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February 25, 2020

RE: AN ACT to amend the public health law and the insurance law, in relation to utilization review of coverage of nursing home care following an inpatient hospital admission

A9086 (Gottfried)
S7525 (Rivera)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shields Plans oppose enactment of this bill, which would reduce the time frame in which health insurance plans have to make nursing home eligibility determinations from three days to one day following an inpatient hospital stay. This bill would jeopardize the quality of care provided to patients, as well as increase administrative costs associated with both provider and enrollee transitions to nursing home care.

The utilization review process is an essential tool used to ensure that health care decisions are consistent and clinically appropriate. It requires careful analysis of each patient's unique needs and situation, and involves significant time, resources, and personnel. Currently, insurers are required to provide a utilization review determination within three business days of the time they receive a request. During this already stringent timeframe clinical peer reviewers must analyze requests against evidence-based clinical guidelines, make frequent requests for additional medical information from providers and, where necessary, consult with licensed specialty physicians. Indeed, the current timeframe provides significant challenges to ensure the appropriate level of care is approved.

Currently, utilization review requests requiring a determination within 24 hours apply only to patients undergoing a course of continued treatment after an inpatient hospital stay. Services such as rehabilitation, home care and other health care services are part of a continuum of care for acute healthcare episodes. Rapid utilization review is appropriate to ensure that such an acute episode is resolved without expensive re-hospitalization or other significant regression and the appropriate level of care post inpatient hospitalization may be determined more efficiently and timely when dealing with the limited scope of a continued course of treatment. In contrast, nursing home care, is typically does not provide continued acute care treatment, but instead provides twenty-four hour skilled nursing for chronic conditions. As such, unlike the current

one-day utilization review requests, the care provided is less continual and the need for an accelerated timeline is unnecessary. This legislation would improperly facilitate a response reserved only for the most dire and emergent of medical circumstances, not only increasing costs for all enrollees, but also opening the door for other non-emergent services being carved into this limited exception.

Moreover, this bill would require health plans to cover the cost of nursing home care while a utilization review determination is pending, regardless of actual medical necessity. Such a provision is irresponsible as it undermines the importance and necessity of utilization review. By permitting hospitals to unilaterally determine medical necessity, this bill unjustifiably places patients at risk by deferring medical decisions regarding nursing home placement to a hospital clinician, even in cases where that clinician disregards nationally recognized best-practice standards. This bill is especially troubling, given that, as the sponsor notes, hospitals are financially incented to transfer patients out of their facilities as quickly as possible under the DRG system. Frequently, the placement to a nursing home is not the desired venue of the patient and such a unilateral transfer would be against the wishes of the patient.

In cases where a health insurer ultimately determines that nursing home placement is not in the best interest of the patient, this bill would create significant distress and burden for patients that have already been admitted to such a facility. The transition process is already a tumultuous life event requiring careful consideration on the part of the patient, their family, the hospital discharge planning team, and prospective facilities. Where proper utilization review determines that such a transition was not appropriate, patients, many of whom are required to move great distances from their homes, would be left to secure alternate living and provision of care arrangements, all without aid of a hospital discharge planning team. Establishing a mechanism whereby patients are routinely forced to agonize through multiple care transitions is irresponsible and a disservice to patients, families, and facilities alike.

For the foregoing reasons, the Blue Cross and Blue Shield Plans urge that this bill not be enacted.

Respectfully submitted,

HINMAN STRAUB ADVISORS, LLC

Legislative Counsel for the Blue Cross and Blue Shield Plans

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