From: DMHC Licensing eFiling

Subject: APL 20-040 - Network Stability

Date: Monday December 14, 2020 3:32 PM

Attachments: APL 20-040 - Network Stability (12.14.2020).pdf
Template APL Priority Practice Report.xlsx
Template APL Sale or Closure Report.xlsx

Dear Health Plan Representative,

Please see attached All Plan Letter 20-040 and Templates, regarding Network Stability and Health Plan Reporting.

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Sacramento, CA 95814
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ALL PLAN LETTER

DATE: December 14, 2020

TO: All Full-Service Health Care Service Plans[1]

FROM: Sarah Ream
Acting General Counsel

SUBJECT: APL 20-040 - HEALTH PLAN REPORTING REGARDING NETWORK STABILITY

Given the ongoing state of emergency due to the COVID-19 pandemic, the Department of Managed Health Care (DMHC) is concerned health plan networks may be significantly affected by provider closures. Such closures could adversely impact enrollees' ability to access health care services in a timely manner.

Accordingly, pursuant to the authority granted by the Executive Order Governor Gavin Newsom issued on September 23, 2020, health plans (including Medi-Cal managed care plans) must report to the DMHC information regarding contracted primary care practices identified as "priority practices" as defined in this APL, closures or sales of their contracted primary care practices, and how those closures and/or sales may impact the plan's ongoing ability to provide services to enrollees.[2] This APL shall remain in effect until the Governor declares the California State of Emergency regarding COVID-19 is over or the DMHC terminates the APL, whichever is earlier.

I. Reporting Regarding Priority Provider Practices

Health plans shall identify and report to the DMHC regarding those provider practices in their networks that meet the definition of a "Priority Practice," as that term is defined by this APL.

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[1] This APL applies to full-service health plans. It does not apply to health plans with only Medicare Advantage lines of business licensed by the DMHC. It does not apply to Mexican prepaid plans licensed pursuant to Health and Safety Code section 1351.2.

[2] Plans are reminded that, in addition to the reporting required by this APL, they must continue to update their provider directories as required by Health and Safety Code section 1367.27 and submit block transfer filings pursuant to Section 1373.65 and California Code of Regulations, tit. 28, section 1300.67.1.3, as applicable.

A. Definition of "Priority Practice"

For purposes of this APL, a provider practice is a "Priority Practice" if all of the following are true:

1. the practice provides "primary care," as that term is defined in Health and Safety Code sections 1367.69 and 1375.9 and California Code of Regulations, title, 28, section 1300.45;

2. the plan reimburses the practice primarily on a fee-for-service basis for some or all of the services the practice provides to the plan's enrollees[3]; and,

3. during the period for which data is reported, the practice:

    a. submitted at least twenty-five percent (25%) fewer claims to the reporting plan compared to the number of claims the practice submitted to the reporting plan during the same period the previous calendar year; or,

    b. received total reimbursement that, in the aggregate amount, is at least twenty-five percent (25%) less than the aggregated amount of total reimbursement the practice received from the reporting plan during the same period the previous calendar year.

"Priority Practice" refers to the entity to which claims are reimbursed. For example, for a provider in a solo practice, the solo practice is the entity to which claims are reimbursed and the solo practice would be the "Priority Practice" for reporting purposes per this APL. In a multi-provider practice group that receives claims reimbursement, the "Priority Practice" would be the practice group itself, rather than the individuals working in the practice group.

For purposes of this APL, plans do not need to report data regarding institutional providers, such as hospitals, even if the institutional provider would otherwise meet the definition of a "Priority Practice."

B. Assistance to Priority Practices

In addition to identifying Priority Practices, Plans shall report to the DMHC regarding assistance they provided to Priority Practices during the applicable reporting period. Assistance may include, but is not limited to:

- Monetary grants.
- Loans (indicate whether the loan is forgivable or not forgivable) and the terms of the loans, including repayment timelines, interest rates (if applicable), and the conditions under which the plan will forgive a loan.

[3] A plan should not include a practice as a "Priority Practice" if, during the twelve-month period preceding the first day of the applicable reporting period, the plan's aggregated fee-for-service payments to the provider were equal to or less than 10% of the aggregated capitated payments the plan paid to the provider during the same period.

- Reimbursement for COVID-19 CPT codes 99072, 99000, and 87426, or any additional codes related to COVID-19 supports for providers.
- Procurement and provision of personal protective equipment (PPE).
- Reducing administrative burdens (e.g., suspending prior authorization requirements).
- Assistance, financial or otherwise, with implementing telehealth systems.
- Assistance with or funding for electronic health records systems.

When reporting the types of assistance given, the plan shall identify the monetary value of the assistance offered, the Priority Practice(s) to which the plan offered assistance, and the date(s) the plan offered assistance. The plan shall also report whether the Priority Practice(s) accepted some or all of the assistance the plan offered and, if not, the reasons why the assistance was declined, if known to the plan.

C. Information plans must submit to the DMHC regarding Priority Practices

The plan shall submit to the DMHC on a quarterly basis the information required by this APL regarding Priority Practices. The plan shall report the information to the DMHC using the template spreadsheet, attached.

