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Department of Financial Services

Supplement No. 1 to
Insurance Circular Letter No. 8 (2020)
April 22, 2020

TO:	**All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans, Prepaid Health Services Plans, Utilization Review Agents, and Licensed Independent Adjusters**
RE:	**Coronavirus, Utilization Review Requirements, and Payments to Participating Hospitals**

STATUTORY AND REGULATORY REFERENCES: N.Y. Insurance Law §§ 3224-a, 4902, 4903, 4904, and 4914; Public Health Law §§ 4902, 4903, 4904, and 4914; and Chapter 56 of the Laws of 2020

I. Purpose

The Governor of New York has declared a state of emergency to help New York more quickly and effectively contain the spread of the novel coronavirus ("COVID-19"). The global pandemic has threatened to overwhelm the ability of hospitals in the state to provide COVID-19 patients the care they need. As a result, the Governor has reached an agreement with the statewide healthcare system to coordinate and work together as one entity to balance the load of patients and share staff and resources. In addition, to handle the projected surge of COVID-19

cases, the Governor called on hospitals to increase their capacity, particularly intensive care units, including by adding mobile facilities and eliminating elective hospital procedures.

To accommodate this unprecedented demand for inpatient hospital services, hospitals have had to redeploy all available staff to direct patient care, impacting certain administrative functions which have become less necessary given the suspension of elective surgical procedures. Combined with excessive costs relating to COVID-19, the suspension of elective surgical procedures has also had a significant adverse impact on the cash flow of some hospitals. Against this backdrop, existing rules for preauthorization, concurrent, and retrospective medical necessity reviews impose unnecessarily burdensome administrative requirements on hospitals at a time when all their resources should be devoted to urgent patient care.

During this time of emergency, it is in the interest of all stakeholders to support hospitals, particularly community, rural and safety-net hospitals, to ensure that patients continue to get the care that they need. Recognizing the importance of protecting the public, as well as maintaining the financial stability of hospitals, health insurers are taking steps to work with hospitals during this crisis. The purpose of this circular letter is to advise insurers authorized to write accident and health insurance in this state, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans (collectively "issuers"), independent agents performing utilization review under contract with such issuers, and licensed independent adjusters that certain additional utilization review requirements are prohibited until June 18, 2020, subject to further evaluation as the COVID-19 situation develops, due to the state of emergency. In addition, this circular letter directs issuers to expeditiously resolve and pay hospital claims and work with participating hospitals to assist with cash flow issues. This circular letter supplements Insurance Circular Letter No. 8 (2020) issued on March 20, 2020.

II. Preauthorization and Concurrent Review Requirements for Outpatient Hospital Services

Due to the increased demand for hospital services for COVID-19 patients, many hospitals are shifting staff resources from administrative functions to direct patient care. Insurance Law and Public Health Law §§ 4903 permit issuers to require preauthorization for health care services, other than emergency services, and also permit issuers to concurrently review health care services for medical necessity. However, hospitals may lack the resources for staff to respond to utilization review requests for preauthorization and concurrent review while responding to the surge in patients due to COVID-19. Therefore, the Department of Financial Services

("Department") is directing issuers to suspend preauthorization, and concurrent review for outpatient services provided at hospitals until June 18, 2020, subject to further evaluation as the COVID-19 situation develops. However, a hospital should use its reasonable best efforts to provide 48 hours' notice to the issuer after the provision of outpatient services provided at a hospital.

III. Retrospective Review for Inpatient and Outpatient Services at In-Network Hospitals

Insurance Law and Public Health Law §§ 4903 permit issuers to retrospectively review health care services for medical necessity. Insurance Circular Letter No. 8 (2020) advised issuers that they should suspend retrospective review for emergency services and inpatient services provided at in-network hospitals. Going a step further, Chapter 56 of the Laws of 2020 added Insurance Law § 4902(a)(13) and Public Health Law § 4902(1)(k) to prohibit, not just suspend, issuers from denying emergency department and inpatient hospital services as not medically necessary on retrospective review if the services were rendered by a general hospital certified pursuant to Public Health Law Article 28 to an insured to treat COVID-19 during a declared state of emergency.

The Department is further directing issuers not to conduct retrospective review for any services provided at in-network hospitals until June 18, 2020, subject to further evaluation as the COVID-19 situation develops; provided that, if an issuer has evidence that a hospital is engaging in fraudulent or abusive billing practices, the issuer may, only to the extent necessary, request information to perform a retrospective review of claims alleged to reflect such fraudulent or abusive billing practices, reconcile such claims, and make any payment adjustments with respect to such claims, beginning after June 18, 2020, subject to further evaluation as the COVID-19 situation develops. Issuers shall pay claims from in-network hospitals for inpatient and outpatient hospital services that are otherwise eligible for payment without first reviewing the claims for medical necessity. The timeframes for issuers to conduct retrospective review of claims for fraud or abusive billing, or overpayment recovery should be extended for 90 days once retrospective review is resumed. In addition, if an in-network hospital accepts payment for such claims, the hospital must agree not to enforce any contractual limitations regarding the permissibility of retrospective review or overpayment recovery during such extended 90-day period.

