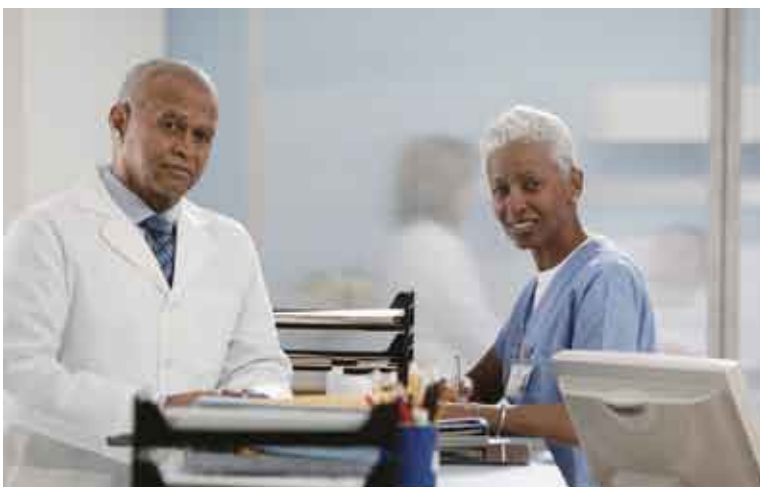


California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Volume III: Payers



California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Foundational Knowledge

Volume I: Hospitals

Volume II: Government-Authorized Alternate Care Sites

Volume III: [Payers](#)

Volume IV: Licensed Healthcare Clinics (available 2008)

Volume V: Long-Term Care Facilities (available 2008)

Volume VI: Licensed Healthcare Professionals (available 2008)

Hospital Operational Tools Manual

Government-Authorized Alternate Care Site Operational Tools Manual

Foundational Knowledge Training Guide

Hospital Training Guide

Government-Authorized Alternate Care Site Training Guide

Payer Training Guide

Reference Manual



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1. California's Healthcare System Response to a Healthcare Surge

An attack using biological, chemical, or radiologic agents, the emergence of diseases such as severe acute respiratory syndrome or pandemic influenza or the occurrence of a natural disaster are threats capable of imposing significant demands on California's healthcare resources and state-wide healthcare delivery system. While California has built a strong network of healthcare services and agencies through local health departments, local emergency medical services agencies, hospitals, clinics, long term care facilities and healthcare professionals, developing a coordinated response to a dramatic increase in the number of individuals requiring medical assistance following a catastrophic event will be challenging. The overwhelming increase in demands for medical care arising out of such an event is called healthcare surge. While many hospitals, clinics and other healthcare providers have developed individualized healthcare surge plans, the sheer magnitude of a disaster or wide-spread disease may require a different planning approach.

In *Emergency Management Principles and Practices for Healthcare Systems*¹, the Institute for Crisis, Disaster, and Risk Management has found that healthcare system response during emergencies demonstrates the following recurrent findings:

- Local response is primary: The initial response to any medical event will be almost entirely based upon locally available health and medical organizations.
- Medical response is complex: The response to a large scale emergency impacts an entire community and involves numerous diverse medical and public health entities, including healthcare systems and facilities, public health departments, emergency medical services, medical laboratories, individual healthcare practitioners, and medical support services.
- Coordinated response is essential: An effective healthcare system response to major events usually requires support from public safety agencies and other community response entities that are not normally partnered with the community healthcare systems during everyday operations.
- Bridging the "public-private divide": Healthcare organizations have traditionally planned and responded to emergencies as individual entities. This has occurred in part because of the "public-private divide," the legal, financial, and logistical issues in planning and coordination between public agencies and primarily private healthcare entities. Healthcare organizations must view themselves as an integrated component of a larger response system.
- Public health as an essential partner: Public health departments are not traditionally integrated with other community emergency response operations, including the acute care medical and mental health communities.



Public health departments are an essential partner in any successful response to a healthcare surge.

- The need for robust information processing: Medical issues that arise from large scale incidents are rarely immediately apparent, and complex information must be collected from disparate sources, processed and analyzed rapidly in order to determine the most appropriate course of action. This requires a robust information management process that can differ markedly from any routinely used healthcare system.
- The need for effective overall management: Medical response to a healthcare surge situation can be exceedingly complex, with many seemingly diverse tasks. Responsibility for each of these activities can vary significantly among organizations in different communities. Even within a single healthcare system, many actions require coordination between disparate operating units that don't work together on a regular basis. Despite these challenges, all necessary functions must be adequately addressed for a successful mass casualty or mass effect response.
- Medical system resiliency: A major hazard impact that creates the need for healthcare surge capacity also is likely to impact the normal functions of the everyday healthcare systems (i.e., some degree of mass effect). Medical system resiliency is necessary for the system to maintain its usual effectiveness and, at the same time, to provide a reliably functioning platform upon which medical surge may occur. Medical system resiliency is achieved by a combination of mitigation measures and adequate emergency preparedness, assuring continuity of healthcare system operations despite emergency.

Healthcare providers face several challenges achieving optimal emergency preparedness. The traditional approaches to delivering healthcare do not typically support an integrated community-wide response that is usually necessary during a healthcare surge. Therefore, it is critical that healthcare systems and providers not only be prepared to provide services on individual basis but also be prepared to participate in an overall emergency community response. An effective response will assure healthcare system resiliency as well as the most efficient care for victims given the severity of the event.

1.1 California Department of Public Health Initiates Planning for Healthcare Surge

In order to assist communities and healthcare providers to successfully plan for a healthcare surge, in 2007 the California Department of Public Health (CDPH) launched a project to address the issues of surge capacity during an emergency. The *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project was initiated to develop standards and guidelines manuals to assist healthcare providers develop plans for responding to a healthcare surge.



A key predecessor to the *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project was the California Hospital Surge Capacity Survey that CDPH conducted in February 2006. Survey findings determined that many California healthcare providers could improve their planning process to identify the resources that would be needed to treat patients during surge emergencies. Based upon these findings, the State Budget Act for fiscal year 2006-2007 authorized CDPH to initiate the *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project to identify obstacles hindering healthcare delivery during a healthcare surge and to identify strategies and recommendations to mitigate the identified obstacles.

To identify key surge planning issues, CDPH undertook a multi-phase process that involved bringing together participants representing federal agencies, national organizations, state agencies, local health departments, healthcare providers, health plans and community organizations to identify issues and develop recommendations to address those issues. The project placed particular emphasis on a framework for standards of care and scope of practice during an emergency, liability of healthcare providers during a surge, reimbursement of care provided during an emergency, planning for and operating alternate care sites and surge capacity operating plans at individual hospitals.

The results of these earlier activities form the basis for the healthcare standards and guidelines manuals, operational tools, reference manual and training curriculum which are intended to help every community and healthcare provider in California plan and put into operation an effective surge response to major disasters.

1.2 Healthcare Surge Standards and Guidelines Manuals, Operational Tools and Training Curriculum

The surge planning materials have been assembled into healthcare surge standards and guidelines manuals which contain recommendations and options for consideration by communities and providers planning for a healthcare surge. Materials should be evaluated for implementation based upon specific needs of the emergency but should not be considered mandates or requirements issued by the State of California. Applicability of an individual guideline and recommendation will be dependent upon the specific emergency or the surrounding circumstances as well as community and provider structure.

The Standards and Guidelines Manuals issued from this project are:

- **Foundational Knowledge.** This manual defines healthcare surge, describes the existing emergency response system in California and how healthcare providers participate in this system. It also discusses transitioning patient care from individually-focused to population-based care in a severe surge. This manual is prerequisite to volumes I -III, operational tools, reference manual and training curriculum described below.



- **Volume I: Hospitals.** Primarily developed for use by hospitals, but also beneficial for use by other providers and health plans, this manual contains information on general emergency response planning and related integration activities for hospitals. This manual also includes guidance for hospitals related to increasing capacity and expanding existing workforce during a surge, augmenting both clinical and non-clinical staff to address specific healthcare demands, addressing challenges related to patient privacy and other relevant operational and staffing issues during surge conditions. This manual addresses the assets under a hospital's control that can be used to expand capacity and respond to a healthcare surge.
- **Volume II: Government-Authorized Alternate Care Sites.** This manual contains planning information related to the establishment of government-authorized Alternate Care Sites that may be used for healthcare delivery during a healthcare surge. It includes specific guidance and general planning considerations for coordinating site locations, developing staffing models, defining standards of care and developing administrative protocols. Specific guidance on federal and State reimbursement at government-authorized alternate care sites is also provided.
- **Volume III: Payers.** This manual outlines specific sets of recommendations for commercial health plans to consider when working with providers, employers and others during the surge planning process. Recommended approaches to changes in contract provisions which focus on simplifying administrative and reimbursement requirements are included. This volume also contains specific information on the impact that a healthcare surge may have on a health plan's administrative and financial relationship with Medicare Advantage, Medi-Cal Managed Care and Workers' Compensation.
- **Other Reference Material:**
 - **Operational Tools Manuals.** Includes forms, checklists and templates that might be used by providers and health plans to assist in the implementation of recommendations and strategies outlined in the respective Standards and Guidelines Manual.
 - **Reference Manual.** The reference manual contains an overview of federal and State regulations and compliance issues, including statutes, laws, regulations and standards and their corresponding legal interpretations and potential implications for use during a healthcare surge. Also included in the reference manual is detailed information regarding Hospital Incident Command System roles and responsibilities to assist with planning for command staff at a hospital. In addition, information regarding funding sources that may be available during a declared healthcare surge is included as well as those funding sources that were used during previous states of emergency.



Training Curriculum. Outlines the intended audience, methods of delivery and frequency of training for the information presented in the manuals.

These volumes are meant to be actively used for community and provider planning for a healthcare surge. The information contained in the materials will be updated as new information is learned and community surge planning practices evolve.

Additional volumes, operational tools and training curriculum that address clinics, licensed healthcare professionals and long-term care facilities are in development and are scheduled to be issued in 2008.

1.3 Key Healthcare Surge Planning Concepts for California

The following key healthcare surge planning concepts provide the context and perspective to understand the information presented in the healthcare surge standards and guidelines manuals for California.

During a catastrophic emergency, the movement from individual-based care to population-based outcomes challenges the professional, regulatory, and ethical paradigms of the healthcare delivery system. The standard of care will focus on saving the maximum number of lives possible. The standard of care during a healthcare surge is defined as the utilization of skills, diligence and reasonable exercise of judgment in furtherance of optimizing population outcomes that a reasonably prudent person or entity with comparable training, experience or capacity would have used under the circumstances.

Under current state statute and regulations, a move to a population-based healthcare response may be challenging. When a State statute or regulation does not provide flexibility during a healthcare surge, Executive Standby Orders issued by the Governor following his/her issuance of a declaration of emergency may result in suspensions that allow for flexibility. The manuals provide relatively straightforward examples of Executive Standby Orders and possible suspensions that may be put into effect during surge conditions.

In California, a healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee,² using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local jurisdiction/Operational Area medical and health status.



The coordination of activities during a healthcare surge entails significant responsibilities for local government as well as hospitals and other community healthcare professionals. Local government will be responsible for determining the state of the healthcare surge and the identification of and planning for the operations of Government-Authorized Alternate Care Sites. While the ultimate determination regarding surge related activities will be made by local government, healthcare providers and payers will be kept informed to provide a coordinated and integrated response.

A key barrier to effective healthcare surge response is the complexity of the healthcare delivery system. The intent of the *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project is not to solve the challenges of the current healthcare delivery system but to operate within it. This is primarily addressed by considering the elements of response from an operating rather than a regulatory point of view.

While the current healthcare delivery system is complex, several areas can be simplified, such as professional scope of practice, recruitment of personnel, and patient tracking for clinical and administrative purposes. This simplification emphasizes the operational necessities of a coordinated response in a catastrophic event.

Preserving the overall financial liquidity of the healthcare delivery system during a catastrophe is an issue that is larger than any single stakeholder. There are practical ways that hospitals can take proactive steps to preserve a revenue stream during a surge event, while payers (government and commercial) can more effectively meet their obligations for their covered beneficiaries under the traditional third party payer system.

Ultimately, effective surge response requires all stakeholders to accept new responsibilities, behave differently than they may have been trained, and cooperate with each other in unprecedented ways. The purpose of these and future surge standards and guideline materials is to proactively engage California communities in advance planning for a healthcare surge and provide tools and training to support the surge planning process.

