S T A T E O F N E W Y O R K

4511

2011-2012 Regular Sessions

I N S E N A T E

April 8, 2011

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the insurance law, in relation to certain application and referral forms for health care plans

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subdivision 1 of section 4406-d of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

1. (a) A health care plan shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the health care plan. The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements. A health care plan shall complete review of the health care professional's UNIVERSAL HEALTH CARE PROFESSIONAL application [to participate] FOR PARTICIPATION in the in-network portion of the health care plan's network and shall, within ninety days of receiving a health care professional's completed UNIVERSAL application to participate in the health care plan's network, notify the health care professional as to: (i) whether he or she is credentialed; or (ii) whether additional time is necessary to make a determination in spite of the health care plan's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible.

(b) If the completed application of a newly-licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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state, who joins a group practice of health care professionals each of whom participates in the in-network portion of a health care plan's network, is neither approved nor declined within ninety days pursuant to paragraph (a) of this subdivision, the health care professional shall be deemed "provisionally credentialed" and may participate in the in-network portion of the health care plan's network; provided, however, that a provisionally credentialed physician may not be designated as an enrollee's primary care physician until such time as the physician has been fully credentialed. The network participation for a provisionally credentialed health care professional shall begin on the day following the ninetieth day of receipt of the completed application and shall last until the final credentialing determination is made by the health care plan. A health care professional shall only be eligible for provisional credentialing if the group practice of health care professionals notifies the health care plan in writing that, should the application ultimately be denied, the health care professional or the group practice: (i) shall refund any payments made by the health care plan for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the enrollee's contract with the health care plan; and (ii) shall not pursue reimbursement from the enrollee, except to collect the copayment that otherwise would have been payable had the enrollee received services from a health care professional participating in the in-network portion of a health care plan's network. Interest and penalties pursuant to section three thousand two hundred twenty-four-a of the insurance law shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent a health care plan from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim. A health care plan shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

(C) THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE, AND REPRESENTATIVES OF HEALTH CARE PLANS, HOSPITALS AND HEALTH CARE PROFESSIONALS SHALL ADOPT BY REGULATION SUCH UNIVERSAL HEALTH CARE PROFESSIONAL APPLICATION FOR PARTICIPATION FORM, AND A FORM FOR THE RENEWAL OF CREDENTIALING WHICH SHALL BE AN ABBREVIATED VERSION OF THE UNIVERSAL APPLICATION FORM, FOR USE BY HEALTH CARE PLANS WHICH OFFER MANAGED CARE PRODUCTS FOR THE PURPOSE OF CREDENTIALING AND RE-CREDENTIALING HEALTH CARE PROFESSIONALS WHO SEEK TO PARTICIPATE IN A HEALTH CARE PLAN'S PROVIDER NETWORK AND FOR THE PURPOSE OF CREDENTIALING AND RE-CREDENTIALING HEALTH CARE PROFESSIONALS WHO ARE EMPLOYED OR HAVE STAFF PRIVILEGES AT HOSPITALS OR OTHER HEALTH CARE FACILITIES WHICH SEEK TO PARTICIPATE IN A PROVIDER NETWORK.

(D) THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE, AND REPRESENTATIVES OF HEALTH CARE PLANS, HOSPITALS AND HEALTH CARE PROFESSIONALS SHALL ADOPT BY REGULATION A UNIVERSAL HEALTH CARE PROFESSIONAL REFERRAL FORM FOR THE PURPOSE OF SIMPLIFYING THE PROCESS OF REFERRAL OF PATIENTS TO OTHER HEALTH CARE PROFESSIONALS.

(E) THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE, AND REPRESENTATIVES OF HEALTH CARE PLANS, HOSPITALS AND HEALTH CARE PROFESSIONALS SHALL REVISE THE UNIVERSAL APPLICATION, RE-CREDENTIALING AND UNIVERSAL HEALTH CARE PROFESSIONAL REFERRAL FORMS AS NECESSARY, TO CONFORM WITH INDUSTRY-WIDE, NATIONAL STANDARDS OF CREDENTIALING, RE-CREDENTIALING AND HEALTH CARE REFERRAL.

(F) IN DEVELOPING THE UNIVERSAL HEALTH CARE PROFESSIONAL APPLICATION RE-CREDENTIALING FORMS, THE COMMISSIONER SHALL ENSURE THAT THE CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS FOR PARTICIPATION IN THE MEDICAID PROGRAM, THE STATE CHILD HEALTH PLUS PROGRAM AND THE FAMILY HEALTH PLUS PROGRAMS ARE ADEQUATELY REFLECTED ON THE HEALTH CARE PROFESSIONAL APPLICATION AND RE-CREDENTIALING FORMS.

(G) ALL THE CREDENTIALING AND RE-CREDENTIALING FORMS REQUIRED FOR DEVELOPMENT UNDER THIS SUBDIVISION SHALL BE THE ONLY FORMS THAT MAY BE USED FOR CREDENTIALING AND RE-CREDENTIALING HEALTH CARE PROFESSIONALS BY HEALTH CARE PLANS, HOSPITALS, AND OTHER HEALTH CARE FACILITIES.

(H) THE PROFESSIONAL REFERRAL FORM REQUIRED FOR DEVELOPMENT UNDER THIS SUBDIVISION SHALL BE THE ONLY FORM THAT A HEALTH CARE PLAN MAY REQUIRE A HEALTH CARE PROFESSIONAL TO USE FOR THE PURPOSES OF MAKING A PROFESSIONAL REFERRAL; PROVIDED, HOWEVER, THAT A HEALTH CARE PLAN MAY REQUEST ADDITIONAL PATIENT INFORMATION SEPARATELY FROM THE PROFESSIONAL REFERRAL FORM FOR THE PURPOSES OF REVIEWING SUCH PROFESSIONAL REFERRAL.