IV. Resumption of Retrospective Review for Inpatient and Outpatient Services at In-Network Hospitals

Upon resumption of retrospective review for inpatient and outpatient services at in-network hospitals, and for purposes of the limited retrospective review permitted in Section III, issuers

are directed to ensure that documentation requirements for retrospective review are reasonable, and to take into consideration the extraordinary circumstances that existed at the time the health care services were provided. Hospitals may not be able to provide the typical level of documentation as resources have been shifted away from administrative functions to direct patient care. In addition, the New York State Department of Health has relaxed certain documentation requirements.

V. Retrospective Medical Necessity Denials Prohibited for Emergency Department and Inpatient Hospital Services for COVID-19

Chapter 56 of the Laws of 2020 added Insurance Law § 4902(a)(13) and Public Health Law § 4902(1)(k) to prohibit issuers from denying emergency department and inpatient hospital services as not medically necessary on retrospective review if the services were rendered by a general hospital certified pursuant to Public Health Law Article 28 to an insured to treat COVID-19 during a declared state of emergency. The effective date of these provisions was agreed upon and intended to apply to services performed immediately. However, due to an inadvertent bill drafting issue, the effective date section specifies that the amendment applies to services performed on or after January 1, 2021. It is the Department's understanding that the January 1, 2021 date will be changed to April 1, 2020. Issuers should therefore not deny emergency department and inpatient hospital treatment provided during the state of emergency for diagnosed or suspected COVID-19 cases as not medically necessary on retrospective review.

VI. Internal and External Appeal Timeframes for Hospitals

Insurance Law § 4904(c) and Public Health Law § 4904(3) provide that a health care provider has a period of no less than 45 days after receipt of notice of an adverse determination to file an internal appeal with the issuer. Insurance Law § 4914(b)(1) and Public Health Law § 4914(2)(a) provide that the insured's health care provider has 60 days to initiate an external appeal after the health care provider receives notice of a final adverse determination. The timeframes for a hospital to submit an internal or external appeal should be considered tolled until June 18, 2020, subject to further evaluation as the COVID-19 situation develops.

VII. Expediting Payment of Hospital Claims

Insurance Law § 3224-a provides that issuers must pay claims within 30 days of electronic submission and 45 days of paper submission unless the obligation to make payment is not reasonably clear due to certain good faith disputes regarding coverage or the amount of the claim. Providing timely payments of amounts due to hospitals is important, especially during the COVID-19 crisis, due to the financial stress on hospitals. Issuers are directed to immediately

process for payment all undisputed outstanding claims for services rendered prior to March 7, 2020, and all claims for services rendered on or after March 7, 2020 until June 18, 2020, subject to further evaluation as the COVID-19 situation develops. In addition, issuers are directed to quickly and efficiently resolve any claims for services rendered prior to March 7, 2020 disputed by either party. In processing claims for payment, it is understood that issuers may confirm member eligibility, coverage, and cost-sharing. Also, an issuer should contact the Department if payments due to the issuer from the state for Medicaid managed care coverage hinders that issuer's ability to comply with this Section.

VIII. Other Payments to Hospitals

As elective surgeries have been canceled, and some hospitals are experiencing excessive costs related to COVID-19, some hospitals are facing unprecedented cash flow issues. Issuers are directed to work with such hospitals in their networks to provide assistance if financially feasible and prudent (including considering the liquidity and solvency of the issuer). As soon as possible, and in no event later than five days of this circular letter, issuers shall contact the Department, which will collaborate with State regulatory agencies, issuers and hospitals to develop a process for identifying which hospitals have the greatest liquidity needs, with a particular focus on community, rural, and safety-net hospitals. Issuers shall then contact those identified hospitals in their network to initiate a discussion as to whether and, if so, to what extent a hospital requires assistance. Where assistance is warranted, the issuer and the hospital will work together to develop a mutually acceptable plan to provide assistance to the hospital, which may include, to the extent an issuer does not currently provide such payment or other advances, periodic interim payments during the state of emergency for COVID-19. If requested, the Department shall work with the issuer and the hospital to facilitate discussions and resolution of any issues.

IX. Applicability to Third-Party Administrators of Self-Funded Plans

Adherence to this circular letter is essential to ensure that hospitals are able to direct resources to patient care in order to handle the increases in patient volume due to the COVID-19 state of emergency. Third-party administrators, which are licensed by the Department as independent adjusters, are strongly encouraged to seek to apply the provisions of this circular letter to their administrative services arrangements with self-funded plans.

X. Conclusion

During this time of emergency, it is in the interest of all stakeholders to support hospitals, particularly community, rural and safety-net hospitals, to ensure that patients continue to get the care that they need. Issuers are directed to remove administrative burdens on hospitals,

expeditiously resolve and pay hospital claims, and work with participating hospitals to assist with cash flow issues. The limitations on prior authorization, concurrent, and retrospective review in this circular letter and in Circular Letter No. 8 (2020) shall not apply to "non-essential elective surgeries and non-urgent procedures," within the meaning of the New York State Department of Health's "COVID-19 Directive to Increase Availability of Beds by a Minimum of 50% and Provide Necessary Staffing and Equipment," dated March 23, 2020, that the Governor and/or Commissioner may allow after the date of this circular letter.

Please direct any questions regarding this circular letter to Colleen Rumsey, Supervising Attorney, Health Bureau, by email at Colleen.Rumsey@dfs.ny.gov.

Very truly yours,

Lisette Johnson
Chief, Health Bureau

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