1.4 Overview of Payers Volume

A catastrophic emergency, whether a natural disaster, infectious disease or terrorist attack, will dramatically impact California's healthcare system. It is critical that hospitals, healthcare professionals and health plans doing business in California proactively work together to redefine the nature of their relationships to prepare for a healthcare surge and mitigate its potential impact on patient care, access and funding. Given the unpredictable nature of a disaster and its potential to significantly impact the healthcare delivery system, sufficient planning and coordination between providers and payers will be essential to maintain business continuity and sustain operations at facilities providing medical care.



During a healthcare surge, the delivery of care will be different. The standard of care may change based on available resources. The scope of a provider's practice may change based on need, sites of care may look different due to access issues, and the traditional methods of claims identification and submission may be forced to undergo adjustments that require practical solutions. Additionally, during a catastrophic emergency, the primary focus of the healthcare community will be on responding to the emergency and caring for the ill and injured. These changes will require providers to work with health plan partners to meet the needs of the healthcare surge environment and ensure adequate provisions of care and cash flow.

“Healthcare surge” has varying meanings to participants in the healthcare system. For planning a response to a catastrophic emergency in California, “healthcare surge” is defined as follows: A healthcare surge is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment, determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services.

Health plans play a key but distinct role during a catastrophic emergency and have unique issues that must be addressed. Key issues for health plans during a catastrophic emergency to consider include the following :

- Within California, the structure of the relationship between the health plan and provider, in most instances, is based on the network model, which may include a gatekeeper, a predetermined set of providers and defined protocols and standards of care. The network model in a surge environment may be disrupted as the provision of care in a catastrophic emergency will reflect the care appropriate to the resource demands of the disaster. Access to the appropriate provider and/or level of care, as dictated by a health plan or assigned medical group, may not be possible due to situational constraints.
- Noncompliance with pre-authorization requirements could limit provider payment for some services, and the plan requirement that physicians be licensed in the state in which they practice may preclude out-of-state healthcare professionals from providing assistance.
- Recognizing that healthcare surge conditions may preclude the ability to follow normal reimbursement rules and protocols while providing care that would be reimbursable under nonsurge conditions, health plans and providers should proactively develop streamlined reimbursement mechanisms to solve administrative complications and deficiencies that may present themselves during a healthcare surge.
- There is a strong likelihood that health plans will receive a significant increase in the volume of claims. Furthermore, health plans should anticipate that they may be



challenged by administrative complexities due to an increase in paper claims, claims from non-network providers, incomplete and/or late claims, claims sent in error, or claims for members who are no longer eligible. The increased volume of claims may put a strain on health plan reserves, systems and processes.

- Employer premium payments and eligibility listings during a healthcare surge may be late, missing and/or inaccurate.
- The circumstances surrounding a healthcare surge may create business continuity challenges when information technology is unavailable, impacting communication with providers, continuity of care, claims submission and payments.
- Health plan members may receive healthcare services at an Alternative Care Site during a healthcare surge. Health plans are not financially liable for services rendered to members at unlicensed healthcare facilities. However, surge planning for health plans should include a process to collect health related data from Alternative Care Sites for tracking and reporting, as well as for health related follow-up with their primary care provider.

To address these and other considerations, it is recommended that health plans develop disaster recovery plans. Some guidelines for such a plan have been developed by the U.S. Office of Personnel Management, the details of which will be discussed later in this document.

While viability of the post-emergency healthcare system should be strongly considered in any healthcare surge planning efforts, this document is not intended to address the inefficiencies and fragmentation of the current system nor the restructuring of the financial mechanisms supporting that system. Although longer term follow-up and solutions may be needed to address all the financial challenges that a healthcare surge may pose on both health plans and providers, this document solely addresses how the current system can meet the financial needs of a healthcare surge.

This document is intended to serve as a guide to assist representatives from commercial health plans, network providers, public payers and employer groups to work together to address the impact that a healthcare surge might have on the healthcare system, including health plan and provider operations, contractual requirements, premium payments and member coverage. The content in this volume addresses health plans with respect to licensed healthcare providers and is not intended to apply to Alternate Care Sites. With this goal in mind, this document contains general and specific planning considerations that health plans can use in managing their various products and relationships during a healthcare surge, thus promoting patient care, access and funding, business continuity and sustained operations at facilities providing medical care.



2. Planning Considerations

While each catastrophic emergency brings its own set of unique operational and financial challenges, health plans can take steps to develop a healthcare surge response that will be flexible and adaptable to the specific needs of the situation.

As a guide, this section contains tools to assist in the development of a proactive plan for health plans, such as developing a disaster recovery plan, as well as product-specific planning considerations and suggested guidelines for health plans to manage commercial, Medicare Advantage and Medi-Cal Managed Care business. Also included are planning considerations and discussion points for health plans' interactions with providers and employer groups.

2.1. Healthcare Surge Response and Disaster Recovery

As current policies and regulations do not fully address all of the funding and reimbursement issues that may arise during a healthcare surge, it is recommended that health plans develop disaster recovery plans to address how their organization will respond during a healthcare surge. Developing these plans preemptively limits the confusion that may arise during a catastrophic event and provides the health plans' members, providers and community with the opportunity to prepare appropriately.

The rules, requirements, policies and procedures that health plans enforce during normal operating procedures may present impediments to healthcare delivery during a healthcare surge. Health plans may want to address and minimize these anticipated risks in their disaster recovery plans, outlining how their rules, requirements, policies and procedures may be altered during a healthcare surge to meet the needs of their members in the affected area. For example, in accordance with the U.S. Office of Personnel Management requirements, health plans currently serving federal employees through the Federal Employee Health Benefits Plan are developing disaster recovery plans that address flexibility for the following payer rules, requirements, policies and procedures:

- Medical and pharmacy procedures and requirements
- Barriers to accessing needed healthcare
- Authorization for out-of-network medical services
- Alternatives for medical pre-certification, referrals, medical necessity review and notification of hospital admissions
- Accessing other primary care physicians or specialists
- Pharmacy restrictions, refills, additional supplies of medications as backup
- Mail order pharmacy



- Adhering to recommendations for vaccinations from the Center for Disease Control
- Claims payment
- Crisis toll free hotline
- Ability to identify current members
- Recovery procedures for critical business functions (i.e., system, network, communication, work area recovery)
- Secure backup site (hot/cold). A 'hot work site' is a designated location where employees can go in the event of a disaster that is fully prepared for continuation of work. A 'cold work site' is a designated location where employees can go in the event of a disaster that is not fully prepared for continuation of work.³

These elements are purposefully nonprescriptive to allow each health plan to respond to specific issues that are most appropriate for that organization. The U.S. Office of Personnel Management disaster recovery plan requirements can serve as guidance for health plans to develop their own approach to a healthcare surge for other market segments, addressing each topic with the appropriate key constituents. Each health plan can choose to address or modify these issues, as appropriate, to their own organization's operational needs.

2.2. Planning Considerations Across Multiple Product Types

In order to prepare financially for a healthcare surge, health plans and providers should initiate discussions to address the potential challenges and barriers that a healthcare surge may generate. Maintaining existing revenue streams during healthcare surge will likely depend on health plan and provider organizations addressing disaster-related concerns in advance through contract provisions. Sufficient planning and coordination between health plans and providers will be essential to maintaining business continuity and sustaining operations at facilities providing medical care during a healthcare surge. During a healthcare surge it will be reasonable to expect that most healthcare personnel will be devoted to patient care. Additionally, current electronic systems may be nonfunctional or unavailable. As such, administrative billing functions under healthcare surge conditions may need to be reduced or retooled to meet minimum requirements.

Health plans often offer multiple products, including commercial, Medicare Advantage, Medi-Cal Managed Care and Workers' Compensation. Many of the recommendations for managing and preparing for a healthcare surge response are applicable to multiple products. The following tables provide a summary snapshot of steps pertaining to rates, policies and procedures, and access and coverage that health plans may want to consider in managing multiple products before and during a healthcare surge. More detail on product specific recommendations are included in the product specific sections of this volume.



	Product Type			
	Commercial	Medicare Advantage	Medi-Cal Managed Care	Workers' Compensation
Rates Issues				
Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care.	X	X	X	
Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow.	X	X	X	
Consider modifying contract language with independent practice associations / medical groups and hospitals to provide for an automatic increase in per-member per-month payment (capitation) during a surge, when appropriate.	X	X	X	
Move toward a common reimbursement system, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process.	X	X	X	
Policies and Procedures Issues				
Modify timely filing provisions to accommodate late or delayed claims which may be due to lack of correct benefit and eligibility information.	X	X	X	
Proactively develop messaging for providers, employer groups and members to communicate surge protocols and administrative procedures.	X		X	
Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses.	X	X	X	X
Create policies to expedite cash flow during a declared healthcare surge.	X	X	X	X



	Product Type			
	Commercial	Medicare Advantage	Medi-Cal Managed Care	Workers' Compensation
Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into the provider contracts.	X	X	X	X
Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge.	X	X	X	X
Accommodate late or delayed premium payments through change in contract language.	X	X		X
Access and Coverage Issues				
For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available.	X	X		
Maintain full benefits for members seeking care or accessing care at out-of-network providers due to availability.	X	X		X

While the considerations in the table above are recommendations currently up to the discretion of health plans to implement, health plans should be prepared for the possibility that during a catastrophic emergency, the Governor and the Department of Managed Health Care may mandate the adoption of some of these policies. Health plans that independently and proactively address these issues prior to mandates from the Department of Managed Health Care will be better prepared to meet the challenges of a catastrophic emergency. For more information on the Department of Managed Health Care and its authority during a healthcare surge see Section 4.1: The Department of Managed Health Care's Role During a Healthcare Surge.

2.3. Health Plans and Commercial Products

The majority of health plans in California provide healthcare coverage to individuals and families through either an employer sponsored plan or individual purchase. The availability of specific networks, providers and healthcare benefits varies based on the health plan and



coverage that was purchased. For fully insured employer sponsored benefit plans, the employer is responsible for all premium payments to the health plan. These payments are based on eligible subscribers and dependents for the payment period. Payment to the health plan for individual coverage comes directly from the covered member to the health plan. While health maintenance organization benefit plans continue to be the dominant model in California, health plans are offering a greater selection of plans with consumer driven features, including greater out-of-pocket costs for the member as well as co-payment differentials based on cost and quality. These trends cause additional administrative challenges for both the health plan and the provider.

In commercial health insurance, employer groups and their covered members generally gain access to healthcare providers through an organized network of providers. Provider networks are built through a complex set of contractual relationships, which include agreement between the health plan and providers on all aspects of the relationship including rate provisions, administrative procedures, claims requirements and payment obligations.

If a healthcare surge develops, health plans and providers may be challenged to meet their contractual obligations. While considerations related to general disaster planning were discussed above, outlined below are steps health plans may want to consider when working with providers and employer groups to prepare for a healthcare surge.

Health Plans and Commercial Products Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care. Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow. Consider modifying contract language with independent practice associations / medical groups and hospitals to provide for an automatic increase in capitation during a surge, when appropriate. 	<ul style="list-style-type: none"> Modify timely filing provisions to accommodate late or delayed claims which may be due to lack of correct benefit and eligibility information. Proactively develop messaging for providers, employer groups and members to communicate surge protocols and administrative procedures. Accommodate late or delayed premium payments through change in contract language. 	<ul style="list-style-type: none"> For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available. Maintain full benefits for members seeking care or accessing care at out-of-network providers due to availability.



Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> • Move toward a common reimbursement system, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process. • Consider premium payment deferrals for employer groups with reasonable time frames around premium payments. 	<ul style="list-style-type: none"> • Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow during a declared healthcare surge. • Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into the provider contracts. • Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge. 	

One of the challenges in preparing for the financial consequences of a healthcare surge is the highly situational nature of any healthcare surge response. As such, it may be helpful to review in greater depth the California and federal laws and regulations addressing how health plans can respond to patient care, access and financing issues during a healthcare surge, as well as the types of responses that have occurred historically. In some cases, laws and regulations dictate how health plans must respond during a catastrophic emergency, what health plans are required to provide their members and what protections their members are afforded. In other cases, past responses can serve as a reference with specific examples of the kinds of responses that *may* occur in the future. The tables that follow outline certain rules, requirements and other issues that may impact commercial health plan products, members and providers, pertinent regulations that affect how a health plan can respond to the issue, and examples or applications from previous catastrophic events. The tables serve as a reference tool to assist health plans as they develop plans to address specific issues. The regulations identified are not all inclusive but are those deemed most appropriate and applicable to health plans during a healthcare surge. The examples of previous responses are not meant to prescribe any future health plan response but act as guidelines for future planning.