S 2. Subsection (a) of section 4803 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(a) (1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within ninety days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to: (A) whether he or she is credentialed; or (B) whether additional time is necessary to make a determination in spite of the insurer's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible. THE PLANS SHALL ALSO IMPLEMENT PROCEDURES TO PERMIT NEWLY LICENSED HEALTH CARE PROFESSIONALS TO RENDER CARE AND RECEIVE PAYMENT FOR CARE PROVIDED TO ENROLLEES ON A PROVISIONAL BASIS DURING THE PENDENCY OF THE APPLICATION PROCESS OF SUCH NEWLY LICENSED HEALTH CARE PROFESSIONALS.

(2) If the completed application of a newly-licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this state, who joins a group practice of health care professionals each of whom participates in the in-network portion of an insurer's network, is neither approved nor declined within ninety days pursuant to paragraph one of this subsection, such health care professional shall be deemed "provisionally credentialed" and may participate in the in-network portion of an insurer's network; provided, however, that a provisionally credentialed physician may not be designated as an insured's primary care physician until such time as the physician has been fully credentialed. The network participation for a provisionally credentialed health care professional shall begin on the day following the ninetieth

day of receipt of the completed application and shall last until the final credentialing determination is made by the insurer. A health care professional shall only be eligible for provisional credentialing if the group practice of health care professionals notifies the insurer in writing that, should the application ultimately be denied, the health care professional or the group practice: (A) shall refund any payments made by the insurer for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the insured's contract with the insurer; and (B) shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of an insurer's network. Interest and penalties pursuant to section three thousand two hundred twenty-four-a of this chapter shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent an insurer from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim. An insurer shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

(3) THE SUPERINTENDENT, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, AND REPRESENTATIVES OF HEALTH CARE PLANS, HOSPITALS, AND HEALTH CARE PROFESSIONALS SHALL ADOPT BY REGULATION A UNIVERSAL HEALTH CARE PROFESSIONAL APPLICATION FOR PARTICIPATION FORM, AND A FORM FOR THE RENEWAL OF CREDENTIALING WHICH SHALL BE AN ABBREVIATED VERSION OF THE UNIVERSAL APPLICATION FORM FOR USE BY HEALTH CARE PLANS WHICH OFFER MANAGED CARE PRODUCTS FOR THE PURPOSE OF CREDENTIALING AND RE-CREDENTIALING HEALTH CARE PROFESSIONALS WHO SEEK TO PARTICIPATE IN A HEALTH CARE PLAN'S PROVIDER NETWORK AND FOR THE PURPOSE OF CREDENTIALING AND RE-CREDENTIALING HEALTH CARE PROFESSIONALS WHO ARE EMPLOYED OR HAVE STAFF PRIVILEGES AT HOSPITALS OR OTHER HEALTH CARE FACILITIES WHICH SEEK TO PARTICIPATE IN A PROVIDER NETWORK.

(4) THE SUPERINTENDENT, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, AND REPRESENTATIVES OF HEALTH CARE PLANS, HOSPITALS AND HEALTH CARE PROFESSIONALS SHALL ADOPT BY REGULATION A UNIVERSAL HEALTH CARE PROFESSIONAL REFERRAL FORM FOR THE PURPOSE OF SIMPLIFYING THE PROCESS OF REFERRAL OF PATIENTS TO OTHER HEALTH CARE PROFESSIONALS.

(5) THE SUPERINTENDENT, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, AND REPRESENTATIVES OF HEALTH CARE PLANS, HOSPITALS AND HEALTH CARE PROFESSIONALS SHALL REVISE THE UNIVERSAL APPLICATION, RE-CREDENTIALING AND UNIVERSAL HEALTH CARE PROFESSIONAL REFERRAL FORMS AS NECESSARY, TO CONFORM WITH INDUSTRY-WIDE, NATIONAL STANDARDS OF CREDENTIALING, RE-CREDENTIALING AND HEALTH CARE REFERRAL.

(6) IN DEVELOPING THE UNIVERSAL HEALTH CARE PROFESSIONAL APPLICATION RE-CREDENTIALING FORMS, THE SUPERINTENDENT SHALL ENSURE THAT THE CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS FOR PARTICIPATION IN THE MEDICAID PROGRAM, THE STATE CHILD HEALTH PLUS PROGRAM AND THE FAMILY HEALTH PLUS PROGRAMS ARE ADEQUATELY REFLECTED ON THE HEALTH CARE PROFESSIONAL APPLICATION AND RE-CREDENTIALING FORMS.

(7) THE CREDENTIALING AND RE-CREDENTIALING FORMS REQUIRED FOR DEVELOPMENT UNDER THIS SUBSECTION SHALL BE THE ONLY FORMS THAT MAY BE USED FOR CREDENTIALING AND RE-CREDENTIALING HEALTH CARE PROFESSIONALS BY INSURERS, HOSPITALS AND OTHER HEALTH CARE FACILITIES.

(8) THE PROFESSIONAL REFERRAL FORM REQUIRED FOR DEVELOPMENT UNDER THIS SUBSECTION SHALL BE THE ONLY FORM THAT AN INSURER MAY REQUIRE A HEALTH CARE PROFESSIONAL TO USE FOR THE PURPOSES OF MAKING A PROFESSIONAL REFERRAL; PROVIDED, HOWEVER, THAT AN INSURER MAY REQUEST ADDITIONAL PATIENT INFORMATION SEPARATELY FROM THE PROFESSIONAL REFERRAL FORM FOR THE PURPOSES OF REVIEWING SUCH PROFESSIONAL REFERRAL.

S 3. This act shall take effect on the one hundred eightieth day after it shall have become a law.