Suburban Hospital Alliance of New York State, LLC

SUPPORT MEMO

Date: **May 8, 2024**
To: **Hudson Valley and Long Island Members of the Legislature**
From: **Wendy Darwell, President & CEO**
Re: **Managed Care Priorities**

Commercial health insurers continue to develop new tools and processes to delay care, deny payment for care already provided, and generate dividends for their shareholders from these delays. The Suburban Hospital Alliance, on behalf of hospitals and health systems on Long Island and in the Hudson Valley, has repeatedly called for holding these predominantly for-profit corporations accountable for fulfilling their commitments to patients. We urge your support for the following bills that help achieve this goal:

Prior Authorization Reform – A. 7268 (Weprin) / S.3400 (Breslin)
Prior authorization can play an important role in ensuring that patients get the right care in the right place, but health plans have turned it into a tool for delaying or denying even the most routine care. This unnecessarily consumes provider resources, frustrates patients and, in some cases, results in consumers giving up on needed care altogether.

A.7268/S.3400 addresses these bureaucratic obstacles that unreasonably impact patient care. This legislation would:

- Require that health plans utilize evidence-based and peer-reviewed clinical criteria to make determinations about medical necessity. Plans should be held to rigorous standards in their review of treatment recommended by a qualified clinician, not using proprietary products that cannot be externally verified.
- Require that health plans' utilization review agents generally make determinations within 72 hours of receiving the provider's request, as opposed to the three business days required by current law. When the patient's clinical condition demands it, this legislation would shorten that timeframe to 24 hours. Patients need care seven days a week; plans insisting on these utilization review mechanisms should likewise be available to support the beneficiaries' needs seven days a week. Patients should not remain in a hospital bed for excess days, often without any additional reimbursement for the hospital, if they are clinically appropriate for a different level of care.
- Extend the validity of an authorization for the duration of treatment for a specific condition if requested by a provider. It places an undue burden on the patient and provider to continue seeking new authorizations for ongoing treatment, which can lead to delayed care.

- Require that plans pay for a service that has been authorized when eligibility is confirmed on the date of service. Providers should not have to forego payment for care provided to patients if the plan later determines that it made an error in the patient's coverage status.

Claims Approval if Insurers Fail to Issue Timely Response – A.6898 (Weprin) / S.3402 (Breslin)
Under current statute, if a health plan fails to respond to an authorization request within the statutory timeframe, the request for health services is deemed to be denied. This requires the healthcare provider to file an appeal, which is difficult and time-consuming to argue when the plan has not provided any justification for the denial. Ultimately, medically necessary care gets approved, but not until the healthcare provider has spent days or weeks pursuing the claim. Once again, this delays care for patients and creates costly administrative burdens for providers, diverting resources that would be better deployed for patient care.

Plans are incentivized by current law to delay or ignore requests for care. A.6898/S.3402 would ensure better enforcement of the statutory timeframes for insurers to issue determinations. If insurers fail to timely issue a determination upon receipt of the clinical documentation requested from the provider, the care would be deemed to be approved. Patients should not be forced to wait for medically necessary care because a health plan failed or intentionally refused to respond in a timely manner to a clinician's request.

Address Down-Coding Abuses – A.6937 (Weprin)
Health insurers are increasingly abusing the practice known as "down-coding," changing the claim to a lower level of service than what was submitted by the provider. Sometimes this is done at the initial submission of a bill, relying only on the final diagnosis to set a payment level and ignoring the patient's presenting symptoms and any interim course of treatment provided before a final diagnosis was determined. In other cases, health plans will use post-payment audits to reverse or downgrade medical necessity determinations that had already been made. As a result, providers' payments are reversed for services long since rendered, often without the insurer having ever reviewed the patient's medical record – typically this downgrading is done by their proprietary software.

Under current law, providers generally do not have the ability to challenge down-coded claims. A.6937 would expand the definition of "adverse determination" to include the decision to downgrade the coding of a claim to a lower-level service than the one submitted, making such cases subject to internal and external appeals processes established in the law. The legislation would also prohibit plans from reversing medical necessity determinations made by a utilization review or external appeals agent.