The Commercial Products Rule/Requirement/Issue Reference Tables shown on the following page address the following rules/requirements/issues:

- Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member



- Pre-authorization: Issues surrounding providing services with or without prior authorization
- Pharmaceutical coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions
- Co-pay requirements: Issues surrounding member responsibility for co-payments
- Nonpayment of premiums and coverage continuity: Issues surrounding non-payment of premiums and termination of coverage
- Claims management: Issues surrounding claim payments for members with late or non-current premium payments
- Insurance questions and coverage verification: Issues surrounding verifying insurance coverage and other insurance communication needs

Commercial Products Rule/Requirement/Issue Reference Tables

Physician / Network Requirements : Issues surrounding which licensed healthcare professional provides services to a member	
<p>Pertinent California Regulations Related to Accessing Standard Emergency Care</p>	<p>Per 28 CCR 1300.67, "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director of Managed Health Care may approve:</p> <p>Emergency healthcare services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week basis within the healthcare service plan area. Emergency healthcare services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.</p> <p>Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in 28 CCR 1317.1 include active labor. 'Urgently needed services' are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. 'Urgently needed services' include maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area."⁴</p>
<p>Pertinent California Regulations Relating to Coverage During Acts of War</p>	<p>Per 28 CCR 1300.67.05, "no healthcare service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude healthcare services based on a determination that the need for the healthcare service arose as a result of an act of war.</p> <p>The term 'act of war' includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism or warlike action by any individual, government, military, sovereign group, terrorist or other organization."⁵</p>



Physician / Network Requirements : Issues surrounding which licensed healthcare professional provides services to a member	
<p>Pertinent Federal Regulations Relating to Standard Emergency Care for Health Maintenance Organization Members</p>	<p>42 USC Section 300e indicates the "basic health services (and only such supplemental health services as members have contracted for) shall, within the area served by the health maintenance organization, be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency healthcare service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury or condition."⁶</p>
<p>Pertinent Federal Regulations Relating to Coverage During a Natural Disaster</p>	<p>42 USC Section 300e further indicates, "to the extent that a natural disaster, war, riot, civil insurrection or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel or resources."⁷</p>
<p>Pertinent California Regulations Pertaining to Utilizing Out-of-State Healthcare Practitioners</p>	<p>Per Business and Professions Code Section 900:</p> <ol style="list-style-type: none"> a. "Nothing in this division applies to a healthcare practitioner licensed in another state or territory of the United States who offers or provides healthcare for which he or she is licensed, if the healthcare is provided only during a state of emergency as defined in Government Code Section 8558(b), which emergency overwhelms the response capabilities of California healthcare practitioners and only upon the request of the Director of the Emergency Medical Services Authority. b. The Director shall be the medical control and shall designate the licensure and specialty healthcare practitioners required for the specific emergency and shall designate the areas to which they may be deployed. c. Healthcare practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. d. Healthcare practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. e. Healthcare practitioners providing healthcare pursuant to this chapter shall have immunity from liability for services rendered as specified in Government Code Section 8659.



Physician / Network Requirements : Issues surrounding which licensed healthcare professional provides services to a member	
<p>Pertinent California Regulations Pertaining to Utilizing Out-of-State Healthcare Practitioners</p>	<p>f. For the purposes of this chapter, 'healthcare practitioner' means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division.</p> <p>g. For purposes of this chapter, 'Director' means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 of the Health and Safety Code Section 1797."⁸</p>
<p>Pertinent California Regulations Relating to Utilizing Healthcare Practitioners with Lapsed or Inactive Licenses</p>	<p>Per Business and Professions Code Section 921 - 922, Health Care Professional Disaster Response Act:</p> <p>1. "A physician and surgeon who satisfies the requirements of Business and Professions Code Section 2439 but whose license has been expired for less than five years may be licensed under this chapter.</p> <p>2. To be licensed under this chapter, a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of California, and submit it to the board, along with the following:</p> <ul style="list-style-type: none"> a. Documentation that the applicant has completed the continuing education requirements described in Business and Professions Code Section 2190, Chapter 5, Article 10 for each renewal period during which the applicant was not licensed. b. A complete set of fingerprints as required by Business and Professions Code Sections 144 and 2082, together with the fee required for processing those fingerprints. <p>3. An applicant shall not be required to pay any licensing, delinquency, or penalty fees for the issuance of a license under this chapter."⁹</p>
<p>Previous Response Example, Pertinent Waivers or other Application During a Healthcare Surge</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These emergency rules suspended certain statutes and regulations regarding health insurance in Louisiana.¹⁰ • These rules applied to primary and limited secondary parishes in Louisiana affected by the hurricanes over specific time periods.^{11,12} • These rules applied only to products regulated by the Louisiana Department of Insurance. • These rules waived all restrictions relative to out-of-network access. <p>Along with the Governor's emergency rules:</p> <ul style="list-style-type: none"> • Aetna implemented policies for its members in the affected area to receive in-network benefits for care out of their network in any state, and seek care from providers, including dentists, other than their designated primary care physicians.¹³ • United Healthcare provided emergency transportation and treated all area hospitals as participating network hospitals under existing emergency benefit provisions.¹⁴ • Members from the affected disaster areas who could not access CIGNA participating physicians, hospitals or other providers for the dates of service from August 27, 2005, to September 30, 2005, were able to seek care as needed, for which in-



Physician / Network Requirements : Issues surrounding which licensed healthcare professional provides services to a member

	<p>network benefits applied. If members were unable to see their primary care physician, they sought care as needed from any available medical professional.¹⁵</p> <ul style="list-style-type: none"> • Blue Cross of California made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that allowed the affected members to see any physician necessary to provide access to care • Blue Cross of California paid all claims as in-network, regardless of whether or not the healthcare provider was in network.¹⁶
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Pre-Authorization: Issues surrounding providing services with or without prior-authorization

<p>Pertinent California Regulations Relating to Authorization for Medically Necessary Services</p>	<p>Per 28 CCR Section 1300.71.4, "the following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary healthcare services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized healthcare service plan contract that does not provide for medically necessary healthcare services following stabilization of an emergency condition.</p> <ol style="list-style-type: none"> Prior to stabilization of an enrollee's emergency medical condition or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary healthcare services, a healthcare service plan shall pay for all medically necessary healthcare services rendered to an enrollee. In the case when an enrollee is stabilized but the healthcare provider believes that the enrollee requires additional medically necessary healthcare services and may not be discharged safely, the following applies: <ol style="list-style-type: none"> A healthcare service plan shall approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request. If a healthcare service plan fails to approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the healthcare service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided that the healthcare service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition. Notwithstanding the provisions of subsection (b) of this rule, a healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee which are necessary to maintain the enrollee's stabilized
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Pre-Authorization: Issues surrounding providing services with or without prior-authorization

	<p>condition up to the time that the healthcare service plan effectuates the enrollee's transfer or the enrollee is discharged.</p> <p>c. In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another healthcare provider, the following applies:</p> <ol style="list-style-type: none"> 1. When a healthcare service plan responds to a healthcare provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another healthcare provider, the plan shall effectuate the transfer of the enrollee as soon as possible. 2. A healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer. <p>d. All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary healthcare services shall be fully documented. All provision of medically necessary healthcare services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the healthcare provider making the request and the name of the plan representative responding to the request."¹⁷</p>
<p>Previous Response Example, Pertinent Waivers or other Application During a Healthcare Surge</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules suspended: <ul style="list-style-type: none"> – Medical certifications – Referrals – Medical necessity reviews – Notification of hospital admissions – Right to conduct medical necessity reviews (for nonelective services)¹⁸ <p>Some private payers in California updated their force majeure clauses to excuse parties from some of the terms and conditions of the contract if a major disaster occurs.</p> <p>Along with the Governor of Louisiana's emergency rules:</p> <ul style="list-style-type: none"> • Aetna implemented policies for its members in the affected area to receive treatment covered under their plan without medical pre-certification, referrals or notification of hospital admissions.¹⁹ • CIGNA temporarily modified certain standard claim approval requirements including requirements for pre-certification, referrals, medical necessity determinations and hospital admission procedures. Essentially, this entailed suspending the need for members and their providers to get pre-certifications or referrals for procedures and treatments that usually require it. Similarly, they were not reviewing claims for medical necessity.²⁰ • WellPoint Health Networks, the parent company of Blue Cross of California, made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of Hurricane Katrina that:



Pre-Authorization: Issues surrounding providing services with or without prior-authorization

- Suspended requirements for prior authorization and pre-certification
- Suspended requirements for authorization or referral from a primary care physician²¹

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions

Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge

Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.

- These rules stipulated that claims for an initial 30-day supply of prescription medication could not be rejected or pended regardless of date of last refill.²²

Along with the Governor's emergency rules:

- Aetna implemented policies for its members in the affected area to refill prescriptions even if they were not due to be filled and, for those who use Aetna's mail-order pharmacy, receive replacement for any lost or damaged prescriptions for no additional costs.²³
- WellPoint Health Networks, parent company of Blue Cross of California, made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that:
 - Suspended early refill limits and shipping prescriptions to members at alternative addresses
 - Waived co-payments for prescriptions²⁴
- United Healthcare allowed members who needed prescription refills to replace them quickly at local pharmacies or via mail service. Even before the hurricane hit, United Healthcare began allowing members to obtain early refills and extra prescription levels in Alabama, Louisiana and Mississippi.
- For United Healthcare members, local pharmacies in the affected areas were notified about these changes. Members were given a toll-free number to call with any questions on how to replace lost prescriptions. Members who normally used mail pharmacy services and who were in short supply were eligible to obtain medications through their local retail pharmacy. Mail pharmacy orders were expedited by key zip codes to crisis areas. All mail orders for temperature-sensitive prescriptions were assessed on a daily basis to determine appropriate and safe handling for fulfillment.²⁵
- CIGNA Pharmacy Management allowed members to order refills of their prescription medications early to replace medicines lost or destroyed, and waived medical necessity reviews.
- Members who normally received their prescriptions in the mail through CIGNA Tel-Drug were allowed to have medications shipped overnight at no additional cost. If shipping to the member was not feasible, the member could request that the prescription be transferred to a local retail pharmacy. CIGNA Tel-Drug replaced lost or damaged medication at no charge to members.²⁶



Co-Pay Requirements: Issues surrounding member responsibility for co-payments

<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules stipulated that when a claim is submitted but the premium has not been received, the insured was responsible for co-payments, deductibles and coinsurance.²⁷ <p>Along with the Governor's emergency rules:</p> <ul style="list-style-type: none"> • WellPoint Health Networks made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that waived co-payments for prescriptions.²⁸
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Non-Payment of Premiums and Coverage Continuity: Issues surrounding non-payment of premiums and termination of coverage

<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules stipulated that: <ul style="list-style-type: none"> – Individual and group policies could not be cancelled or terminated during the state of emergency even if premiums had not been received.²⁹ – No renewals were allowed until January 1, 2006. – No rate increases were allowed until January 1, 2006. – Employees must be continued under their previous insurance provisions until the state of emergency was lifted if they were laid off. – COBRA and state-continuation (“mini-COBRA”) enrollment timeframes were extended. <p>Along with the Governor's emergency rules:</p> <ul style="list-style-type: none"> • United Healthcare offered deferred payment options to customers and individuals affected by the disaster. • United Healthcare established a multi-million-dollar pool of emergency resources and funds to assist their customers and consumers. United Healthcare used the resources to address insurance premium concerns for affected employers and their employees.³⁰ • CIGNA HealthCare announced that the grace period for receipt of premium payment by their affected customers was extended an additional 30 days, to a total of 61 days, to help offset business challenges caused by the disaster. CIGNA Group Insurance announced it would allow an appropriate extension of time for making premium payments for life, accident and disability coverage, and for certain other time-sensitive policy transactions, such as receipt of medical information and conversion requests for certificate holders in the affected areas.³¹
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Claims Management: Issues surrounding claim payments for members with late or non-current premium payments

<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules stipulated that when a claim is submitted but the premium has not been received: <ul style="list-style-type: none"> – The insured was responsible for co-payments, deductibles and coinsurance. – The insurer paid 50 percent of either the contracted rate or the non-participating rate. – The provider accepted 50 percent as payment in full and could not bill the patient. – If the entire premium was subsequently received, the claim was readjusted and paid according to the contract.³²
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Insurance Questions and Coverage Verification: Issues surrounding verifying insurance coverage and other insurance communication needs

<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<ul style="list-style-type: none"> • America's Health Insurance Plans published a 1-800 number where anyone could call to find their coverage/doctors. America's Health Insurance Plans connected them with their appropriate health plan. Most health plans had a 1-800 number as well. This process remains enabled for future emergency or disaster situations.³³ • United Healthcare established a 24-hour crisis toll-free hotline for anyone in the Gulf Coast.³⁴
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2.4. Health Plans and Medicare Advantage

Many Medicare eligible individuals, those over the age of 65, some people with disabilities under age 65 and individuals with end stage renal disease voluntarily choose to obtain their healthcare through Medicare Advantage programs. Health plans are licensed by the federal government to offer Medicare Advantage products within specified geographic regions which are defined by counties. For each enrolled member, the health plan receives a county specific dollar amount per member per month, with additional dollars being paid for certain clinical diagnosis. Benefit levels are equal to those provided under the traditional Medicare product. Any additional benefits offered by health plans are not mandatory but are offered for competitive differentiation and other purposes.

