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ALL PLAN LETTER

DATE: May 20, 2020
TO: All Health Care Service Plans With Commercial Lines of Business¹
FROM: Sarah Ream, Acting General Counsel
SUBJECT: APL 20-020 – Ensuring Continued Network Adequacy and Removing Unnecessary Burdens on Providers

Health plans have an on-going duty to ensure they have adequate networks to provide enrollees with all medically necessary services in a timely and geographically appropriate manner.² Providers, including medical and dental clinics and hospitals, report experiencing significant financial difficulties due to COVID-19, as patients have delayed receiving all but emergency and urgent medical services.

I. Filing Regarding Steps to Ensure Continued Adequacy of Networks

To address the concerns highlighted above, each plan subject to this All Plan Letter must submit an informational filing to the DMHC explaining the steps the plan has taken, and/or will take, to ensure continued network adequacy. We are also aware that some plans have taken steps to directly assist their provider network.

If you have taken such actions, please provide details regarding: the approximate dates the plan took or will take the actions described; the amount of investments made to support California providers; the geographic areas in California where the plan has targeted or will target its actions; and, whether the actions apply to provider groups, hospitals and/or other entities.

Please note, this APL applies only to plans with commercial lines of business. If a plan has both commercial and other lines of business (e.g., Medi-Cal, Medicare Advantage),

¹ For purposes of this All Plan Letter, “commercial lines of business” means individual, small group and large group products sold on or off the California Health Benefits Exchange. This APL applies to restricted health care service plans that cover enrollees in a commercial line of business. It also applies to specialized health care service plans with commercial lines of business. This APL does not apply to health plans with only Medi-Cal managed care or Medicare Advantage lines of business.

² See e.g., Health and Safety Code sections 1367, 1367.03, and 1367.035; California Code of Regulations, title 28, sections 1300.51(c)(H), 1300.67.2.1, and 1300.67.2.2.

the plan may submit information applicable only to the providers in networks serving the plan's commercial products, or the plan may submit information applicable to providers in networks serving both its commercial and other products.

Please submit the information to the DMHC via the eFiling portal as an Exhibit E-1, with the filing type "Report/Other." Attached to this APL is a template E-1 plans may use; plans may use their own format if they chose.

Please title the filing in eFiling as "Informational Filing Regarding Network Stability." The deadline for submitting the filing to the DMHC is **June 5, 2020**.

Please note, these filings will be disclosable in response to Public Records Act requests. The DMHC will not grant confidential treatment for the filings.

II. Ways Health Plans and Risk Bearing Organizations (RBOs) Can Assist Providers

To help ensure a stable health care delivery system, and within the context of plan financial stability, the DMHC encourages health plans and RBOs to communicate with their contracted providers to determine whether the providers are experiencing financial difficulties that may threaten the adequacy of the plans' networks. If providers are experiencing financial difficulties, the DMHC, in the context of plan financial stability, encourages plans and RBOs to take one or more of the following steps:

1. Expedite claims review and payment to decrease the accounts receivables owed to providers. As a reminder, the DMHC will continue to monitor timely payment of claims during our financial exams.
2. Identify and remove administrative burdens that may be delaying providers' abilities to submit and be paid for claims. For example, providers report experiencing extended telephone wait-times to talk with plan personnel and limits on the number of cases a provider may discuss with a plan in one phone call. The DMHC encourages plans to remove or reduce these burdens when possible.
3. Work with the plan's contracted providers to give the providers advance payments when feasible and desired by the provider. These payments could include advances on capitation payments or no-interest loans to assist providers with remaining solvent while they begin to provide more non-urgent and non-emergent procedures that were deferred during the previous several months.
4. Amend coordination of benefit procedures in situations where the enrollee has not yet verified he/she does not have alternative coverage, such that the default is to pay the claim. The DMHC understands that in some instances plans will delay reimbursement until the enrollee confirms in writing they do not have alternate coverage. During this time when many providers are delivering services via telehealth, obtaining information from enrollees may be very difficult, resulting in delayed payment to the provider. The DMHC encourages plans to pay the claims and then follow up with the enrollee regarding the existence of alternate coverage. If the enrollee did have alternative coverage that should have paid the claim, the plan could seek recoupment, as appropriate, from the provider.

If you have questions or concerns regarding this APL, please contact your health plan's assigned reviewer in the Office of Plan Licensing.

E-1 Suggested Template

Each plan subject to this All Plan Letter must submit an informational filing to the DMHC explaining the steps the plan has taken, and/or will take, to ensure continued network adequacy

As part of this information filing, please indicate if [Insert name of plan] has taken/will take the following actions:

[Check all that apply and provide a detailed description of the steps the plan has taken or will take, including:

- approximate dates the plan took or will take the actions described;
 - the amount of investments made to support California providers;
 - the geographic areas in California where the plan has targeted or will target its actions; and,
 - whether the actions apply to provider groups, hospitals and/or other entities.]
- Advancing Pay for Performance and/or Practice Improvement Program payments, increasing incentive payments.
- Flexibility with payments to providers
- Capitating fee-for-service providers (must be agreed to by the provider)
- Increasing capitation and fee-for-service payments
- Expediting claims processing and payments
- Removing telehealth from capitation arrangements (i.e., paying fee-for-service for telehealth services)
- Providing grants or loans to providers
- Accelerating claims payment process
- Donating personal protective equipment (PPE) or funding providers' purchases of PPE.
- Other