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

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2015-2016 Regular Sessions

I N A S S E M B L Y

January 8, 2015

Introduced by M. of A. LAVINE -- read once and referred to the Committee on Health

AN ACT to amend the public health law and the insurance law, in relation to health care professional applications and terminations

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

Section 1. Section 4406-d of the public health law, as added by chapter 705 of the laws of 1996, subdivision 1 as amended by chapter 237 of the laws of 2009, is amended to read as follows;

S 4406-d. Health care professional applications and terminations. 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 application to participate 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 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.

2. (a) A health care plan shall not terminate OR NOT RENEW a contract with a health care professional unless the health care plan provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

(b) The notice of the proposed contract termination OR NON-RENEWAL provided by the health care plan to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel [appointed by the health care plan] COMPRISED OF NO FEWER THAN THREE HEALTH CARE PROFESSIONALS LICENSED TO PRACTICE IN THE STATE OF NEW YORK;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing; and

(iv) a time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

(c) The hearing panel shall be comprised of three [persons appointed by the health care plan] HEALTH CARE PROFESSIONALS LICENSED TO PRACTICE

BY THE STATE OF NEW YORK IN THE SAME PROFESSION AS THE SUBJECT OF THE REVIEW, ONE OF WHOM IS APPOINTED BY THE HEALTH CARE PLAN, ONE OF WHOM IS APPOINTED BY THE HEALTH CARE PROFESSIONAL WHO IS THE SUBJECT OF THE HEARING. THE REMAINING MEMBER OF THE PANEL SHALL BE CHOSEN BY THE OTHER TWO PANEL MEMBERS. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel AND PROVIDED FURTHER THAT THE RATIO OF THE NUMBER OF HEALTH CARE PROFESSIONALS APPOINTED BY THE HEALTH CARE PLAN TO THE NUMBER OF HEALTH CARE PROFESSIONALS APPOINTED BY THE SUBJECT OF THE HEARING TO THE NUMBER OF HEALTH CARE PROFESSIONALS CHOSEN BY THE OTHER PANEL MEMBERS REMAINS ONE TO ONE TO ONE.

(d) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the health care plan, provisional reinstatement subject to conditions set forth by the health care plan or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(e) A decision by the hearing panel to terminate OR NOT RENEW a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision; provided, however, that the provisions of paragraph (e) of subdivision six of section [four thousand four] FORTY-FOUR hundred three of this article shall apply to such termination OR NON-RENEWAL.

(f) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

3. [Either party to a contract may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for purposes of this section.

4.] A health care plan shall develop and implement policies and procedures to ensure that health care professionals are regularly informed of information maintained by the health care plan to evaluate the performance or practice of the health care professional. The health care plan shall consult with health care professionals in developing methodologies to collect and analyze health care professional profiling data. Health care plans shall provide any such information and profiling data and analysis to health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the health care professional's profile and to work cooperatively with the health care plan to improve performance.

[5.] 4. No health care plan shall terminate a contract or employment, or refuse to renew a contract, solely because a health care provider has:

(a) advocated on behalf of an enrollee;

(b) filed a complaint against the health care plan;

(c) appealed a decision of the health care plan;

(d) provided information or filed a report pursuant to section forty-four hundred six-c of this article; or

(e) requested a hearing or review pursuant to this section.

[6.] 5. Except as provided herein, no contract or agreement between a health care plan and a health care professional shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination OR NON-RENEWAL and the opportunity for a hearing or review concerning such termination OR NON-RENEWAL.

[7.] 6. Any contract provision in violation of this section shall be deemed to be void and unenforceable.

[8.] 7. For purposes of this section, "health care plan" shall mean a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article or an independent practice association certified or recognized pursuant to this article.

[9.] 8. For purposes of this section, "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

S 2. Section 4803 of the insurance law, as added by chapter 705 of the laws of 1996, subsection (a) as amended by chapter 237 of the laws of 2009, is amended to read as follows:

S 4803. Health care professional applications and terminations. (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.

(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.

(b) (1) An insurer shall not terminate OR NOT RENEW a contract with a health care professional for participation in the in-network benefits portion of the insurer's network for a managed care product unless the insurer provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

(2) The notice of the proposed contract termination OR NON-RENEWAL provided by the insurer to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel [appointed by the insurer] COMPRISED OF NO FEWER THAN THREE HEALTH CARE PROFESSIONALS LICENSED TO PRACTICE BY THE STATE OF NEW YORK;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing or review; and

(iv) a time limit for a hearing date which must be held within not less than thirty days after the date of receipt of a request for a hearing.

(3) The hearing panel shall be comprised of three [persons appointed by the insurer] HEALTH CARE PROFESSIONALS LICENSED TO PRACTICE BY THE STATE OF NEW YORK IN THE SAME PROFESSION AS THE SUBJECT OF THE REVIEW, ONE OF WHOM IS APPOINTED BY THE INSURER, ONE OF WHOM IS APPOINTED BY THE HEALTH CARE PROFESSIONAL WHO IS THE SUBJECT OF THE HEARING. THE REMAIN-

ING MEMBER OF THE PANEL SHALL BE CHOSEN BY THE OTHER TWO PANEL MEMBERS. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel AND PROVIDED FURTHER THAT THE RATIO OF THE NUMBER OF HEALTH CARE PROFESSIONALS APPOINTED BY THE HEALTH CARE PLAN TO THE NUMBER OF HEALTH CARE PROFESSIONALS APPOINTED BY THE SUBJECT OF THE HEARING TO THE NUMBER OF HEALTH CARE PROFESSIONALS CHOSEN BY THE TWO OTHER PANEL MEMBERS REMAINS ONE TO ONE TO ONE.

(4) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the insurer, provisional reinstatement subject to conditions set forth by the insurer or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(5) A decision by the hearing panel to terminate OR NOT RENEW a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision; provided, however, that the provisions of subsection (e) of section four thousand eight hundred four OF THIS ARTICLE shall apply to such termination.

(6) In no event shall termination OR NON-RENEWAL be effective earlier than sixty days from the receipt of the notice of termination OR NON-RENEWAL.

(c) [Either party to a contract for participation in the in-network benefits portion of an insurer's network for a managed care product may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for purposes of this section.

(d)] An insurer shall develop and implement policies and procedures to ensure that health care providers participating in the the in-network benefits portion of an insurer's network for a managed care product are regularly informed of information maintained by the insurer to evaluate the performance or practice of the health care professional. The insurer shall consult with health care professionals in developing methodologies to collect and analyze provider profiling data. Insurers shall provide any such information and profiling data and analysis to these health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of such a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each such health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the professional's profile and to work cooperatively with the insurer to improve performance.

[(e)] (D) No insurer shall terminate or refuse to renew a contract for participation in the in-network benefits portion of an insurer's network for a managed care product solely because the health care professional

has (1) advocated on behalf of an insured; (2) has filed a complaint against the insurer; (3) has appealed a decision of the insurer; (4) provided information or filed a report pursuant to section forty-four hundred six-c of the public health law; or (5) requested a hearing or review pursuant to this section.

[(f)] (E) Except as provided herein, no contract or agreement between an insurer and a health care professional for participation in the in-network benefits portion of an insurer's network for a managed care product shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination OR NON-RENEWAL and the opportunity for a hearing concerning such termination OR NON-RENEWAL.

[(g)] (F) Any contract provision in violation of this section shall be deemed to be void and unenforceable.

[(h)] (G) For purposes of this section, "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

S 3. This act shall take effect immediately.