Similar to the commercial products, health plans develop networks of providers to provide healthcare services to Medicare Advantage enrollees. The physician and hospital networks are often smaller than those offered under the commercial product and contracts are usually limited to the specific counties where the health plan offers the Medicare Advantage product. While historically many hospitals were at financial risk, or paid a per member per month capitation, for a specific population of Medicare Advantage enrollees, the majority of hospitals today are paid a form of fee-for-service reimbursement.



Most physician groups and independent practice associations continue to be paid on an 'at risk', or capitated basis.

Although the administrative and financial issues for health plans administering the Medicare Advantage program are similar to those faced while managing commercial products, Medicare Advantage enrollees pose unique challenges and require that creative solutions be considered during the planning process. The table below presents ideas for health plans to consider in managing these products during a healthcare surge.

Health Plans and Medicare Advantage Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> • Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care. • Move toward a common reimbursement system, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process. • Since Medicare networks are typically smaller than commercial networks, and across fewer counties, negotiate both professional and facility rates with the commercial network that would apply to Medicare Advantage recipients in the event of a healthcare surge. Focus should be on those geographies where a contracted network does not exist. Establish reciprocity rates for other network providers to access, as well. • Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow. 	<ul style="list-style-type: none"> • Modify timely filing provisions to accommodate late or delayed claims which may be due to lack of correct benefit or eligibility information. • Establish clear messaging for Medicare enrollees during the enrollment process and through ongoing communication related to accessing care during a healthcare surge. • Accommodate late or delayed premium payments through change in contract language. • Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow during a declared healthcare surge. • Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into the provider contracts. 	<ul style="list-style-type: none"> • Consider waiving certain requirements when transferring members from one level of care to another. • During a surge, consider expanding coverage for Medicare Advantage members that would facilitate the movement of patients to skilled nursing facilities and home healthcare. • For closed network models, revise preauthorization and referral requirements to allow access to care when needed. • Maintain full benefits for members seeking care or accessing care at out of network providers due to availability. • Proactively address continuity of care issues for Medicare Advantage members.



Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> Consider modifying contract language with medical groups, independent practice associations and hospitals that provide for an automatic increase in capitation during a surge. 	<ul style="list-style-type: none"> Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge. 	

Similar to dealing with commercial products, one of the challenges in preparing for the financial consequences of a healthcare surge with Medicare Advantage products is the highly situational nature of any healthcare surge response. As such, it may be helpful to review in greater depth the California and federal laws and regulations addressing how health plans can respond to patient care, access and financing issues during a healthcare surge, as well as the types of responses that have occurred historically. In some cases, laws and regulations dictate how health plans must respond during a catastrophic emergency, what health plans are required to provide their members and what protections their members are afforded. In other cases, past responses can serve as a reference with specific examples of the kinds of responses that *may* occur in the future. The tables that follow outline certain rules, requirements and other issues that may impact commercial Medicare Advantage products, members and providers, pertinent regulations that affect how a health plan can respond to the issue, and examples or applications from previous catastrophic events. The tables serve as a reference tool to assist health plans as they develop plans to address specific issues. The regulations identified are not all inclusive but are those deemed most appropriate and applicable to health plans during a healthcare surge. The examples of previous responses are not meant to prescribe any future health plan response but act as guidelines for future planning.

The Medicare Advantage Rule/Requirement/Issue Reference Tables shown below address the following rules/requirements/issues:

- **Physician/network requirements:** Issues surrounding which licensed healthcare professional provides services to a member
- **Pre-authorization:** Issues surrounding providing services with or without prior-authorization
- **Pharmaceutical coverage:** Issues surrounding early refills and member co-payments for pharmaceutical prescriptions
- **Nonpayment of premiums and coverage continuity:** Issues surrounding non-payment of premiums and termination of coverage



Medicare Advantage Rule/Requirement/Issue Reference Tables

Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member	
<p>Pertinent Federal Regulations Related to Accessing Standard Emergency Care</p>	<p>According to the Centers for Medicare and Medicaid Services' website, "for Medicare enrollees of a Medicare Advantage plan, there exists no 'good faith' provision similar to the Public Health Service Act provision. Therefore, Medicare Advantage plans are required to continue directly providing all Part A and Part B services, or otherwise arranging for such services to be provided, so that statutory and regulatory requirements for accessibility and availability of services continue to be met.</p> <p>For Medicare enrollees, Medicare Advantage plans have financial responsibility for emergency services and 'urgently needed' services.</p> <p>The term 'urgently needed services' are covered services medically necessary and immediately required when the Medicare beneficiary is temporarily outside of the plan's service area. Medicare Advantage plans are also required to cover urgently needed services within the service area when, due to unusual and extraordinary circumstances, the organization's provider network is temporarily unavailable or inaccessible, for example, because of a natural disaster or electrical power outage. Urgently needed services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through the plan's provider network."³⁵</p>
<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<ul style="list-style-type: none"> • Following Hurricane Katrina, Health and Human Services issued a waiver permitting Medicare Advantage enrollees to use out-of-network providers in an emergency situation. This waiver was applied retroactively.³⁶ • The Secretary of Health and Human Services may waive limitations on payments under 42 USC Section 1395w-21(i) for healthcare items and services furnished to individuals enrolled in a Medicare+Choice plan by healthcare professionals or facilities that are not included under that plan.³⁷

Pre-Authorization: Issues surrounding providing services with or without prior-authorization	
<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<ul style="list-style-type: none"> • Following Hurricane Katrina, the Centers for Medicare and Medicaid Services deemed it acceptable for Medicare Advantage plans to implement a liberal service authorization policy. In the past, Medicare Advantage plans have approved all urgent requests for authorizations for participating/nonparticipating providers, including facility transfers to participating/nonparticipating hospitals. In addition, most plans approve urgent referral requests. • In the case of Hurricane Andrew in South Florida and also the hurricanes in Florida during 2004, Medicare Advantage plans in affected states advised the Centers for Medicare and Medicaid Services of their intention to be liberal in the interpretation of emergent and urgent care during the worst days of the effects of the hurricane. One health plan publicly announced that, for beneficiaries residing in a certain geographic area, the plan would pay all claims from all providers for medically necessary care during a specified number of days.³⁸



Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions

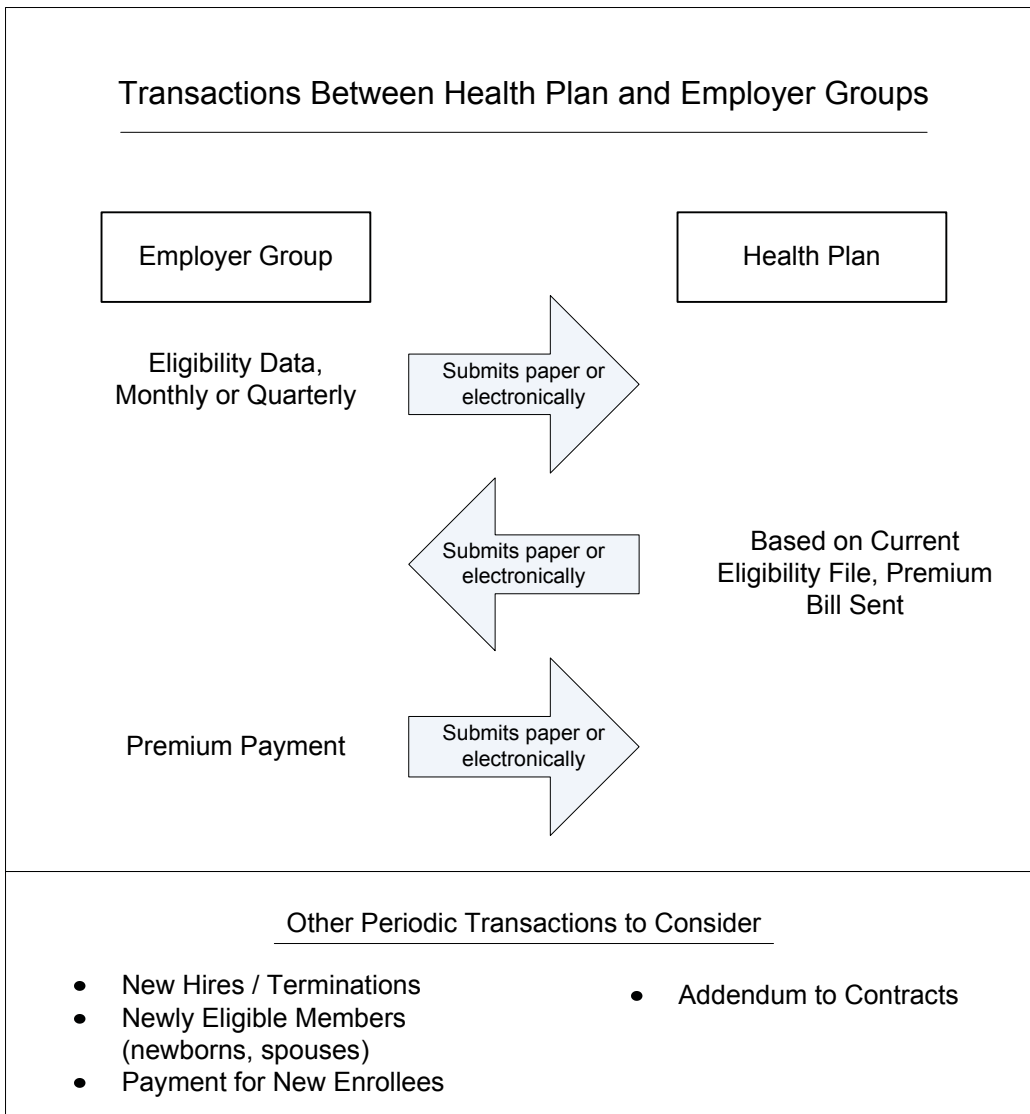
<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<ul style="list-style-type: none"> • With past emergency situations, Medicare Advantage plans have stipulated that for areas sustaining major damage, all pharmacy requests should be filled at participating level benefits for either participating or nonparticipating pharmacies. • Following Hurricane Katrina, managed care plans in the affected areas made special arrangements to ensure that members had access to needed medications. The plans permitted early refills, lifted other restrictions and arranged with a number of major pharmacy chains across the country to fill the prescriptions. These pharmacies, in turn, contacted the managed care organization or physician if the member did not know the name of the drug. The managed care organization reimbursed the member for any out-of-pocket costs associated with the prescription drug. Further information about access to pharmacies could be received through the plans' individual toll-free member hot lines.³⁹
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Non-Payment of Premiums and Coverage Continuity: Issues surrounding non-payment of premiums and termination of coverage

<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<ul style="list-style-type: none"> • Following Hurricane Katrina, Medicare Advantage enrollees who could not pay the premiums they owed their managed care plan had up to 60 days to submit premium payment. They were not terminated from their plan for nonpayment of the premium during the post-evacuation time. • Following Hurricane Katrina, Medicare Advantage members were not disenrolled from their plan unless they wanted to be, even if their plan was affected by the hurricane. They remained enrolled in their Medicare managed care plan even while they were temporarily unable to use it. While they were unable to use their Medicare health plan they got healthcare from healthcare providers that were not part of their managed care plan's network.⁴⁰
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2.5. Health Plans and Employers

Health plans receive the majority of their enrollment through relationships with employer groups. Employer groups provide healthcare coverage to their beneficiaries through products they purchase directly from the health plan. Once agreement is reached between the health plan and the employer group, the predominant feature of this relationship is a continuous exchange of information and dollars during the contract term. A healthcare surge may create additional challenges for the health plan since the relationship is transaction based and, in most cases, reliant on the accuracy of the information and access to technology. The table below illustrates certain critical transactions that occur during the term of the agreement.