If the plan had no contracted providers meeting the definition of a Priority Practice during the applicable reporting period, the plan shall submit a concise narrative report indicating the plan has not identified any Priority Practices. The report shall include a description of efforts the plan undertook to identify distressed practices during the reporting period.

D. Confidentiality of Priority Practice reports

The DMHC will treat the raw data health plans submit per section I of this APL as confidential information. However, the DMHC may aggregate the data submitted and make that aggregated data publicly available. The DMHC may aggregate the data by plan or may combine the data of one or more plans when making data publicly available. The DMHC will take reasonable steps to ensure the data is aggregated in such a way that no particular practice will be able to be identified from the aggregated data.

II. Reporting Regarding Closed Or Sold Practices

In addition to quarterly reporting regarding Priority Practices as required by Section I of this APL, health plans shall report on a quarterly basis regarding primary care practices in their network(s) that closed or were sold during the reporting period. If the health plan has not identified any provider closures or sales during the reporting period, the plan shall submit a concise narrative report so indicating. The report shall include a description of efforts the plan undertook to identify closed or sold practices during the reporting period.

Plans shall report regarding all primary care practices closed or sold during the period, regardless of whether the plan reimbursed the practice on a fee-for-service basis, a capitated basis, or a mix of the two.

For purposes of this APL, a practice is "closed" if it ceased to provide any services (including telehealth) to any enrollees and the provider anticipates it will either permanently cease providing services (e.g., the provider retired) or will cease providing any services (including telehealth) to any enrollees for four or more consecutive weeks.

For purposes of this APL, a practice is "sold" if the owner(s) of the practice: transferred an interest in the practice to cause change of ownership or control of the beneficial interest in the practice during the reporting period; or, transferred, sold, or effectuated a change of control of fifty percent (50%) or more of the assets of the practice.

Plans do not need to include in their reports submitted per this APL provider information related to a contract termination between the plan, the plan's delegate(s) and the provider, unless such termination was the result of a closed or sold practice.[4]

A. Information plans must submit to the DMHC regarding closed or sold practices

Plans shall submit to the DMHC on a quarterly basis the information required by this APL regarding primary care practices that closed or were sold during the reporting period. Plans shall report the information to the DMHC using the template spreadsheet, attached.

B. Analysis of impact of closures on plan's networks

In addition to providing the data specified above, plans must also provide the DMHC with an analysis of the impact of the practice closures and sales on the plan's networks. The plans must provide the following information for each network impacted by a closure or sale:

1. The total number of individual providers no longer available in the network and the percentage change in the number of providers available in the network due to the closure. Plans shall report this data in two ways: (1) for the current reporting period; and (2) cumulatively to include the current and all previous reporting periods.

[4] The filings required by this APL do not relieve plans of their obligation to file other reports as required by the Knox-Keene Act or its regulations, including a block transfer filing pursuant to Health and Safety Code section 1373.65 or an amendment filing pursuant to California Code of Regulations, tit. 28, section 1300.52(f). S*ee Networks eFiling Instruction Manual,* available in the Downloads section of the eFile web portal, for more information on filing 10% change network amendment filings, pursuant to California Code of Regulations, tit. 28, section 1300.52(f).

2. Geographic and Timely Access: Any ZIP codes that are no longer compliant, as a result of the closures or sales, with the 15 miles/30 minutes requirements for primary care providers or any applicable alternative access standards the DMHC has approved.[5]

3. Capacity: Any plan networks that are no longer able to provide one full-time equivalent primary care provider for every 2000 enrollees in each applicable service area.

III. Plans To Include Information Regarding Sub-Delegated Practices

If the reporting plan's networks contain provider practices that do not contract directly with the reporting plan, but instead are included in the plan's network via subcontracting arrangements, the reporting plan shall nevertheless include information regarding such subcontracted provider practices, as applicable, if the subcontracted provider practice meets the definition of "Priority Practice." As necessary, the reporting plan must obtain this information from its delegated entities.

Plans that hold a restricted or limited license issued by the DMHC do not need to report *to the DMHC* the information required by this APL. However, such plans must report applicable information "upstream" to the fully-licensed health plan(s) with whom they contract (either directly or indirectly), upon request from the fully-licensed health plan(s).

IV. Due Dates Of Reports And How To File

Health plans shall submit their reports through the DMHC's eFiling system as a "Report/Other" (for the filing type) and an E-1 (for the exhibit type) as follows:

Report filed by…	**…will report data from…**	**…and will be titled…**
February 1, 2021	March 1, 2020 through September 30, 2020	"Network report for March 2020-September 2020"
March 1, 2021	4th quarter 2020 (October 1, 2020 through December 31, 2020)	"Network report for 4th quarter 2020"
June 1, 2021	1st quarter 2021 (January 1, 2021 through March 31, 2021)	"Network report for 1st quarter 2021"
Sept. 1, 2021	2nd quarter 2021 (April 1, 2021 through June 30, 2021)	"Network report for 2nd quarter 2021"

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

[5] California Code of Regulations, tit. 28, sections 1300.51(d)(H) & 1300.67.2.1.