. They also suggested that the bill should be written in plain language so that patients are able to understand the charges, whether a claim for services has been submitted to a health plan, which providers must be paid, and the amounts owed to those providers. Workgroup members representing hospitals indicated that a single, consolidated bill inclusive of both hospital and physician services is not currently possible because physicians and independent practices that provide services at the hospital are not employed by the hospital and therefore bill separately. In addition, hospital Workgroup members stated that hospitals are not privy to the terms of those physicians' contractual agreements with the health plans. The Workgroup recommends that DOH continue discussions with stakeholders to explore ways to make billing easier for consumers to understand.

Notification of Hospital Admissions, Discharges or Transfers

Background

A Workgroup member representing health plans raised the topic of hospitals providing timely notification for admissions, discharges, and transfers. Timeframes for notification are typically addressed in the contract between a health plan and a hospital. However, the Insurance Law and Public Health Law prohibit health plans from denying payment to a hospital for failure to comply with administrative requirements, including notification, but permit a hospital and health plan to agree to a penalty up to 7.5% of the payment otherwise due.²⁰

Discussion

A Workgroup member representing health plans explained that notification of hospital admissions, discharges, or transfers helps health plans better coordinate care. A Workgroup member representing hospitals agreed that notification, when done to affirmatively assist with coordinating care, discharge planning, and arranging home health care services, serves a useful purpose. The Workgroup discussed a 24-hour notification timeframe and whether that should include weekends. Hospital Workgroup members noted that some health plans do not have staff available on weekends to receive and act on notifications. Hospital Workgroup members also noted that changes in the Insurance Law and Public Health Law prohibit health plans from denying certain hospital claims due to late notification, and if the health plan and hospital otherwise agree to a notification requirement, it must allow for a reasonable extension of timeframes for weekends and federal holidays. Workgroup members representing health plans stated that some plans make care managers available over the weekend, and for those that do, the 24-hour standard should remain the best practice on weekends. Workgroup members representing consumers stated that a consumer should not be held financially liable should such notification not occur. The Workgroup recommends that hospitals notify health plans of hospital admissions, discharges, or transfers within 24 hours, or one business day for those

²⁰ Insurance Law §§ 3217-b(j), 4325(k), and Public Health Law § 4406-c(8).

that occur on a weekend and health plan staff are unavailable, as a best practice in order to facilitate discharge planning and care coordination.

Claim Deadlines, Duplicate Claims, and Accounts Receivable

Background

A Workgroup member representing health plans raised the topic of claim submission timeframes. The Insurance Law states that health care claims must be submitted by providers within 120 days after the date of service to be valid and enforceable against the health plan. However, the health plan and provider may agree to a time period more favorable to the provider.²¹

Discussion

Workgroup members noted that providers and health plans typically contractually agree to extend the claim submission deadline longer than 120 days. A Workgroup member representing health plans expressed concern with providers submitting claims in a timely manner or duplicate claims. Workgroup members representing health plans noted that claims are sometimes submitted well after services are provided and expressed the need to have finality with claims so that health plans and providers have accurate accounts receivable balances. A Workgroup member representing hospitals stated that if a provider is not paid the expected amount billed for a service, the outstanding receivable should be considered part of the accounts receivable balance carried by the hospital. Workgroup members representing both health plans and hospitals agreed that there is frustration on both sides with accounts receivable balances and data on claim denials. The Workgroup recommends that health plans and hospitals work collaboratively to develop standard terms, definitions, and methodologies to improve communication and reduce friction around claims activity. The Workgroup did not reach consensus on the development of a standard claim submission deadline.

²¹ Insurance Law § 3224-a(g).

Health Care Claims Reports

Background

The Insurance Law requires health plans to submit a claims report to DFS quarterly and annually on health care claims payment performance with respect to comprehensive health insurance coverage, with the first report due May 15, 2022.²² The law states that the report must include the number and dollar value of health care claims by major line of business and categorized by health care claims received, paid, pending, and denied during the respective quarter or year. The data must be provided in the aggregate and by major category of health care provider. The report must be submitted in the manner and form prescribed by DFS, after consultation with representatives of health plans and health care providers, and must be made publicly available, including on the DFS website.

The Workgroup discussed the parameters of the claims report during two meetings. DFS shared an initial draft template of the health care claims report, responded to initial questions regarding the template, and solicited feedback from Workgroup members. Some Workgroup members provided extensive technical comments and questions. One question raised was whether the Insurance Law requirements for submission of the claims report apply to Medicaid managed care plans, Child Health Plus, and the Essential Plan. Workgroup members representing consumers noted that since many consumers move between public coverage, New York State of Health (“NYSOH”) coverage, and employer-based coverage, it would be helpful to have this data for all lines of business. Workgroup members representing hospitals and consumer groups stated that the requirements should apply to these coverages, as this information is a relevant metric for plan performance, and that the statute specifies that this information is to be reported by line of business. However, Workgroup members representing health plans stated that, as written, the law does not apply to government programs. DFS and DOH are analyzing the statute to determine whether the Insurance Law applies to these coverages. Workgroup members that represent health plans also stated that the final health care claims report

²² Insurance Law § 345.

template is needed with sufficient lead time so that health plans are able to program systems to populate the template. The Workgroup recommends finalizing the template for the health care claims report in a timely manner. DFS is reviewing the feedback provided, revising the draft health care claims report, and developing related instructions and any other necessary materials. The Workgroup acknowledges that work on the template will continue after the issuance of this report.