While it is good business practice to establish proper administrative protocols, exchange appropriate information and collect the correct premiums for all eligible members, it becomes critical during a healthcare surge to ensure the flow of dollars from the employer group to the health plan is adequate to reimburse providers treating eligible members. Focusing on the key transactions described above, the table below highlights specific issues for a health plan to consider related to employer groups to mitigate risks when working through the planning process.



Health Plans and Employers Planning Considerations Table

Premiums	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> Consider establishing an average premium level based on eligibility levels at contract inception during the surge period to compensate for lapses in information typically exchanged between the parties. Establish a streamlined reconciliation process with employer group for those individuals added or deleted during the surge period. 	<ul style="list-style-type: none"> If information and payments are typically sent electronically, prepare a process in advance which details a manual process for the exchange of information and payments. 	<ul style="list-style-type: none"> Similar to Commercial and Medicare Advantage, consider working proactively with employer groups on plan design changes that would accommodate services typically seen during a surge period.

2.6. Health Plans and Medi-Cal Managed Care

Several California health plans have contracts in place with Medi-Cal to offer managed care plans to Medi-Cal beneficiaries. Currently, three different models operate in 22 counties across California, with Knox-Keene-licensed commercial health plans participating in two of the models, Geographic Managed Care and the Two Plan Model. In the third model, County Organized Health Systems, a county operates the managed care plan and must meet Knox-Keene requirements but does not need a Knox-Keene license. The Two Plan Model was selected to be implemented in counties that had high Medi-Cal populations. Where managed care plans exist, there is mandatory enrollment for all children, pregnant women and non-disabled parents.

The benefits and provider network configurations of Medi-Cal Managed Care plans are designed with a key focus on prevention, women's services and primary care. Unlike commercial networks where a large segment of care is delivered by independent practitioners, many Medi-Cal Managed Care enrollees are treated within a clinic setting. Therefore, commercial and Medi-Cal networks are often different for the same health plan.

Like the commercial or Medicare Advantage business, health plans with Medi-Cal Managed Care membership must address similar issues and challenges during a healthcare surge. The table below presents some issues for health plans to consider in managing Medi-Cal Managed Care plans during a healthcare surge.



Health Plans and Medi-Cal Managed Care Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> • Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care. • Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow. • Consider modifying contract language with independent practice associations / medical groups and hospitals to provide for an automatic increase in capitation during a surge, when appropriate. • Move toward a common reimbursement, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process. • Leverage the health plan's commercial network and negotiate reciprocity rates to accommodate out of network utilization during a healthcare surge. 	<ul style="list-style-type: none"> • Modify timely filing provisions to accommodate late or delayed claims which may be due to lack of correct benefit and eligibility information. • Proactively develop messaging for members to communicate surge protocols and administrative procedures. • Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow during a declared healthcare surge. • Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into the provider contracts. • Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge. 	<ul style="list-style-type: none"> • For closed network models, revise preauthorization and referral requirements to allow access to care when needed and where available. • Due to a limited network of providers in some geographies, maintain full benefits for members seeking care or accessing care at out-of-network providers due to availability.

Similar to dealing with commercial products, one of the challenges in preparing for the financial consequences of a healthcare surge and Medi-Cal Managed Care products is the highly situational nature of any healthcare surge response. As such, it may be helpful to review in greater depth the California and federal laws and regulations addressing how health plans can respond to patient care, access and financing issues during a healthcare surge, as well as the types of responses that have occurred historically. In some cases, laws and regulations dictate how health plans must respond during a catastrophic emergency, what health plans are required to provide their members and what protections their members are afforded. In other cases, past responses can serve as a reference with specific examples of the kinds of responses that *may* occur in the future. The tables that follow outline certain rules,



requirements and other issues that may impact commercial Medi-Cal Managed Care products, members and providers, pertinent regulations that affect how a health plan can respond to the issue, and examples or applications from previous catastrophic events. The tables serve as a reference tool to assist health plans as they develop plans to address specific issues. The regulations identified are not all inclusive but are those deemed most appropriate and applicable to health plans during a healthcare surge. The examples of previous responses are not meant to prescribe any future health plan response but act as guidelines for future planning.

Medi-Cal Managed Care Rule/Requirement/Issue Reference Table

Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member	
Pertinent California Regulations Related to Accessing Standard Emergency Care	<p>For Medi-Cal, under 22 CCR 51056, "emergency services" mean services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. For purposes of treating eligible aliens, "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:</p> <ul style="list-style-type: none"> • placing the patient’s health in serious jeopardy • serious impairment to bodily functions • serious dysfunction of any bodily organ or part
Pertinent California Regulations Relating to Physician Requirements for Medi-Cal Eligibility	<p>Per 22 CCR 51228, "a physician shall be licensed as a physician and surgeon by the California Board of Medical Quality Assurance or the California Board of Osteopathic Examiners or similarly licensed by a comparable agency of the state in which he practices."⁴¹</p>
Pertinent California Regulations Related to Facility Reimbursement for Emergency Services	<p>Per 22 CCR 51207, "a hospital not meeting all the requirements may be paid for services furnished to eligible beneficiaries on an emergency basis per 22 CCR 51056 – only until such time as the patient may be moved safely to an institution that meets the requirements."</p> <p>Per 22 CCR 51056:</p> <ol style="list-style-type: none"> a. "Emergency services mean services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. b. For purposes of treating eligible aliens, it means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: <ol style="list-style-type: none"> 1. Placing the patient’s health in serious jeopardy 2. Serious impairment to bodily functions 3. Serious dysfunction of any bodily organ or part"



Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member

<p>Pertinent California Regulations Related to Noncontracted Facility Reimbursement</p>	<p>Per 22 CCR 51541(c)(6), "noncontracted hospitals are not eligible to service Medical beneficiaries, except under one of the following:</p> <ol style="list-style-type: none"> a. They provide stabilizing services as required to program beneficiaries located in a closed health facility planning area who are in a life-threatening or emergency situation before the beneficiary may be transported to a contracting hospital. b. A beneficiary is located in a closed health facility planning area and experiencing a life-threatening or emergency situation but cannot be stabilized sufficiently to facilitate a transfer to a contracting facility, those health services medically necessary for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to significant disability or death. c. They provide services to beneficiaries who are also eligible for benefits under the federal program of hospital insurance for the aged and disabled. d. They provide services to beneficiaries who live or reside farther than the community travel time standard from a contract hospital, as defined by the department, if the hospital providing services is closer than a contract hospital. <ol style="list-style-type: none"> 1. Provision of services to beneficiary where travel time from home to contract hospital exceeds the normal practice for the community or 30 minutes (whichever is greater) and the noncontracting hospital is closer 2. Provision of services to a Medicare cross-over patient, subsequent to exhaustion of Medicare benefits and patients in a life-threatening or emergency situation which could result in permanent impairment."
<p>Pertinent California Regulations Related to Out-of-State Facility Reimbursement</p>	<p>Per 22 CCR 51006, Out-of-State Coverage:</p> <p>(a) "Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:</p> <ol style="list-style-type: none"> (1) When an emergency arises from accident, injury or illness; or (2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or (3) Where the health of the individual would be endangered if he undertook travel to return to California; or (4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or (5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the State. (6) Prior authorization is required for all out-of-state services, except: <ul style="list-style-type: none"> • Emergency services as defined in 22 CCR Section 51056 (see above). • Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the State."⁴²



Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member

	<p>Per 22 CCR 51543, Out-of-State Hospital Inpatient Services Reimbursement:</p> <ul style="list-style-type: none"> a. "Out-of-state inpatient hospital services which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained shall be reimbursed at an amount not to exceed the current statewide average of contract rates for acute inpatient hospital services negotiated by the California Medical Assistance Commission or the actual billed charges, whichever is less. b. Hospitals may request an administrative adjustment to the rate within 60 days of notice of payment. The request, which must be in writing, should be mailed to the California Department of Health Care Services, Hospital Reimbursement Unit, 714 P Street, P.O. Box 942732, Sacramento, CA 94234-7320. The decision on the administrative adjustment shall be final and is not subject to further appeal."⁴³ <p>Per 22 CCR 51006, Foreign Facilities:</p> <p>"No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico."⁴⁴</p>
<p>Previous Response Example, Pertinent Waivers or Other Application during a Surge</p>	<p>Section 1135 Waivers</p> <p>Under 42 USC Section 1320b-5, the Secretary of Health and Human Services has authority to waive certain requirements of the Centers for Medicare and Medicaid Services programs in an "emergency area" during a federal "emergency period" (Section 1135 Waivers). An emergency area is a geographical area in which, and an emergency period is the period during which there exist two types of declared emergencies: an emergency or disaster declared by the President under the National Emergencies Act or the Stafford Act, and a public health emergency declared by the Secretary of Health and Human Services. [42 USC Section 1320b-5(g)(1).] At the Secretary's discretion, waivers that are authorized after the emergency has occurred may be made retroactive to the beginning of the emergency period. [42 USC Section 1320b-5(c).] With two exceptions (Emergency Medical Treatment and Active Labor Act and HIPAA), the waivers generally last for the duration of the emergency period or until the Centers for Medicare and Medicaid Services determines that the waiver is no longer necessary. However, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, the waiver of that requirement no longer applies to that hospital.⁴⁵</p> <p>The Secretary of Health and Human Services may waive:</p> <ul style="list-style-type: none"> a. Conditions of participation or other certification requirements for an individual healthcare provider or types of providers b. Program participation and similar requirements for an individual healthcare provider or types of providers c. Pre-approval requirements⁴⁶ <p>The Secretary of Health and Human Services may waive sanctions under 42 USC Section 1395 (g), relating to limitations on physician referrals.⁴⁷</p>



Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member

The Secretary of Health and Human Services may waive “requirements that physicians and other healthcare professionals be licensed in the state in which they provide services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that state or in any state a part of which is included in the emergency area.”⁴⁸

2.7. Health Plans and Workers' Compensation

Workers' compensation is an additional product that is likely to be impacted during a healthcare surge. In the State of California, employers are required to carry Workers' Compensation insurance from either a licensed insurance company or through the State Compensation Insurance Fund.⁴⁹ As such, any injury or illness that occurs during a healthcare surge due to employment would be covered under the employer's workers' compensation policy, not the individual's or employer sponsored health and medical policy. Additionally, health plans and their employees will likely be affected by the emergency and may utilize workers' compensation for injuries to their employees.

Workers' Compensation is a significant funding source for health plans to consider because it covers “every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed.”⁵⁰ This includes aliens and minors, making it one of the only funding sources to cover the costs of healthcare for individuals not entitled to other programs because of their legal status.

