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MEMORANDUM IN OPPOSITION

FOR IMMEDIATE RELEASE: MAY 4, 2018

Re: S.7871 (Hannon)/A.7108 (Gottfried) – An act to amend the public health and the insurance law, in relation to utilization review of coverage of nursing home care following an inpatient hospital admission.

This legislation, S.7871/A.7108, would require health plans to make determinations on requests for nursing home care following an inpatient hospital admission within 24 hours of receipt of the request. The New York Health Plan Association (HPA) opposes this legislation because it undermines the quality of care for patients and does not solve the concerns articulated by the bill's proponents.

Hospitals claim that they are experiencing delays in discharging patients to nursing homes, and that the source of the delay results from health plans taking too long to make the necessary authorizations. That is a far too simplistic and inaccurate view of the issue. There are several factors and multiple entities that are involved in discharge planning and the resulting authorizations necessary for post-acute nursing home care.

This legislation puts the onus for the delay on health plans and the review of the hospital discharge plan, and imposes an expedited 24-hour review clock where the patient is not in an emergent situation. Discharge planning from a post-acute hospital stay into a skilled nursing facility for rehabilitation purposes requires input from the patient (and in most cases their family), the hospital, the nursing home, the health plan, and in some instances government (Medicare/Medicaid). Health plans work closely with each of these entities to ensure that the needs of the patient are met and that a high quality medically necessary care is provided. To single out health plans as the source of the delay is not accurate nor in the best interests of patients.

Prior authorization is a tool used by insurers to hasten service delivery to the enrollee and facilitate proper provider reimbursement. The process is most typically used for elective, non-emergency services that historically have evidenced abuse or improper utilization. Prior authorizations also serve as a quality assurance tool that facilitates members receiving the right care at the right time and in the right setting. Prior authorization is not a blank check – rather, it means that, based on the information from the provider and member, the requested service will be covered as long as:

- The member is eligible for coverage;
- The information on which the authorization was granted is accurate; and
- The care to be provided is in fact appropriate and there is no fraud.

While hospitals may be experiencing delays in discharging patients into nursing homes it is not the result of health plans failing to make timely authorizations. The bill fails to address the main issue: ensuring proper discharge planning that ensures that the patient is the focus and not the bottom line of the hospital. We urge you to say no to S.7871/A.7108.

The New York Health Plan Association represents 29 managed care health plans that provide comprehensive health care services to nearly 8 million New Yorkers.