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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, and Emergency Admission Notification Requirements

STATUTORY AND REGULATORY REFERENCES: N.Y. Insurance Law §§ 3216, 3217-b(j), 3217-d(d), 3221, 3224-a, 3224-b(b), 4303, 4305(m), 4306(n), 4306-c(d), 4325(k), 4804(a), 4900(c), 4903, 4904, and 4914; Public Health Law §§ 4403(6), 4406-c(8), 4900(3), 4903, 4904, and 4914

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”). As hospitals plan for high demand on inpatient hospital services and redeploy staff to provide direct patient care, certain administrative functions will be impacted. Moreover, with the suspension of non-time sensitive scheduled procedures, the need for certain administrative functions is less necessary. 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 utilization review and notification requirements should be suspended for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops, due to the state of emergency declared by the Governor of New York for COVID-19.

II. Suspension of Preauthorization Requirements for Scheduled Surgeries or Admissions at Hospitals Due to the likely increased demand for inpatient 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. However, hospitals may lack the resources for staff to respond to utilization review requests for preauthorization while responding to the surge in patients due to COVID-19. Therefore, the Department of Financial Services (“Department”) is advising issuers that they should suspend preauthorization review for scheduled surgeries or admissions at hospitals for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. However, a hospital should use its best efforts to provide 48 hours’ notice to the issuer after the admission to a hospital, including information necessary for an issuer to assist in coordinating care and discharge planning. Issuers may retrospectively review these services upon the resumption of retrospective review.

III. Suspension of Concurrent Review for Inpatient Hospital Services Insurance Law § 4903(c)(1) and Public Health Law § 4903(3)(a) permit issuers to concurrently review services for medical necessity, and require them to make determinations involving continued or extended health care services or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, within one business day of receipt of the necessary information. This review is known as concurrent review. Hospitals may lack the resources for staff to respond to utilization review requests for concurrent review while responding to the surge in patients due to COVID-19. Therefore, the Department is advising issuers that they should suspend concurrent review for inpatient hospital services provided for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers may retrospectively review these services upon the resumption of retrospective review.

IV. Suspension of Retrospective Review for Inpatient Hospital Services and Emergency Services at In-Network Hospitals and Payment of Claims Insurance Law § 4903(d) and Public Health Law § 4903(4) permit issuers to retrospectively review services for medical necessity and require them to make a determination involving health care services that have been delivered within 30 days of receipt of the necessary information. This review is known as retrospective review. Hospitals may lack the resources for staff to respond to utilization

review requests for retrospective review while responding to the surge in patients due to COVID-19. Therefore, the Department is advising issuers that they should suspend retrospective review for inpatient hospital services and emergency services provided at in-network hospitals for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers should pay claims from in-network hospitals that are otherwise eligible for payment without first reviewing the claims for medical necessity. Issuers may, to the extent necessary, request information to perform a retrospective review, reconcile claims, and make any payment adjustments beginning after 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. If an in-network hospital accepts payment for such claims, it should not enforce any contractual limitations regarding the permissibility of retrospective review or overpayment recovery. The timeframes for issuers to conduct retrospective review or overpayment recovery should be extended for 90 days once retrospective review is resumed. Upon the resumption of retrospective review, issuers are reminded that the “prudent layperson” standard, as described in Insurance Law § 4900(c) and Public Health Law § 4900(3), applies to emergency services, and issuers should take into consideration the circumstances involving the COVID-19 pandemic when reviewing such claims.

V. Hospital Discharge Planning and Preauthorization for Home Health Care and Inpatient Rehabilitation Services Following an Inpatient Hospital Stay Insurance Law and Public Health Law §§ 4903 permit issuers to require preauthorization for health care services other than emergency services. In order to permit hospitals to discharge patients to lower levels of care when medically appropriate, the Department is advising issuers that they should suspend preauthorization requirements for home health care services following an inpatient hospital admission for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers may review home health care services for medical necessity concurrently or retrospectively. Issuers subject to the Insurance Law are also reminded that, pursuant to Insurance Law §§ 3216(i)(6), 3221(k)(1), and 4303(a)(3), the plan of care for home health care services must be established and approved in writing by a physician, and this requirement remains unchanged by this guidance, except to the extent that the State has permitted telehealth and verbal orders to suffice for this requirement for the duration of the COVID-19 emergency. Furthermore, the Department is also advising issuers that they should suspend preauthorization requirements for inpatient rehabilitation services following a hospital admission. Insurance Law § 4903(b)(1) and Public Health Law § 4903(2)(a) require issuers to make a determination on health care services which require preauthorization within three business days from receipt of the necessary information. In order to enable hospitals to readily discharge patients to lower levels of care when medically appropriate, the Department is advising issuers that they should suspend preauthorization requirements for inpatient rehabilitation services following a hospital admission for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers should provide hospitals with an up-to-date list of all in-network rehabilitation facilities and skilled nursing facilities in order to facilitate such discharges. Hospitals should use their best efforts to transfer insureds to in-network providers. An issuer may require the

