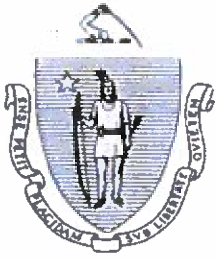

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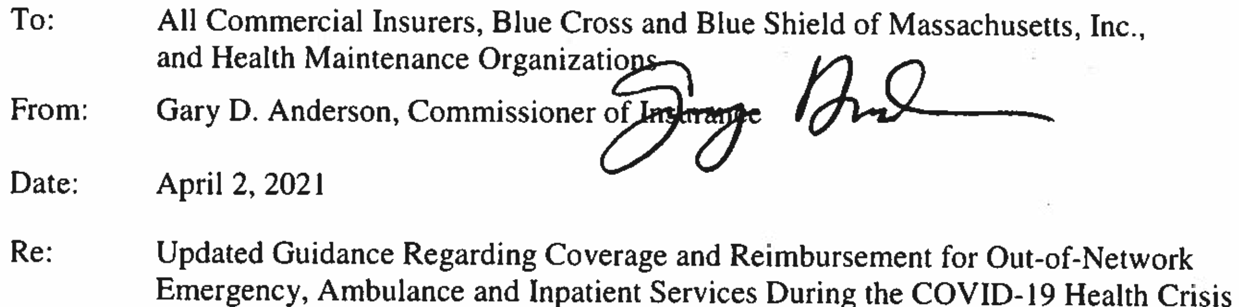
BULLETIN 2021-03



To:	All Commercial Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations
From:	Gary D. Anderson, Commissioner of Insurance
Date:	April 2, 2021
Re:	Updated Guidance Regarding Coverage and Reimbursement for Out-of-Network Emergency, Ambulance and Inpatient Services During the COVID-19 Health Crisis

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The Division of Insurance ("Division") issues this this Bulletin to supplement and in some cases supersede the provisions of Bulletin 2020-10 ("Credentialing and Prior Authorization during COVID-19 (Coronavirus) Health Crisis") and Bulletin 2020-13 ("Coverage for COVID-19 Treatment and Out-of-Network Emergency and Inpatient Reimbursement During the COVID-19 Health Crisis") to provide information to Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations ("Carriers") in response to Chapter 260 of the Acts of 2020 ("Chapter 260"), "An Act Promoting a Resilient Health Care System that Puts Patients First." This Bulletin outlines the Division's expectations regarding steps Carriers are to take regarding coverage of services related to and impacted by COVID-19.

As noted in Bulletin 2020-13, Governor Baker issued an "Order Expanding Access to Inpatient Services" ("COVID-19 Order No. 25") that became effective on April 9, 2020. The Division issued Bulletin 2020-13 to implement COVID-19 Order No. 25, to establish standards for making medically necessary emergency department and inpatient services to treat COVID-19 as widely available as possible, and to ensure that the cost of those services would not pose a barrier to Massachusetts residents receiving care during the period of the Commonwealth's public emergency. Among the provisions of Chapter 260, Section 70 ("Section 70") requires that Carriers' insured health plans issued or renewed in Massachusetts "shall provide coverage, without any requirement of cost sharing by the insured, for all emergency, inpatient and cognitive rehabilitation services, including all professional, diagnostic and laboratory services, related to the 2019 novel coronavirus, also known as COVID-19, at both in-network and out-of-network providers." With the passage of

Chapter 260, effective January 1, 2021, Massachusetts has established a statutory requirement that insured health plans issued or renewed in the Commonwealth of Massachusetts provide appropriate access to care related to COVID-19 without the need for the continuation of the COVID-19 Order No. 25. On January 21, 2021, Governor Baker issued a "Revised Order Expanding Access to Inpatient Services" ("COVID-19 Order No. 61"), rescinding COVID-19 Order No. 25 and reiterating the coverage requirements of Section 70.

Carriers are, therefore, required to follow the statutory standards as created under Chapter 260. The Division issues this guidance to clarify the provisions of Chapter 260 and COVID-19 Order No. 61, while notifying Massachusetts Carriers that it expects them to take all necessary steps to enable their covered members to obtain medically necessary and appropriate testing and treatment that will help fight the spread of this disease.

Treating COVID-19

Carriers are to do the following regarding COVID-19 related services:

- When delivered by in-network providers who are licensed by DPH, Carriers are to provide coverage and forego any cost-sharing (deductibles, coinsurance, or copayments) for medically necessary outpatient COVID-19 treatment and cognitive rehabilitation services, including professional, diagnostic, or laboratory services, in accordance with DPH and CDC guidelines.
- When delivered by either in-network or out-of-network providers who are licensed by DPH, Carriers are to provide coverage, and forego any cost-sharing (deductibles, coinsurance, or copayments) for medically necessary emergency department inpatient, and cognitive rehabilitation services for COVID-19 treatment, including professional, diagnostic, or laboratory services, in accordance with DPH and CDC guidelines.
- All in-network providers are to be reimbursed at the contractually allowed amounts for those members with whom the Carrier has a contract and who participate in a member's health plan.

The standards for medically necessary COVID-19 treatment not related to this Bulletin remain unchanged from what was stated in Bulletins 2020-02, 2020-04, and 2020-10. Carriers can proceed with concurrent reviews of stays as permitted by law.

