

April 24, 2020

Shelley Rouillard  
Director  
California Department of Managed Health Care  
980 9th Street, Suite 500  
Sacramento, CA 95814-2725

**Re: Supporting Hospitals During the COVID-19 Crisis**

Dear Ms. Rouillard:

California's collective response to the COVID-19 threat is unprecedented. The state, its health care providers, and its residents have acted swiftly and at great risk, in service of one goal: to save as many lives as possible.

Hospitals, as front line partners, immediately responded to the need to prepare for a surge of tens of thousands of COVID-19 patients by canceling non-essential elective surgeries, moving patients to other settings, rebuilding and repurposing space to be used for intensive care, securing and preserving personal protective equipment, increasing staff capacity and training, and more.

As we continue to work together to save lives, hospitals have a simultaneous challenge — significant revenue loss due to the emptying of hospitals — that is today already an impediment. Hospitals are running out of cash. For some, it means they cannot make payroll and pay bills. Others are risking their bond covenants, which threatens default on funds already borrowed. And still others are forced to sell investments at significant losses to continue providing care as the crisis continues.

During this time of crisis, health plans have continued to receive premiums, while claims for services rendered have been significantly reduced. While a few plans have taken small steps to rebalance cash flow by providing loans or accelerated payments to hospitals, it's time for all health plans to quickly do more, in order to safeguard consumer access to health care services.

Specifically, we urge you to direct all health plans that DMHC regulates — including commercial, Medi-Cal, and behavioral health carveout plans — to:

**1. Resolve all unpaid claims to hospitals within 30 days.**

Hospitals are currently owed billions of dollars in claims for care that remain unpaid by health plans. Some plans take 90 days or more to pay hospital claims, relying upon administrative technicalities to circumvent timely payment requirements. Given that hospitals have cancelled services and emptied to prepare for COVID-19 patients, there are far fewer claims for plans to process. Directing health plans to pay all outstanding hospital claims within 30 days, and to continue to pay new claims within 30 days, would immediately create much-needed cash flow. The department should require plans to pay claims as fast as possible — not hold funds for the maximum time period arguably allowed by law.

2. **Support hospitals by offering voluntary advance payment programs.**

Following the model set by Medicare, health plans should offer options for hospitals to volunteer to receive accelerated or advance claims payment. This would allow hospitals in need to receive payments in advance, smoothing cash flow now, and reconcile those claims later.

3. **Remove administrative barriers to speed payment to hospitals.**

Health plans can help by speeding or eliminating prior authorization processes and temporarily changing other administrative practices that often delay or unfairly deny hospital claims, such as the automatic request for a copy of medical records in all cases and lengthy phone-based admission and post-stabilization notification requirements. These practices delay care to patients and slow payments to hospitals. Specifically, we ask that the following administrative processes be suspended:

- **Payment denials or retrospective review for medical necessity of suspected or confirmed COVID-19 care.** All claims for services rendered to patients with COVID-19 or under investigation for COVID-19 should be paid immediately. Plans should not be permitted to second-guess the treating physician’s determination of medical necessity for the care provided.
- **Admission and post-stabilization notification requirements.** Patients should not be transferred unnecessarily given the risk of COVID-19 transmission and limited staffing and personal protective equipment. Treating physicians should be fully empowered to make decisions about where the patient can best be cared for and claims should be paid immediately, regardless of network status.
- **Prior authorization, referral, and concurrent review requirements.** Plans should be required to pay all claims for medically necessary care provided to their enrollees, even if a hospital or other facility was unable to meet all of the plan’s administrative requirements. In addition, plans should be prohibited from implementing inefficient and unnecessary barriers to timely care and payment. For example, several plans enforce arbitrary limits of a single account/patient per phone call, which impedes hospitals’ ability to efficiently communicate with the plan.
- **Retrospective reduction of the level of care and associated payment.** Plans should not be permitted to second-guess the treating physician’s determination of the level of care needed by a patient.
- **Post-acute care services.** Skilled-nursing facilities and other post-acute services are experiencing tremendous challenges during this pandemic. Plans should be required to reimburse hospitals for care provided at the level billed when an alternative post-acute care setting — including skilled nursing, acute rehabilitation, long-term acute care, and home health — is not available. In addition, plans should not require preauthorization for post-acute placements.
- **Extend prior authorizations and referrals.** Hospitals have created capacity for the surge by postponing a significant number of elective procedures. All prior authorizations and referrals that would otherwise have expired during the pandemic should be automatically extended throughout the Governor’s emergency declaration, and for 180 days thereafter — even if the patient lost coverage in the interim. The patient should not be penalized because of the COVID pandemic; neither should the health plan get a windfall by not having to pay for a

procedure that it received premium for, budgeted for, and authorized. Plans should be required to honor these prior authorizations; they have received millions of dollars in premiums for these services that could not be provided.

- **Automatic medical record requests.** Many health plans automatically request a copy of the patient’s medical record prior to processing a claim. Plans should be required to pay the claim prior to requesting the record, to ensure that they request medical records only when necessary and not just to delay payment.
- **Coordination of benefits.** Some plans automatically deny payment if the patient has not signed a form indicating whether they have other coverage. Patients often have difficulty returning these forms, a fact that plans may rely on to delay or deny payment. Plans should be required to pay these claims without delay.
- **Timely filing requirements.** Plans require hospitals to file claims within specified timeframes. Given that hospitals have had to move their employees quickly to remote work, and have had to adjust their workforce due to sick workers and workers losing their child care, some claims may not be filed in the usual time frame. Timely filing requirements should be extended during this pandemic and for 180 days afterwards to ensure claims for medically necessary services are paid.
- **Share of cost.** Many plans have waived patient share of cost requirements for COVID-19. This should be broadly applied. Plans should also develop and clearly communicate procedures to ensure the provider receives full reimbursement; providers should be made financially whole for the waiver of any cost-sharing obligations.
- **Network provider and location restrictions.** Contracted hospitals, affiliated medical groups and partners have been making rapid staffing, service, and physical plant changes. Plan credentialing and network status requirements should be revised so all providers and locations are considered in-network and patients are protected from unexpected out-of-network charges — particularly since in-network options may not be available.
- **Value-based care.** Hospitals should not be penalized for the extraordinary measures taken to manage the COVID-19 public health emergency. Instead, providers should be held harmless for downside risk.

This short-term financial relief will help hospitals continue to care for patients suspected and confirmed to have COVID-19 during this public health emergency. Hospitals are here for all Californians during this crisis and, with future assistance, will be here during the long road to recovery.

Sincerely,



Dietmar Grellmann  
Senior Vice President, Policy

cc: Bradley Gilbert, MD, MPH, Director, Department of Health Care Services  
Jacey Cooper, Chief Deputy Director and State Medicaid Director, Department of Health Care Services