While it is not a requirement for a commercial health plan to offer a Workers' Compensation product, some plans have opted to participate and have developed Medical Provider Networks to provide workers' compensation health related services. A "Medical Provider Network" is an entity or group of healthcare providers set up by an insurer or self-insured employer and approved by the Division of Workers' Compensation's administrative director to treat workers injured on the job. Each Medical Provider Network must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. Medical Provider Networks are required to meet access to care standards for common occupational injuries and work-related illnesses. Further, the regulations require Medical Provider Networks to follow all medical treatment guidelines established by the Division of Workers' Compensation and must allow employees a choice of provider(s) in the network after their first visit. Medical Network Providers also must offer an opportunity for second and third opinions if the injured worker disagrees with the diagnosis or treatment offered by the treating physician. If a disagreement still exists after the second and third opinion, a covered employee in the Medical Provider Network may request an independent medical review. Unless exempted by law or the employer, all medical care for workers injured on the job whose employer has an approved



Medical Provider Network will be handled and provided through the Medical Provider Network.”^{51,52}

All employees of an employer with an approved Medical Provider Network are required to receive medical treatment through the Medical Provider Network for work injuries, except:

- Those employees who properly pre-designate a physician anytime before an injury occurs, even if the pre-designated physician is a provider in the Medical Provider Network’s network^{53,54}
- Those employees with injuries prior to the effective date of the Medical Provider Network whose care has not been transferred into the Medical Provider Network⁵⁵
- Those employees who are otherwise exempted from the Medical Provider Network by the Medical Provider Network payer or employer”⁵⁶

Additional guidance on workers' compensation comes from the California Labor Code and is included below as a reference tool for commercial health plans. The Workers' Compensation Rule/Requirement/Issue Reference Tables shown below address the following rules/requirements/issues:

- Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member
- Pre-Authorization: Issues surrounding providing services with or without authorization
- Utilization: Issues surrounding what care is provided to patients

Workers' Compensation Rule/Requirement/Issue Reference Table

Physician / network requirements: Issues surrounding which healthcare professional provides services to a member	
<p>Pertinent California Regulations Relating to Physician Referrals</p>	<p>Per Labor Code Section 139.31(a), “a physician may refer a patient for a good or service otherwise prohibited by [Labor Code Section 139.3(a)] if the physician’s regular practice is where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. A physician who refers to, or seeks consultation from, an organization in which the physician has a financial interest under this subdivision shall disclose this interest to the patient or the patient’s parents or legal guardian in writing at the time of referral.”</p>
<p>Pertinent California Regulations Relating to Accessing Emergency Care</p>	<p>Additionally, Labor Code Section 139.31(g) states that “A physician may refer a person to a health facility for any service classified as an emergency under Health and Safety Code Section 1317.1 (a) or (b). For nonemergency outpatient diagnostic imaging services performed with equipment for which, when new, has a commercial retail price of four hundred thousand dollars (\$400,000) or more, the referring physician shall obtain a service preauthorization from the insurer, or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.”</p>



<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<p>None Identified.</p>
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Pre-Authorization: Issues surrounding providing services with or without authorization

<p>Pertinent California Regulations Relating to Employers and Health Plans' Responsibility in Authorizing Workers' Compensation Claims</p>	<p>Labor Code Section 5402 requires the employer to authorize medical care within one day of receipt of a claim form and to reimburse for all medical treatment in accordance with the American College of Occupational and Environmental Medicine's guidelines or utilization schedules adopted by the Division of Workers' Compensation administrative director. Until the claim is accepted or denied, liability for medical treatment is limited to \$10,000. The legislation does not address an employer's recovery rights on denied claims.⁵⁷ The health plan is required to accept or deny a claim within a reasonable period of time^{58,59}, and a new claim is presumed to be covered if not denied within 90 days.⁶⁰</p>
<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<p>None Identified.</p>

Utilization: Issues surrounding what care is provided to patients

<p>Pertinent California Regulations Relating to Workers' Compensation Utilization Schedule</p>	<p>Labor Code Section 5307.27 indicates that "a medical treatment utilization schedule that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Labor Code Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases" shall be adopted on or before December 1, 2004.</p>
<p>Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge</p>	<p>None Identified.</p>



During a healthcare surge, some of the workers' compensations requirements, such as those involving Medical Provider Networks and utilization schedules, may pose challenges. To mitigate these challenges, health plans that manage Workers' Compensation policies may want to consider the options in the table below.

Health Plans and Workers' Compensation Planning Considerations Table

Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> • Proactively develop messaging for employers and providers to communicate surge protocols and administrative procedures. • Accommodate late or delayed premium payments through change in contract language. • Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow during a declared healthcare surge. • Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into the provider contracts. • Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge. 	<ul style="list-style-type: none"> • Modify utilization schedule requirements to facilitate access to care when needed and where available. • Maintain full benefits for members seeking care or accessing care outside of their designated medical provider network or pre-designated physician.

The process flow that begins on the next page depicts how workers' compensation may play a role during a healthcare surge. For additional information on how Workers' Compensation may play a role as a payer of healthcare services for those injured at work during a healthcare surge, please refer to the California's Division of Workers' Compensation website, which includes up-to-date information on how to file a workers' compensation claim, how to request a qualified medical evaluation and other information. This website can be accessed at <http://www.dir.ca.gov/dwc/>.



Workers' Compensation During Declared Disaster – General Population

<p>Change in Event(s)</p>	<p>Catastrophic event causes injuries to employees while at work</p>	<p>Worker's Compensation Eligibility</p> <ul style="list-style-type: none"> Workers' compensation covers injuries or illnesses that occur due to employment, including single events or injuries caused by repeated exposure (Labor Code Section 3208 and Section 3208.1) Workers' Compensation does not cover first aid (Labor Code Section 5401) Employees covered under Workers' Compensation are "every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes (a) aliens and minors (Labor Code Section 3351) <p>Employee Responsibility</p> <ul style="list-style-type: none"> Report any injury or illness to employer as soon as possible. Complete the Workers' Compensation Claim Form and submit to employer within 30 days of the date of injury (Labor Code Section 5400) Should the employee disagree with any of the actions of the workers' compensation policy, submit an Application for Adjudication of Claims with the Workers' Compensation Appeals Board within one year of the date of the injury, or one year from the "last furnishing of indemnity or medical treatment benefits" by the employer or workers' compensation insurance carrier (State Compensation Insurance Fund) Pre-designate a physician, if interested, following certain rules and requirements. Each employee who chooses to pre-designate a physician must provide the name and address of the physician to his or her employer prior to becoming injured The law states that employees are not responsible for co-payments or balance-due after the workers' compensation insurance carrier has paid the provider <p>Employer Responsibility</p> <ul style="list-style-type: none"> Provide the employee with a Workers' Compensation Claim Form within one working day after the injury or illness has been identified. (Labor Code Section 5401(a)) Submit the completed claim form to the appropriate workers' compensation insurance carrier Authorize medical treatment as required and limited by the law within one day after an employee files a claim. This authorization pertains until the claim is accepted or rejected, up to \$10,000 in total Report "within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond first-aid" within one day after an employee files a claim (State Compensation Insurance Fund) Employer must pay for workers' compensation and must have insurance or be self-insured. (Labor Code Section 3600 and Section 3700) <p>Payer Responsibility</p> <ul style="list-style-type: none"> Accept or deny new claim within a reasonable time (Labor Code Sections 5814 and 5814.6; 8 CCR Section 10109) New claim presumed to be covered by workers' compensation if not denied within 90 days (Labor Code Section 5402(b)) The workers' compensation insurance carrier pays for all authorized treatment
<p>Population</p>	<p>Employee</p>	
<p>Subsequent Coverage</p>	<p>Employer provides employee with a claim form within one working day of awareness of injury or illness and subsequently reports the injury or illness within five days.</p> <p>Employee seeks medical attention for his or her injuries at a pre-designated provider, or provider in his employer's medical provider network, if available during the surge.</p> <p>Employee submits claim form to his or her employer within 30 days of the date of injury.</p> <p>Employer authorizes medical treatment within one day after an employee files a claim form, as required and limited by the law.</p> <p>Workers' compensation carrier processes claim and pays for all authorized treatment</p>	



3. Health Plan and Provider Planning Considerations

Administrative duties and obligations for both the health plan and provider should be evaluated to identify those areas that can be simplified or eliminated to accommodate the demands of the healthcare surge. Those areas that should be considered include data elements for charge capture and billing, claims policies including timely filing and periodic billing, determination of medical necessity, health plan's utilization management and discharge planning protocols, authorization procedures, health plan's medical policies, eligibility verification, benefits determinations, collection of co-payments and for-cause termination provisions. Additionally, health plans and providers should consider amending contract language which relieves the parties from certain obligations not critical to patient care during a healthcare surge.

The following sections include recommended data elements for charge capture and billing based on Medicare paper claims forms. It is recommended that private payers consider a similar list for their in-network providers.

3.1. Minimum Required Data Elements and Templates for Charge Capture

Charge capture is the process of collecting charges for services, supplies and pharmaceuticals provided to patients during a healthcare encounter. While charge capture is a provider activity, the billing process relies on such data to create a bill. Maintaining accurate charge capture information allows facilities to properly bill for services, receive reimbursement, and maintain cash flow and business continuity during a healthcare surge. During a healthcare surge, current electronic methods of charge capture within existing facilities may be unavailable. It is also reasonable to expect that most healthcare personnel will be devoted to patient care and may not be able to adhere to existing charge capture protocols. Therefore, paper-based methods for capturing charges may be required. This section recommends a list of minimally required data elements for charge capture that health plans can use to develop and approve minimum data sets for billing that work for their organizations.

Suggested Minimum Data List for Charge Capture

The following recommended list of minimum required data for charge capture was derived from current standard charge capture elements:

- Patient name
- Medical record number
- Date of service
- Capture units/dose/quantity
- Department services provided in
- Service description



- Disaster incident number
- Work related injury Y/N

3.2. Minimum Required Data Elements for Billing

In addition to charge capture, billing processes may pose a challenge during a healthcare surge. Billing is the process of transmitting the patient information, diagnoses, procedures and charges. Whenever possible, providers should follow normal billing processes and submit complete data. However, in the event that systems are impaired and/or staff are unavailable at provider sites, the use of minimum billing elements may become necessary. Implementing minimum data elements for billing requires coordination and approval between both health plans and providers and may require technological intervention to process accurately. In a healthcare surge, providers may be unable to collect and transmit standard billing data and reducing required data elements may become necessary to facilitate payment. As such, it is recommended that health plans develop a list of minimum data elements for billing for their organization. The minimum data elements in this section are included as recommendations only; ultimately health plans must agree to accept these recommended minimum data elements from providers for billing purposes.

Recommended Minimum Required Data Elements for Billing

The following lists were derived from existing Uniform Billing form 04 (Uniform Billing 04 or Centers for Medicare and Medicaid Services 1450) and Centers for Medicare and Medicaid Services 1500 forms. Under normal conditions, the Uniform Billing 04 form is used by institutional providers (e.g., hospitals, skilled nursing facilities, hospices) to submit Medicare paper claims and the Centers for Medicare and Medicaid Services 1500 form is used by noninstitutional providers (e.g., physicians) to submit Medicare paper claims. It is recommended that private payers consider a similar list for their in-network providers.

Institutional Providers Uniform Billing 04 Data Elements	Noninstitutional Providers Centers for Medicare and Medicaid Services 1500 Data Elements
<ul style="list-style-type: none"> • Subscriber Identification/policy number • Time in, time out • Is injury work-related? <p>1: Provider name, address, phone number</p> <p>4: Type of bill</p> <p>8b: Patient name</p> <p>42: Revenue codes</p> <p>43: Revenue description</p>	<ul style="list-style-type: none"> • Subscriber Identification/policy number • Time in, time out • Is injury work-related? <p>1: Select which payer: Medicare / Medicaid / Champus / Champva / Group Health Plan/ Federal Employees Compensation Act Black Lung / Other</p> <p>1a: Insured's Identification number</p> <p>2: Patient name</p>



Institutional Providers Uniform Billing 04 Data Elements	Noninstitutional Providers Centers for Medicare and Medicaid Services 1500 Data Elements
44: Healthcare Common Procedure Coding System rates/codes 46: Units of service 47: Total charges 50: Payer 56: National Provider Identifier 58: Insured's name 67: Principal diagnosis code 69: Admitting diagnosis 74: Principal procedure code 76: Attending 77: Operating	3: Patient's birth date 5: Patient's address 21: Diagnosis or nature of illness or injury 24 A-G: date of service, place of service, type of service, procedures/services/supplies, diagnosis code, \$ charges, days or units 24K: Use space to include condition code 25: Federal tax Identification number 27: Accept assignment? (yes/no) 28: Total charge 33: Physician's/supplier's billing name, address, zip code & phone number

3.3. Additional Billing and Coding Guidance

Additional guidance regarding billing and coding during a disaster is included in this section and can be used by health plans to develop future policies on billing and coding during a healthcare surge.

Administrative Simplification Compliance Act Waiver Application⁶¹

According to the Centers for Medicare and Medicaid Services' website, "The Administrative Simplification Compliance Act prohibits payment of services or supplies that a provider did not bill to Medicare electronically." The Administrative Simplification Compliance Act Waiver Application allows for flexibility in this rule and stipulates that "There are also some situations when this electronic billing requirement could be waived for some or all claims, however, a provider must obtain Medicare pre-approval to submit paper claims in these situations:

- Any situation where a provider can demonstrate that the applicable adopted HIPAA claim standard does not permit submission of a particular type of claim electronically
- Disability of all members of a provider's staff prevents use of a computer for electronic submission of claims
- Other rare situations that cannot be anticipated by the Centers for Medicare and Medicaid Services where a provider can establish that, due to conditions outside of their control, it would be against equity and good conscience for the Centers for Medicare and Medicaid Services to enforce this requirement



A request for this type of waiver must be sent by letter to the Medicare contractor to which a provider submits claims.”