rehabilitation facility or skilled nursing facility to provide notification of the admission to the issuer. Issuers may review inpatient rehabilitation services for medical necessity concurrently and retrospectively. Issuers are also reminded that Insurance Law §§ 3217-d(d), 4306-c(d), and 4804(a) and Public Health Law § 4403(6) require an issuer that does not have an in-network provider, including an inpatient rehabilitation services provider, able to accept the insured, to provide access to an out-of-network provider at the in-network cost-sharing. For 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops, issuers, rehabilitation facilities, and skilled nursing facilities should adhere to the following procedures for inpatient rehabilitation services following a hospital admission if an in-network provider is not able to accept the insured. It is the Department of Health's expectation that out-of-network rehabilitation facilities and skilled nursing facilities will use their best efforts to provide notice to the issuer within 48 hours of the admission. Issuers should negotiate a rate with the out-of-network facility within 48 hours from the notification. If no agreement is reached, the issuer should reimburse an out-of-network facility providing inpatient rehabilitation services for Medicaid managed care enrollees at the Medicaid benchmark rate. An issuer should reimburse an out-of-network facility providing inpatient rehabilitation services for insureds covered under individual or group comprehensive health insurance policies or contracts at the lesser of: (a) the issuer's prevailing in-network reimbursement rate for such services with respect to insureds covered under such policies or contracts or (b) the Medicare reimbursement rate for such services. It is the Department of Health's expectation that a rehabilitation facility or skilled nursing facility will not balance bill insureds for such services other than for the insured's in-network cost-sharing.

VI. Hospital Discharge Planning and Preauthorization for Inpatient Substance Use Disorder Treatment and Inpatient Mental Health Services Issuers are reminded that under the Insurance Law, preauthorization is prohibited and concurrent review is limited for inpatient substance use disorder treatment at in-network facilities certified by the Office of Addiction Services and Supports. Issuers are also reminded that preauthorization is prohibited and concurrent review is limited for inpatient mental health treatment at in-network facilities licensed by the Office of Mental Health for insureds under the age of 18. See Insurance Circular Letter No. 13 (2019) for more information on these requirements. To the extent that preauthorization is required for inpatient rehabilitation services for mental health or substance use disorder treatment following a hospital admission, issuers should suspend preauthorization for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops.

VII. Notification Requirements for Emergency Hospital Admissions Hospitals typically notify issuers that an insured has been admitted to a hospital through the emergency department. Insurance Law §§ 3217-b(j) and 4325(k) and Public Health Law § 4406-c(8) provide that an issuer may not deny payment to a hospital for a claim for medically necessary inpatient services resulting from an emergency admission provided by a general hospital solely on the basis that the general hospital did not timely notify such issuer that the services had been provided. An issuer and hospital may agree to other requirements for timely notification that medically necessary inpatient services resulting from an emergency admission have been provided and to reductions in payment for failure to provide timely notification, subject to certain limitations. In circumstances where hospitals and issuers have

agreed to such notification requirements, hospitals should use their best efforts to continue to provide to issuers notifications, including information necessary for the issuer to assist in coordinating care and discharge planning, of emergency hospital admissions. Absent a contractual agreement to provide notification, hospitals are encouraged use their best efforts to provide notifications to issuers of an emergency admission to assist in coordinating care and discharge planning. However, such notification requirements should not be overly burdensome, and issuers should not require the submission of medical records as part of the notification for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops. Issuers are encouraged to work with hospitals during the state of emergency for COVID-19 to ensure that care is coordinated to the extent practicable. Issuers should not impose a financial penalty on a hospital for a failure to provide notification of an emergency admission due to staffing issues related to COVID-19.

VIII. 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 time frames for a hospital to submit an internal or external appeal should be considered tolled for 90 days from the date of this letter, subject to further evaluation as the COVID-19 situation develops.

IX. Issuer Audits of Hospital Payments and Overpayment Recovery Issuers typically audit payments to hospitals to ensure that such payments were proper. Insurance Law § 3224-b(b) provides that an issuer may not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider. During the state of emergency for COVID-19, issuers should suspend non-essential audits of hospital payments. Issuers should toll the 24-month time limit on overpayment recovery in Insurance Law § 3224-b(b), or any other agreed upon time limit between the hospital and issuers during the suspension.

X. Prompt Payment and Timely Submission of Claims Insurance Law §§ 3216(d)(1)(G), 3221(a)(9), 3224-a(g), 4305(m), and 4306(n) state that health care providers and insureds shall have 120 days to submit claims under a health insurance policy or contract. Insurance Law § 3224-a establishes standards and time frames regarding the prompt payment of health insurance claims by issuers. The Department is aware that issues may develop that hinder the timely submission and payment of claims due to the situation regarding COVID-19. The Department is monitoring the situation and may provide further guidance on these issues.

XI. 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 apply the provisions of this circular letter to their administrative services arrangements with self-funded plans.

XII. Conclusion As hospitals plan for high demand for inpatient hospital services and redeploy staff to provide direct patient care, certain administrative functions will be impacted. Issuers and hospitals are encouraged to work together to ensure that patients get the care that they need while hospitals shift

resources in order to respond to COVID-19. Please direct any questions regarding this circular letter to Colleen Rumsey, Supervising Attorney, Health Bureau, by email at [email protected]

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Very truly yours, Lisette Johnson Chief, Health Bureau Have a question or need help? Check our FAQs . If you still need help, contact DFS . Who We Supervise Institutions That We Supervise The Department of Financial Services supervises many different types of institutions. Supervision by DFS may entail chartering, licensing, registration requirements, examination, and more. Learn More Department of Financial Services About Us Mission and Leadership Advisory Boards Institutions That We Supervise Contact Us State Laws & Regulations State Codes, Rules & Regulations (NYCRR) State Laws (LBDC) State Bills & Laws (Senate) Website Accessibility & Reasonable Accommodations Disclaimer Privacy Policy Site Map Language Assistance Language Access Policies and Plans Department of Financial Services CONNECT WITH US