

MANAGED CARE LAW OF 2009

Chapter 237 of the Laws of 2009 amended statutes related to claims processing and managed care organization procedures regarding credentialing, utilization review and external appeals as well as reimbursement arrangements in provider contracts. All network practitioners, providers, and facilities (individually or collectively referred to as Provider) contracted with GHI HMO Select Inc., Group Health Incorporated, HIP Health Plan of New York, and HIP Network Services IPA (individually or collectively referred to as Plan), agree to be bound by the following clauses, as applicable to them, which are a part of and incorporated into the Agreements.

- 1. Provisional Credentialing (Applicable only to providers joining group practice in New York.):** This law provides that Plan has procedures regarding provisional credentialing. Plan's policies, procedures and Provider Manual have been updated to reflect this new plan participation status. Plan permits provisional credentialing to take effect prior to completion of the full 90-day credentialing process. This provisional status is available only to Providers who are newly licensed or recently relocated and who join a group practice that already participates with Plan's HMO networks. If a provisional credentialing application is denied, Plan will consider any work performed by that Provider to be an out-of-network service, and the Provider (or their group practice) shall repay the Plan the difference between the in- and out-of-network fees as stipulated under each member's benefit plan. Under no circumstances may the Provider (or group practice) attempt to recover this difference from the Member, except to collect copayment or coinsurance that would otherwise be payable had the Member received Covered Services from a health care professional in the Plan network.
- 2. Adverse Reimbursement Change (Applicable only to health care professionals licensed, registered or certified pursuant to Title Eight of the New York State Education Law.):** Plan may amend its Agreements with network clinicians upon thirty (30) days written notice to network health care professionals for: (i) non-fee schedule changes; (ii) non-adverse fee schedule changes; (iii) adverse fee schedule changes that are the result of a Regulatory Change, and (iv) adverse fee schedule changes that are the result of changes to fee schedules or payment policies established by government agencies; or changes to CPT codes or contractual references to a specific fee schedule, reimbursement methodology or indexing mechanism. The amendment will become effective upon the expiration of the thirty (30) day notice period without action by the clinician. If the clinician objects to the amendment, the clinician may terminate his/her agreement upon sixty (60) days written notice to Plan; however the amendment shall be in full force and effect during the termination notice period.
- 3.** Except for those adverse reimbursement schedule changes noted above, Plan may amend the fee schedule for network clinicians upon ninety (90) days written notice for all adverse reimbursement schedule changes. The amendment will become effective upon the expiration of the ninety (90) day notice period without action on the part of the clinician. If the clinician objects to the adverse fee schedule amendment, the clinician may terminate this agreement upon thirty (30) days written notice to Plan. The fee schedule reimbursement amendment will not be implemented during the termination notice period.
- 4. Claims Processing Time Frames:** Plan must pay claims submitted electronically within 30 days. Paper or facsimile claim submissions must be paid by Plan within 45 days. The 30-day time frame for requesting additional information or for denying the claim was not changed. Plan shall comply with the timeframe for payment of claims specified in the New York Insurance Law Section 3224-a.
- 5. Coordination of Benefits (COB):** Plan may not deny a claim because it is coordinating benefits with another insurer unless it has a reasonable basis to believe that the member has other primary health insurance coverage for the claimed benefit. If a member does not provide the Plan with COB information within 45 days of its request, the Plan will adjudicate the claim. The Plan will not deny a claim on the basis of non-receipt of information about other coverage.
- 6. Overpayment Recovery:** The process for overpayment recoveries now applies to licensed facilities as well as health care professionals. For further information on overpayment recovery requirements, please refer to the Provider Manual at www.emblemhealth.com.
- 7. Claims from a Network Hospital Associated with an Out-of-Network Health Care Provider Claim and Claims from a Network Health Care Provider Associated with an Out-of-Network Hospital Claim:** Plan will not treat a claim from a network hospital as out of network solely on the basis that an out-of-network health care provider treated the member. Likewise, a claim from a network health care provider will not be treated as out of network solely because the hospital is out of network with Plan.
- 8. Rare Disease Treatment:** Denials of rare disease treatment as defined in PHL § 4900(7-g) are now subject to the Plan's utilization review policies and procedures and are eligible for external appeal rights.
- 9. Home Health Care Determinations:** The timeframe for utilization review determinations of home health care services following an inpatient hospital admission was changed. The Plan will provide Provider with notice of its determination within

one (1) business day of receipt of the necessary information or, if the day after the request for services falls on a weekend or holiday, within 72 hours of receipt of necessary information. If a request for home health care services and all necessary information is provided to Plan prior to a Member's inpatient hospital discharge, Plan will not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the review determination is pending. There may, however, be other reasons for denying the service such as the exhaustion of a benefit. Denials for home health services following a discharge from a hospital admission will be treated as expedited appeals.

10. **External Appeal Rights of Concurrent Denials:** The law establishes rules to determine who must pay for an external appeal of a concurrent denial. The party responsible for the cost of the external appeal depends in large part on the external appeal agent's determination.
11. **Alternative Dispute Resolution:** An Article 28 facility may agree to an alternative dispute resolution in lieu of an external appeal. The alternative dispute process does not affect a Member's external appeal rights or the Member's right to establish the Provider as his/her designee.
12. **Hold Harmless:** Provider (acting for himself/herself or as a Member's designee) requesting an external appeal of a concurrent adverse determination, is prohibited from seeking payment, except applicable copays, from a Member for services deemed not medically necessary by the external appeal agent.
13. **Time Frame for Provider Claims Submission:** Unless the Provider's contract provides for a greater period of time, or is otherwise provided by law, providers now have 120 days after the date of the service to submit claims to Plan and, for COB claims, ninety (90) days from the date the Explanation of Benefits was issued by the primary payor. Insurance Law 3224-a was amended with two new provisions related to the time period for submission of claims. New subsection (g) states that providers must initially submit claims within 120 days after the date of the service to be valid and enforceable unless a time frame more favorable to the provider was agreed to by the provider and the plan or a different time frame is required by law. The Plan will reconsider a network provider's late claim if Provider can demonstrate that the late claim resulted from an unusual occurrence and Provider has a pattern of timely claims submissions. The Plan may reduce the reimbursement of a claim by up to 25 percent of the amount that would have been paid had the claim been submitted in a timely manner. The right to reconsideration shall not apply to a claim submitted 365 days after the service. In such cases, the Plan may deny the claim in full.