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

A3077 (Gottfried)
S4335 (Salazar)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The Blue Cross and Blue Shield Plans of New York strongly oppose enactment of this legislation. In addition to establishing a "universal health care professional application", the Bill amends the Insurance Law to require an insurer which offers managed care plans to implement procedures to permit newly licensed professionals to render care and receive payment on a "provisional basis" during the pendency of the application. The Bill, as drafted, contains a technical flaws, ignores the current statutory process for provisional credentialing, and would allow providers to render services and be paid without being subject to the credentialing process.

Currently, the Public Health law (as applied to HMOs) and Insurance law (as applied to insurance managed care products), collectively "health plans", require that health plans make a credentialing determination within 60 days of receipt of a completed application. In the event a third party has failed to provide necessary documentation, the health plan has an additional 21 days from receipt of the necessary information to make its determination. In addition, the Legislature has already established a narrow provision for "provisionally credentialing" newly licensed professionals or professionals who recently relocated from out of state when a health plan fails to make its determination within the 60 day timeframe. Under this scenario, a professional is deemed provisionally credentialed if: (i) the group practice and all individual providers in the group practice participate in the health plan's network; (ii) the provider is not designated as a primary care physician; and (iii) the group practice notifies the health plan, in writing that, should the application be denied, the professional or group practice shall both refund payments made by the health plan which are in excess of out of network benefits for services provided by the provisionally credentialed provider and shall not seek any additional payments from the patient. Thus, provisional credentialing, is intended to be a temporary substitute for full credentialing that only applies if a health plans has not been able to make a

decision on an application after 60 days and when safeguards are in place to ensure that the provider is qualified to provide services.

I. PROVIDER CREDENTIALING IS AN IMPORTANT PROCESS DESIGNED TO PROTECT PATIENTS AND MANAGE HEALTH CARE EXPENSES.

Provider credentialing is not an arbitrary or exclusionary technique, but rather, a necessary tool designed to protect consumers against health care providers who are not qualified or have a history of risking the safety of patients. Currently, all providers wishing to participate in the network must obtain credentials that are approved by a health plan. This is necessary in order for the plan to determine whether the provider is capable of providing the level of care and services to plan members as health plans that establish provider networks assume a responsibility to ensure that their participating providers deliver high quality services.

While credentialing involves a thorough review a provider's qualifications, it also includes verification that the provider is licensed in New York, has not committed a felony, and has not had their license revoked in another state. This Bill would allow an individual that is either not licensed or has had their license revoked to become part of a managed care network and receive payment for services provided simply upon submitting an application. In fact, the application submitted could be completely fabricated and fraudulent, but the individual would be part of the network and able to receive payment until the health plan rejects the application.

To remove this substantial protection is irresponsible and could threaten the health of countless New Yorkers. The National Committee for Quality Assurance ("NCQA") provides guidelines for the credentialing of providers. It is mandatory that HMOs comply with these guidelines. NCQA's intent for this process is "that organizations [HMOs], having assumed responsibility for managing the health care of their members, have a responsibility to implement a rigorous process to select and evaluate practitioners and to monitor sanctions and complaints between credentialing cycles." This Bill would circumvent this process by allowing providers to render care without being subject to the credentialing process.

In addition, the Bill exposes consumers to increased health care expenses as it contains no direction on how an insurer could recapture payments made to a provider who receives payment under its provisions, but is subsequently denied credentialing by the health plan. For example, would the provider (who is ultimately denied by the health plan) be entitled to keep the compensation or would the insurer be entitled to recapture the payment? If the health plan could recapture the payment, from whom would it be reimbursed, the member or the provider?

This is a significant deviation from the existing provisional credentialing process, which requires that when an application is denied, either the professional or group practice shall refund payments made by the health plan which are in excess of out of network benefits for services provided by the provisionally credentialed provider and prohibits the provider from seeking payment from the patient. Under this Bill, if the health plan is successful in obtaining a refund, the patient could be billed by the provider for the services that were provided. If the health plan is unable to obtain a refund, those costs are not simply assumed by the health plan, but will result in higher premiums for consumers. In the absence of a demonstrated need for this provision,

especially in light of the existing process and provisional credentialing structure, providing reimbursement to a non-credentialed provider would unnecessarily expose patients to safety and financial risks.

II. **THIS BILL INEXPLICABLY PERMITS MINIMALLY EXPERIENCED PROVIDERS TO CIRCUMVENT THE CREDENTIALING PROCESS**.

The purpose of provider credentialing is to ensure that consumers are given access to providers of the highest quality and competence. This Bill would continue this practice with regard to all existing providers, but would allow minimally experienced providers to circumvent the process, creating special concessions for the most untried and inexperienced individuals-- those who are newly licensed. In allowing new providers to bypass the credentialing process, this legislation is harmful to patients in that it eliminates a critical quality assurance concept for patient protection. These newly licensed providers should be subject to the same credentialing process as other members of their profession and should not be allowed to provide care and receive payment as a Plan provider when they could subsequently be rejected from participation.

III. **THIS BILL WILL RESULT IN INTERRUPTIONS IN PATIENT CARE OR HIGHER OUT OF POCKET EXPENSES FOR PATIENTS.**

Allowing newly licensed health care professionals to provide services and receive payment from the network during the pendency of their application to become a participating provider will cause unnecessary interruptions and delays in health care services for patients. If these providers are permitted to receive payment, then they will begin to treat plan members during the pendency of their application. If the application is ultimately denied, the patient would have to choose whether to continue their care and pay the non-participating provider's fees out of their own pocket, or change providers. Many are likely to change providers, thus having to establish a relationship with a new provider, experience interruption in the care for an ongoing health problem or experience delays as they select a new provider and arrange for an appointment.

Overall, this Bill would create unnecessary clinical and financial risks for patients and administrative difficulties for certain managed care insurers, without any demonstrated need for creating this special treatment for newly licensed health care providers. In addition to these concerns raised, the Bill fails to amend the corresponding Public Health Law provisions applicable to HMOs and therefore only applies to insurers which offer managed care like products. For these reasons, we oppose the enactment of this legislation.

Respectfully submitted,

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