Changes to Utilization Review – Failure to Respond to Initial Utilization Review Request

Background

A Workgroup member representing hospitals raised the topic of utilization review initial decision timeframes and the consequences of a health plan's or its utilization review agent's failure to meet the timeframes. The Insurance Law and Public Health Law provide that failure by a health plan or its utilization review agent to make a determination within the specified time periods is deemed to be an adverse determination subject to internal appeal, and that failure to make a determination on an appeal within the specified time periods is deemed to be a reversal (so that the services are approved).²³ The timeframes in the Insurance Law and Public Health Law run from the health plan's receipt of all necessary information. However, applicable federal requirements also require that a decision be made regardless of whether all necessary information has been received.²⁴

Discussion

Workgroup members representing hospitals expressed concern that a health plan's or its utilization review agent's failure to make an initial utilization review decision is treated as a denial that can be appealed, instead of an approval. These Workgroup members stated that silence should be considered an approval to ensure that health plans make initial determinations within the required timeframes. However, health plan Workgroup members stated that if a plan fails to make a

²³ Insurance Law § 4903(g) and Public Health Law § 4903(7).

²⁴ 29 C.F.R. § 2560.503-1 and 45 C.F.R. § 147.136.

determination on the internal appeal within the timeframes, the services are then deemed to be approved pursuant to the Insurance Law and Public Health Law, serving as a backstop to any delays in the plan's initial utilization review decision.²⁵ A consensus recommendation was not reached by Workgroup members. DFS also notes that it reviews the timeliness of utilization review determinations during its market conduct exams and pursues corrective actions and penalties when timeframes are not met.

Changes to Utilization Review – Definition of a Clinical Peer Reviewer

Background

A Workgroup member representing physicians raised the topic of which physicians may be a clinical peer reviewer for purposes of a utilization review conducted by a health plan or its utilization review agent. The Insurance Law and Public Health Law define a “clinical peer reviewer,” in part, as a physician who possesses a current and valid non-restricted license to practice medicine.²⁶ For a determination involving treatment for a mental health condition or substance use disorder, the clinical peer reviewer must also specialize in behavioral health and have experience in the delivery of mental health or substance use disorder treatment.

Discussion

Some Workgroup members representing providers and consumers expressed concern that, for services other than mental health or substance use disorder treatment, health plan physician clinical peer reviewers making the determination to deny services as not medically necessary are not in the same specialty as the treating physician and lack experience with the particular condition or treatment. These Workgroup members noted that this lack of experience in the same or similar specialty may result in more denials that must then be appealed. Workgroup members representing health plans

²⁵ Insurance Law § 4904(e) and Public Health Law § 4904(5).

²⁶ Insurance Law § 4900(b) and Public Health Law § 4900(2).

stated that it would be difficult and costly to employ physicians specializing in every treatment that insureds may request. These Workgroup members also noted that insureds have the right to a physician in the same or similar specialty as the health care provider who typically manages their medical condition or disease or provides the health care treatment during the independent external appeal process. A consensus recommendation was not reached by Workgroup members.

CONCLUSION

The Health Care Administrative Simplification Workgroup provided a unique opportunity for health care leaders to come together to discuss ways to reduce health care administrative costs and complexities through standardization, simplification, or technology. Discussions were insightful and productive, but also revealed that much more work is necessary to overcome different views and, in some instances, lack of trust between many providers and health plans, while ensuring that consumers are not caught in the middle. These discussions also noted some statutory and regulatory differences between public and private coverage and that greater uniformity could simplify standards and processes for consumers, providers, and health plans. The Workgroup undertook several extensive projects, and the work on some of them will continue beyond the issuance of this report. Consensus recommendations were reached on many of the issues discussed that will benefit consumers, health plans, and providers. The Workgroup was an important step to bring many diverse voices together to develop workable solutions for all stakeholders and provides a useful framework for continued collaboration on the important issues that remain to be addressed.

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION WORKGROUP MEMBERS

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- **John D. Bennett**, M.D., President and Chief Executive Officer, Capital District Physicians' Health Plan
- **Jennifer Briggs**, Chief Operating and Financial Officer, Greater Rochester Independent Practice Association
- **John Burke**, Chief Executive Officer SOMOS Community Care (replacing former member, **Ricardo A. Rivera-Cardona**, Chief Business Development Officer)
- **Monica Chopra**, Northeast Region Leader, Oscar Health
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- **Brent Estes**, Senior Vice President and Chief Managed Care Officer, Mount Sinai Health System (replacing former member, **Niyum Gandhi**, Executive Vice President and Chief Population Health Officer)
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