Coverage for COVID-19 Treatment in Facilities

The Division encourages patient access to available medically necessary services in order to address issues that may arise due to potential inpatient acute hospital bed shortages during the state of emergency. The Division therefore expects that Carriers, without any prior authorization requirements, will provide coverage for medically necessary emergency department and inpatient services and cognitive rehabilitation services rendered by out-of-network acute care hospitals and non-acute care facilities licensed by DPH, including professional, diagnostic, or laboratory services, in accordance with DPH and CDC guidelines, and that Carriers will enable patient transfer and reimburse for the cost to transfer patients to other facilities as needed to meet the challenges posed by the number of seriously ill COVID-19 patients. During this public health crisis, inpatient hospitals need greater flexibility to move patients among the available ICU, acute, and sub-acute

inpatient beds throughout the health care system so that no patient is forced to remain longer than necessary at a needed bed due to delays in obtaining prior authorization approvals from Carriers' utilization systems.

The Division expects all Carriers to suspend any prior authorization systems that may be delaying patients from being moved to lower levels of needed care, especially from acute care hospitals to noncustodial rehabilitation care in rehabilitation hospitals, skilled nursing facilities, or lower intensity facilities Such lower levels of care should be utilized for those complex patients who no longer need to remain in acute care hospital beds but who continue to require ventilators/respirators to address COVID-19. In addition, Carriers are to suspend any prior authorization systems that may apply to the cost to transport covered persons as noted to the lower levels of needed care.

Carriers should provide inpatient hospitals with up-to-date lists of in-network rehabilitation hospitals and skilled nursing facilities. Hospitals should use their best efforts to transfer patients to an in-network hospital, but a hospital may refer patients to out-of-network facilities when in-network facilities are not available. While Carriers are not permitted to require prior authorization, Carriers may conduct concurrent and retrospective reviews after the patient is admitted. Facilities are required to notify the patient's Carrier within 48 hours of a patient's admission to the rehabilitation hospital or skilled nursing facility.

When patients are transferred from an acute care hospital to an in-network rehabilitation hospital or skilled nursing facility for medically necessary care, the Carrier is to reimburse the facility based upon its contractual rate.

Inpatient Care and Transfer to Home Health Care

The Division expects all Carriers to suspend any prior authorization systems that may impede patients from being able to stay home to receive medically necessary and appropriate home health care.

Carriers should provide inpatient hospitals with up-to-date lists of in-network home health care agencies, and hospitals should use their best efforts to transfer patients to in-network agencies for home health care, but a hospital may refer patients to out-of-network agencies when in-network facilities are not available. While a Carrier is not permitted to require prior authorization for COVID-19 home health care services, there must be a plan of care that has been established and approved in writing by a provider acting within the scope of their licensure. Carriers may conduct concurrent and retrospective reviews after home health care has begun. Home health agencies are required to notify the patient's Carrier within 48 hours of the first home health visit.

When patients are transferred from an acute care hospital to their homes to receive home health care, the Carrier is to reimburse the home health care agency for medically necessary care based upon its contractual rate.

Payment for Out-of-Network Treatment for COVID-19

As required by COVID-19 Order No. 61, during any period in which one or more regions of the

Commonwealth has been identified by DPH as being in the COVID-19 Resurgent Planning and Response level of Tier 2 or higher, in order to treat COVID-19 in accordance with DPH and CDC guidelines, Carriers are expected to reimburse out-of-network acute care hospitals and the out-of-network providers providing emergency department and inpatient services, including professional, diagnostic, or laboratory services for COVID-19 related treatment in the following manner:

- For acute care hospitals and providers providing services at or for patients of such hospital with which the Carrier has a contract, but which do not participate in a member's health plan, medically necessary services, including all professional, diagnostic, and laboratory services, shall be reimbursed at the provider's contracted rate with the Carrier for delivered services;
- For acute care hospitals and non-acute care facilities and providers providing services at or for patients of such hospital and non-acute care facilities with which the Carrier does not have a contract, unless a Carrier is otherwise directed by the Division, medically necessary services including all professional, diagnostic, and laboratory services, shall be reimbursed at a rate equal to 135 percent of the rate paid by Medicare for those services in the provider's geographic region.

The Division will notify carriers once all regions have fallen below Tier 2 of the Resurgence Planning and Response Framework. Until such time, all regions are required to comply with the requirements of COVID-19 Order #61. At this time, none of the regions are below Tier 2, but the Division will notify carriers weekly about the current status of the regions so that carriers can prepare their systems so that appropriate adjustments are made when notified by the Division that all the regions have fallen below Tier 2 of the Resurgence Planning and Response Framework. Carriers will be deemed in compliance with the appropriate status so long as they make adjustments in compliance with said weekly Division guidance within 21 days of the applicable weekly notification.

Providers licensed by DPH shall not be permitted to balance bill the insured for any amount above the Carrier's reimbursement.

Carriers Acting As Administrators

Due to the public health crisis caused by COVID-19, the Division continues to request that when Carriers are acting as administrators for employment-sponsored non-insured health benefit plans, the Division expects Carriers to encourage plan sponsors to take steps that are consistent with the provisions of Bulletin 2021-03. Plan sponsors should be made aware of the public health risks to all Massachusetts residents, and Carriers should do all they can to encourage plan sponsors to take steps to remove barriers to accessing medically necessary testing, diagnosis, counseling, and treatment of Coronavirus and to encourage full coverage for out-of-network emergency department, inpatient services, and cognitive rehabilitation services.

If you have any questions about this Bulletin, please contact Kevin Beagan, Deputy Commissioner for the Health Care Access Bureau, at (617) 521-7323.