National Modifier and Condition Code to Be Used to Identify Disaster-Related Claims⁶²

In response to the emergency healthcare needs of beneficiaries and medical providers affected by Hurricane Katrina, the Centers for Medicare and Medicaid Services assured flexibility by modifying normal documentation requirements. Specifically, a new policy was issued establishing a national modifier for providers to use on claims in order to track and facilitate claims processing for individuals affected by the disaster. According to the new policy, "In order to facilitate claims processing and track services and items provided to individuals affected by Hurricane Katrina and any future disasters, a new modifier and condition code have been established for providers to use on disaster-related claims.

The new modifier and condition code are now effective nationwide. The new modifier is CR (Catastrophe/Disaster Related) and the new condition code is DR (Disaster Related). The new modifier and/or condition code may be used by providers submitting disaster related claims. For physicians or suppliers billing their local carriers or durable medical equipment regional carriers, only the modifier (CR) may be reported and not the condition code. A condition code is used in fiscal intermediary billing. For institutional billing, either the modifier or condition code may be reported. The condition code would identify claims that are or may be impacted by specific payer policies related to a national or regional disaster, while the modifier would indicate a specific Part B service that may be impacted by policy related to the disaster.”⁶³

International Classification of Diseases, Ninth Revision, Clinical Modification Coding for External Causes of Injury

In the event of a disaster, coding professionals can use External Cause codes (E codes) to code healthcare encounters and identify the cause of injury(ies) for those affected by the disaster. "External causes of injury and poisoning codes are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury or poisoning happened (the cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred.”⁶⁴ The use of E codes is supplemental to the application of International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis codes. E codes are never recorded as principal diagnoses: the appropriate injury code should be sequenced before any E codes. E codes may be assigned in all healthcare settings. For the purpose of capturing complete and accurate International Classification of Diseases, Ninth Revision, Clinical Modification data in the aftermath of the natural disaster, a healthcare setting should be considered any location where medical care is provided by licensed healthcare professionals.

The use of E codes is limited to injuries, adverse effects and poisonings. They should not be assigned for encounters to treat the medical conditions of individuals affected by an emergency when no injury, adverse effect or poisoning is involved.



E codes can be used in the following situations:

- Accidents due to natural and environmental factors
- Poisoning and adverse effects of drugs, medicinal substances and biologicals
- Transport accidents
- Accidental falls
- Accidents caused by fire and flames
- Late effects of accidents, assaults or self injury
- Assaults or purposely inflicted injury
- Suicide or self inflicted injury

Catastrophic emergencies, such as natural disasters, take priority over all other E codes except child and adult abuse and terrorism and should be sequenced before other E codes. As many E codes as necessary can be assigned to fully explain each cause. For example, if an injury occurs as a result of a building collapsing during a natural disaster, E codes for both the natural disaster and the building collapse should be assigned with the E code for disaster being sequenced as the first E code.⁶⁵

3.4. Advancing and Expediting Payment to Provider

During a healthcare surge, cash flow may present a significant challenge for large, small and independent providers. As such, the following tool was developed for providers to outline the possible opportunities for advancing and expediting payment from a range of payers. In many cases, health plans do not have a formalized policy or procedure for advancing or expediting payments, but may have established a practice for doing so on an “as needed” basis. The following table summarizes some of the options available by payer type with respect to advancing and expediting payment. Providers may be able to receive advanced or expedited payments by contacting their health plan representatives and discussing these options. It is recommended that health plans prepare for the likelihood that providers in need of expedited or advanced payment options will contact their plan partners or program representative directly to discuss advancing and expediting payments and establish memoranda of understanding and protocols in advance or at the time funds are needed. This same table is included in the Hospital volume in Section 12.2.4: Advancing and Expediting Payment.



Advancing and Expediting Payment

Payer	Option Available	Examples
Medicare Part A	Accelerated Payments	Cash-flow problems can be resolved through accelerated payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for accelerated payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis. ⁶⁶
Medicare Part B	Advance Payments	Cash flow problems can be resolved through advance payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for advance payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the advance payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis. ⁶⁷
Medi-Cal	Advance Payments	<p>Medi-Cal has a process in place for advancing payment to participating hospitals. This interim payment process can be used in instances when hospitals are experiencing cash flow inadequacies, where Medi-Cal is experiencing payment delays or when a hospital’s business operations are temporarily challenged. Medi-Cal will approve advances more readily if there is a problem with the State processing or payment system, not solely because the provider is experiencing billing issues. In the current process, if the hospital has claims pending in the State system, the Department of Health Care Services (DHCS) can issue an interim payment and will reconcile it against future claim submissions and payments. The amount of the advance is usually about 75 percent of the claim value in the Medi-Cal system awaiting payment for that hospital. The hospital must be a Medi-Cal enrolled provider to receive these advance payments. This is a manual process at present and is highly labor intensive. In an emergency, this interim payment process can be invoked to advance a reasonable amount to keep a hospital’s cash flow positive until business operations can resume to normal.</p> <p>Medi-Cal can issue this advance by either valuing the claims that are currently in the State processing system or running a report of a hospital’s claim payment history and issuing an advance in lieu of receiving claims. If DHCS issues an advance without having evidence of claims in the payment system, it has not established its liability to pay and cannot claim the federal match for that payment. In circumstances where claims have not been received, DHCS would have to approve the advance because the funds would come from the State General Fund. This process could theoretically be set up easily, but in a healthcare surge it may take some time to orchestrate given the number of hospitals that may be requesting it.⁶⁸</p>



Payer	Option Available	Examples
<p>Private Payer</p>	<p>Informal Agreements</p>	<p>Some private payers may have informal processes set up in order to advance payment to contracted providers in times of financial need. This advance payment process can be used when providers are experiencing cash flow inadequacies, where the payer is experiencing payment delays or when a hospital's business operations are temporarily challenged. The amount of the advance can vary depending on hospital need, hospital volume, previous payment history, contractual parameters and repayment factors. Upon hospital request, private payers will typically offer one of two options: 1) advance a lump-sum amount for a specified period of time to be repaid in full when the agreed period elapses or 2) advance an agreed amount based upon previous payment history and hospital need to be reconciled against future claim submissions. Contracted hospitals in good standing in need of expedited or advanced payment options will likely need to contact their plan or program representatives directly to discuss advancing and expediting payments and establish memoranda of understanding and protocols in advance or at the time funds are needed.⁶⁹</p>



4. Other Considerations: California Authority Governing Commercial Health Plans During A Healthcare Surge

During the normal course of business, laws and rules prescribe what health plans must make available to their members. During a healthcare surge additional authority may become necessary to address the needs of health plans, their members and the community during an emergency. While general and product specific considerations were included in prior sections of this volume to aid health plans in developing their own response to a healthcare surge, health plans should also be aware of the additional authority that exists and that may be exercised during a healthcare surge, impacting their business and operations. The authority described here, and the potential actions the State of California may take, are included in order to make health plans aware of the kinds of responses that may be mandated. Awareness of these mandates can enable health plans to more adequately prepare their staff and organizations for a healthcare surge response by providing the opportunity to incorporate these mandates into their response plans.

Government Code Sections 8550 and 8567 permit the Governor to issue “orders and regulations necessary to carry out the provisions of” the Emergency Services Act in order “to protect the health and safety and preserve the lives and property of the people of the state.”⁷⁰ Government Code Section 8571 also grants power to the California Governor “during a state of war emergency or a state of emergency, [to] suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency...where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder or delay the mitigation of the effects of the emergency.”⁷¹

Under this authority, the Governor could address private payer administrative rules and requirements that may pose a barrier to financial viability and stability of the healthcare system and ultimately impact access to care. Specifically, the Governor could prevent cancellations of policies during an emergency for nonpayment of premiums or prescribe that minimum data fields be used by health plans and providers.

Within California, there are two agencies that regulate private payers, the California Department of Insurance and the California Department of Managed Health Care. These two agencies have different scopes of authority and ways they may impact private health plans during a healthcare surge. The California Department of Insurance “licenses and regulates the rates and practices of insurance companies, agents and brokers in California.”⁷² This includes all insurance products governed under the California Insurance Code. The California Department of Insurance is primarily involved in consumer protections and advocacy and would play a very limited role during a healthcare surge. A review of the Insurance Code indicates no authority for the Commissioner of Insurance to suspend statutes during an emergency. Action by the Governor would be required to mandate payer action.



The Department of Managed Health Care and its role in a healthcare surge are discussed in the next section.

4.1. The Department of Managed Health Care's Role in a Healthcare Surge

The Department of Managed Health Care licenses and regulates California health maintenance organizations, preferred provider organizations and discount plans governed under the Health and Safety Code and 28 CCR. These are the provisions that govern health maintenance organizations and grant the Department of Managed Health Care its enforcement authority.

Specifically, the Department of Managed Health Care and its Director:

- “Have charge of the execution of the laws of this state relating to healthcare service plans and the healthcare service plan business including, but not limited to, those laws directing the department to ensure that healthcare service plans provide enrollees with access to quality healthcare services and protect and promote the interests of enrollees.”⁷³
- “Are responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws ... [relating to healthcare service plans and the healthcare service plan business..., primarily the Knox-Keene Health Care Service Plan Act of 1975].”⁷⁴
- Have rule making and order making authority to “... adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of ... [the Knox-Keene Act].”⁷⁵
- “May waive any requirement of any rule or form in situations where in the director’s discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to ... [the Knox-Keene Act].”⁷⁶

While the general powers described above may be exercised to address a large excess of demand over supply of healthcare services in a healthcare surge, additional authority may be necessary or appropriate to mitigate the effects of natural, manmade, or war-caused emergencies greatly impacting the healthcare delivery system operated by healthcare service plans. In order to cope proactively with a healthcare surge resulting from a disaster or a state of emergency, responsibility for protection of enrollees may necessitate:

- Keeping healthcare services available to enrollees.
- Keeping the revenue stream flowing to healthcare facilities and professionals



- in order keep to healthcare services available.
- Transferring enrollees from one plan to another in the event of diminished plan capacity to keep healthcare services available.
 - Transferring provider capacity from one plan to another to mitigate a shortage of healthcare services in severely impaired geographic areas.

Depending upon the nature, breadth, and severity of the state of emergency, the statutory and order making powers of the Director of the Department of Managed Health Care may not be sufficient to protect enrollees adequately. Certain powers may have to be ordered or delegated by the Governor through, for example, Government Code Section 8572, which grants the Governor the authority to "commandeer or utilize any private property or personnel deemed by him necessary" during a state of war emergency or state of emergency.⁷⁷ Therefore, certain matters should be considered by the Governor for inclusion in executive orders to facilitate the protection of enrollees.

Such executive orders may include the Governor granting a limited transfer of authority to the Director of the Department of Managed Health Care to issue emergency rules and orders applying to healthcare service plans licensed by the Department of Managed Health Care. This limited transfer of authority would authorize the Director to suspend certain statutes, regulations and healthcare service plan contract provisions and take other actions in order to facilitate mitigation of the emergency and healthcare surge, as indicated by the severity of the emergency. Such delegated authority may be exercised by the Director in whole or in part and from time-to-time, depending upon the severity and duration of the healthcare surge, the state of emergency, and the need to ensure that healthcare service plans provide enrollees with access to healthcare services and that enrollees' interests are protected.

It may be helpful for health plans to understand in more detail the specific kinds of actions the Department of Managed Health Care may take under its delegated authority and the impact these actions will have on access to care and reimbursement. Awareness of these actions may enable health plans to more adequately prepare their staff and organizations for mandated healthcare surge responses by providing the opportunity to incorporate these mandates into their response plans.

