Appendix XX — Provisions from the 2007 Managed Care Reform Bill

Managed Care Reform Bill

This legislation was signed into law in August 2007and imposes new requirements on healthcare payors and providers. Specifically, the bill includes the following provisions:

Claims Deadline for Public Programs (effective January 1, 2008) Requires out-of-network providers of services to Medicaid, FHPlus and CHPlus beneficiaries to submit claims to plans within 15 months from the date of service.

Cooling Off Period for Hospitals and HMOs in Contract Terminations Imposes a two-month "cooling off period" after the expiration of a contract between a hospital and a health plan.

During this period, the terms of the terminated contract remain in place. Health plan members are notified of the impending termination 15 days after the commencement of the cooling off period. For example, if the contract terminated on December 31, 2007, the end of the newly mandated cooling off period is February 28, 2008. The 45-day advance notice to enrolled members would have occurred on January 15, 2008.

The purpose of this provision is to avoid the use of termination notices to health plan members and DOH as a vehicle for leveraging concessions in contract negotiations. The cooling off period may be waived by DOH in the event of a termination for cause. **It is not required in the context of mutual terminations that are recorded in writing.**

Binding Pre-authorizations (effective January 1, 2008) Prohibits plans from denying claims for preauthorized services, except under certain circumstances.

The exceptions include: (1) The patient was not covered at the time the service was provided; (2) The claim was not timely; (3) The patient exceeded policy limits; (4) The preauthorization was based on materially inaccurate or incomplete information; (5) The claim is related to a pre-existing condition that is excluded from coverage; (6) Provider fraud or abuse; and (7) The health plan that pre-authorized the service is not the primary payor.

Of particular importance is the first exception that imposes limits on when health plans may retroactively terminate coverage and thus reverse a preauthorization previously issued by the health plan. The bill states that if a provider submits the claims for per-authorized care within 90 days of the date of service, the health plan's termination may be retroactive more than120 days. If the retroactive period is longer than 120 days, the plan has to pay claims for any pre-authorized care rendered more than 120 days before the retroactive termination date.

Out-of-Network Treatments (effective April 1, 2008) Expands the scope of the external review process to include denials of treatments not approved by a physician participating in the health plan's network and are to be provided by an out-of-network physician.

The appeal process for such denials involves a two-step inquiry: (1) Is the requested treatment materially different from the treatment available in the network? (2) If so, would it be "more clinically beneficial" and not substantially more risky than the in-network treatment?

The appeals process then has two steps. A single external reviewer first determines whether the proposed out of network service is materially different. If so, a larger external review panel is convened to determine whether the alternative is likely to be "more clinically beneficial" and whether the adverse risk of the proposed service would likely not be substantially increased over the in-network service.