Health plans should be aware of the Department of Managed Health Care's delegated authority and the actions that might be taken:



- **To protect enrollees' access to healthcare services:** In the geographic areas of California affected by the state of emergency and healthcare surge and for specified time periods which cover the duration of the state of emergency and healthcare surge, ensuring that enrollees of healthcare service plans have access to healthcare services:
 - Directing the transfer of enrollees from an impaired health plan (due to impaired resources, financial capacity or administrative capacity) to a health plan with greater capacity.
 - Directing transfer of providers from a health plan with adequate provider capacity to a health plan with impaired provider capacity at the compensation rates of the transferee health plan or as otherwise specified to maintain enrollee access to care.
 - Ordering the suspension of requirements of healthcare service plan contracts, statutes and regulations that may prevent, hinder or delay the mitigation of the effects of the emergency, including but not limited to:
 - Prior authorization for referrals and use of out-of-network providers
 - All prior authorization requirements or preadmission certification requirements that could delay the provision of healthcare services
 - All restrictions relative to out-of-network provider access
 - Medical necessity reviews
 - Notification of hospital admissions (when used as a basis of denial of coverage or services)
 - Requirement that enrollees first seek care from their primary care physicians, thereby allowing enrollees to seek care from providers other than their designated primary care physicians
 - Use of participating network hospitals, expanded to require plans to treat all area hospitals as participating network hospitals under existing benefit provisions
 - Out-of-network charges to enrollees, suspended to allow enrollees to seek care from any available medical professional for which in-network benefits would apply
 - Assuring timely access to prescription medications:
 - Directing that a 30-day supply cannot be rejected or pended regardless of date of last refill
 - Directing that maintenance medications may be dispensed in 90-day supplies
 - Assuring continuity of coverage by:
 - Directing that group or individual contracts cannot be cancelled or terminated



- during the state of emergency even if premiums have not been paid
- Assuring collaboration in healthcare surge response and disaster recovery:
 - Directing that health plans rapidly assess the short-term impacts of the healthcare surge and disaster on their individual health plan operations and develop a disaster recovery plan according to a timeline specified by the Department of Managed Health Care
 - Directing that each health plan establish and publicize a 24-hour informational toll-free hotline for enrollees in the geographic area affected by the healthcare surge and disaster, as an information source to facilitate enrollees obtaining access to healthcare services
- **To manage financial risk:** In the geographic areas of California affected by the state of emergency and healthcare surge and for specified time periods which cover the duration of the state of emergency and healthcare surge, managing healthcare service plan financial risk during healthcare surge:
 - For pre-negotiated fee-for-service arrangements with providers, directing that when a provider claim (except Medi-Cal claims) is submitted but the premium is not received, the following rules shall apply to the healthcare service plan contract providing coverage for the enrollee:
 - The enrollee is responsible for co-payments, coinsurance and deductible amounts (collectable from the enrollee by the provider) according to the enrollee's coverage contract or evidence of coverage
 - The health plan pays 50% (or other percentage as directed) of either the contracted rate or the non-participating provider rate
 - The provider accepts 50% (or other percentage as directed) as payment in full and cannot bill the enrollee (except for co-payments, coinsurance and deductible amounts)
 - If the entire premium is subsequently received by the health plan, the provider claim is to be adjusted and paid according to the provider's contract with the health plan
 - For capitated payment service arrangements with providers, directing that when a healthcare service is provided to an enrollee whose coverage eligibility verification identifies that the premium is not received for the healthcare service plan contract providing coverage for the enrollee who received the service from the provider, the Director of the Department of Managed Health Care may devise and order appropriate and necessary financial obligations and arrangements between and among health plans and providers in order to ensure continuity of provider operations for the benefit of enrollees.



- For any other circumstances in which the healthcare surge and state of emergency have greatly challenged the management of financial risk, the Director of the Department of Managed Health Care may assess the circumstances and devise and direct interim modifications of financial obligations and arrangements that ensure continuity of provider operations to enable health plans to provide healthcare services and continuity of access to healthcare services to enrollees.
- **To manage continuation of provider services:** In the geographic areas of California affected by the state of emergency and healthcare surge and for specified time periods which cover the duration of the state of emergency and healthcare surge, assuring continuation of provider services and protection of providers:
 - Authorizing the establishment of a California uncompensated care pool to pay a portion of the costs of care provided to coverage-impaired enrollees.
 - Directing that health plans pay claims as in-network, regardless of whether the healthcare provider was in network.
 - Directing that health plans establish advance payment to contracted providers for use when providers are experiencing cash flow inadequacies, where the health plan is experiencing provider payment delays, or when a provider's business operations are temporarily challenged.
 - Directing other necessary and appropriate actions identified by the Director of the Department of Managed Health Care as warranting urgent financial relief for hospitals and physicians to enable continuity of healthcare services essential for the protection of enrollees.
- **To seek federal waivers:** After the Governor's proclamation of the existence of a state of emergency which includes healthcare surge and a determination that the healthcare surge and impact on the healthcare delivery system are likely to continue for a period of at least 90 days, the Director of the Department of Managed Health Care in cooperation with the Director of DHCS may request that the Governor make the following requests and appeals to the federal government:

Request for federal waivers:

- Request to the Centers for Medicare and Medicaid Services regarding Medicare, Medicaid and State Children's Health Insurance Program services (as provided through healthcare service plans) for a Social Security Act Section 1135 waiver regarding conditions of participation; pre-approval requirements; state licensure requirements for providers; and use of out-of-network providers retroactive to the date of onset of the healthcare surge or state of emergency.



- Request to the Secretary of the U.S. Department of Health and Human Services for emergency Medicaid waivers (for Medi-Cal services provided through health plans with contracts to provide Medi-Cal Managed Care services) for simplified eligibility and expedited patient enrollment; simplified application and self-attestation (waiver of normal burden of documentation and presumption of eligibility); expanded eligibility guidelines; and six months temporary eligibility.

Request for uncompensated care pool¹. Request to the Centers for Medicare and Medicaid Services for approval for the use of a federally funded uncompensated care pool needed because:

- A high percentage of enrollees in healthcare service plans for whom access to needed healthcare is in jeopardy due to employer groups being severely financially impaired or discontinuing business operations due to the emergency situation (“coverage-impaired enrollees”); and
- California experiences a high number of evacuees from other states and those evacuees receive healthcare services from the California healthcare delivery system; and
- The Director of the Department of Managed Health Care identifies circumstances warranting urgent financial relief for hospitals and physicians committed to arrangements with health plans for the provision of essential healthcare services to enrollees.

To receive reimbursement from the uncompensated care pool, providers and health plans would be required to attest that:

- Coverage-impaired enrollees or evacuees had no other healthcare coverage on the date of service.
- The health plan or provider had received no premium payment or reimbursement from any other source for the claim and/or reasonably expected to receive no reimbursement from any other source.
- The recipient of services was from an area impacted by the healthcare surge or disaster.

Collaborative Approach to Surge Response

Given the unpredictable nature of a healthcare surge and the potential for significant disruption to the healthcare system, it is critical that health plans develop a collaborative approach to responding to a catastrophic emergency. The guidelines and considerations included in this document are designed to facilitate planning between health plans and their provider and

¹ More information on how uncompensated care pools have been used in the past can be found in the Reference Manual Section 10: Funding Sources - Lessons Learned from Louisiana.



payer partners with the recognition that maintaining patient care, access and funding during a healthcare surge will require advanced planning and a community approach. Health plans are encouraged to review these guidelines and considerations as part of their efforts to plan and prepare for a healthcare surge in their community.



5. Endnotes

- ¹ *Emergency Management Principles and Practices for Healthcare Systems*. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University; for the Veteran's Health Administration, United States Department of Veteran's Affairs. Washington, D.C., June 2006. Available at <http://www1.va.gov/emshq/>
- ² Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator. A description of these officials is provided later in this document.
- ³ Excerpt from Office of Personnel Management contract language with Federal Employee Health Benefits Plan carriers.
- ⁴ 28 CCR 1300.67(g)
- ⁵ 28 CCR 1300.67.05
- ⁶ 42 USC Section 300e
- ⁷ 42 USC Section 300e
- ⁸ Business And Professions Code Section 900
- ⁹ Business And Professions Code Section 922
- ¹⁰ Louisiana State Medical Society, "Louisiana Department of Insurance's Final Emergency Rules and Directives relative to Suspension of Certain Health Insurance Laws and Regulations Governing Louisiana Licensed Health Insurers Post Hurricane Katrina and Rita" <http://www.lsms.org/Hurricanes/2005%20Emergency%20Rules%20%20Directives.pdf>
- ¹¹ Louisiana Title 37, Insurance, Part XI Chapter 27: Emergency Rule 15 and 17
- ¹² Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections," http://www.lidi.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ¹³ "Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake" http://www.aetna.com/news/2005/pr_20050902.htm
- ¹⁴ United Healthcare Responds to Support Hurricane Victims, August 31, 2005. <http://www.unitedhealthgroup.com/news/rel2005/0831Hurricane.htm>
- ¹⁵ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/cigna.htm>
- ¹⁶ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/cigna.htm>
- ¹⁷ 28 CCR Section 1300.71.4
- ¹⁸ 28 CCR Section 1300.71.4
- ¹⁹ Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake" http://www.aetna.com/news/2005/pr_20050902.htm
- ²⁰ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/cigna.htm>
- ²¹ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/>
- ²² Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections," http://www.lidi.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ²³ Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake" http://www.aetna.com/news/2005/pr_20050902.htm
- ²⁴ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/>
- ²⁵ United Healthcare Responds to Support Hurricane Victims, August 31, 2005. <http://www.unitedhealthgroup.com/news/rel2005/0831Hurricane.htm>
- ²⁶ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/cigna.htm>
- ²⁷ Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections," http://www.lidi.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ²⁸ America's Health Insurance Plans, "Hurricane Katrina Disaster Response", <http://www.ahip.org/HurricaneResponse/>
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- ³² Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections," http://www.lidi.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ³³ Interview with America's Health Insurance Plan representatives, January 30, 2007
- ³⁴ United Healthcare Responds to Support Hurricane Victims, August 31, 2005. <http://www.unitedhealthgroup.com/news/rel2005/0831Hurricane.htm>
- ³⁵ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ³⁶ Health and Human Services - Section 1135 Waiver, Hurricane Katrina. September 4 2005
- ³⁷ 42 USC Section 1320b
- ³⁸ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
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- ⁴¹ 22 CCR 51228
- ⁴² 22 CCR 51006
- ⁴³ 22 CCR 51543
- ⁴⁴ 22 CCR 51006
- ⁴⁵ MA Influenza Pandemic Preparedness Plan, "Section 10: Legal Considerations For Pandemic Influenza," October 2006
- ⁴⁶ 42 USC Section 1320b-5(b)(1)



- ⁴⁷ 42 USC Section 1320b-5(b)(4)
- ⁴⁸ 42 USC Section 1320b-5(b) (2)
- ⁴⁹ <http://igs.berkeley.edu/library/htWorkersCompensation.htm>
- ⁵⁰ Labor Code Section 3351
- ⁵¹ <http://igs.berkeley.edu/library/htWorkersCompensation.htm>
- ⁵² 8 CCR Section 9767.1
- ⁵³ 8 CCR Section 9780.1
- ⁵⁴ 8 CCR Section 9782
- ⁵⁵ 8 CCR Section 9767.9
- ⁵⁶ State of California Division of Workers' Compensation, Division of Workers' Compensation Medical Provider Networks, http://www.dir.ca.gov/dwc/MPN/DWC_MPN_FAQ.html
- ⁵⁷ State of California Division of Workers' Compensation, Frequently Asked Questions - Employers <http://www.dir.ca.gov/dwc/WCfaqEmployer.html>
- ⁵⁸ Labor Code Section 5814 and 5814.6
- ⁵⁹ 8 CCR Section 10109
- ⁶⁰ Labor Code Section 5402(b)
- ⁶¹ http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp#TopOfPage
- ⁶² <http://www.nubc.org/R1810TN.pdf>
- ⁶³ <http://www.nubc.org/R1810TN.pdf>
- ⁶⁴ <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>
- ⁶⁵ http://www.ahacentraloffice.com/ahacentraloffice/images/Katrina_coding%20advice.pdf
- ⁶⁶ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ⁶⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ⁶⁸ Information gleaned from interviews with representatives from Medi-Cal, May 2007.
- ⁶⁹ Discussions with several California private payer representatives during the development of this volume.
- ⁷⁰ Government Code Section 8550
- ⁷¹ Government Code Section 8571
- ⁷² California Department of Insurance, <http://www.insurance.ca.gov/>
- ⁷³ Health and Safety Code Section 1341(a)
- ⁷⁴ Health and Safety Code Section 1341(c)
- ⁷⁵ Health and Safety Code Section 1344(a)
- ⁷⁶ Health and Safety Code Section 1344(a)
- ⁷⁷ Government Code Section 8572