From: DMHC Licensing eFiling

Subject: APL 22-032 – Compliance with Senate Bill 1473 (2022)

Date: Tuesday, December 27, 2022 10:47 AM

Attachments: APL 22-032 – Compliance with Senate Bill 1473 (2022) (12.27.2022).pdf

Dear Health Plan Representative,

The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 22-032 which requires health care service plans (health plans) to cover therapeutics for the treatment of COVID-19 without cost sharing, utilization management, or in-network requirements.

Thank you.

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

DATE: December 27, 2022

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

FROM: Sarah Ream
Chief Counsel, DMHC

SUBJECT: APL 22-032 - Compliance with Senate Bill 1473 (2022)

On September 25, 2022, Governor Gavin Newsom signed Senate Bill (SB) 1473, which requires health care service plans (health plans) to cover therapeutics for the treatment of COVID-19 without cost sharing, utilization management, or in-network requirements. SB 1473 took effect immediately on September 25, 2022, except with respect to provisions covering COVID-19 therapeutics, which apply to health plan contracts issued, amended, or renewed on or after September 25, 2022. In addition to addressing coverage of therapeutics to treat COVID-19, SB 1473 requires plans to cover, without cost sharing or utilization management, therapeutics to treat other diseases for which the Governor has declared a state of emergency. This All Plan Letter (APL) sets forth the Department of Managed Health Care's (DMHC or Department) guidance regarding how plans shall comply with SB 1473.

Health plans that cover medical, surgical, and hospital benefits must cover COVID-19 testing, immunizations, and therapeutics without cost sharing or utilization management, regardless of whether the health care provider prescribing, providing, or administering the service(s) is in the plan's network. Coverage of COVID-19 tests, immunizations, and therapeutics includes coverage of the provider visit necessary for the enrollee to receive said test, immunization, or therapeutic.

A. Reimbursement for COVID-19 Therapeutics During the COVID-19 Federal Public Health Emergency

SB 1473 requires health plans to reimburse out-of-network providers with whom the health plan has no specifically negotiated rates for the cost of administering COVID-19 therapeutics "in an amount that is reasonable, as determined in comparison to

[1] This APL applies to full-service commercial and Medi-Cal managed care plans, including limited or restricted plans to the extent the plan has been delegated responsibility for COVID-19 immunizations, testing, and/or therapeutics. This APL does not apply to Medicare Advantage plans or products.

prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered."[2]

For commercial health plans, reimbursement for COVID-19 therapeutics is currently in "an amount that is reasonable" if the plan reimburses the provider in an amount that is at least 125% of the amount Medicare reimburses on a fee-for-service basis for the therapeutic in the general geographic region in which the therapeutic was delivered. If Medicare does not reimburse for a particular therapeutic, the health plan shall reimburse non-contracted providers who administer the therapeutic at the health plan's reasonable and customary rate for the service(s). Commercial health plans may require out-of-network providers to submit claims for reimbursement through the health plan's existing claims process. Commercial health plans shall reimburse providers according to applicable timeframes set forth in Health and Safety Code section 1371.

Medi-Cal managed care plans should reimburse providers for COVID-19 therapeutics in accordance with federal and state laws and regulations regarding Medi-Cal managed care and guidance issued by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS).

While the public health emergency remains in effect, health plans shall continue to provide reimbursement to out-of-network providers for COVID-19 immunizations and diagnostic and screening testing pursuant to the DMHC's guidance issued in APL 22-014.

B. Reimbursement For COVID-19 Testing, Vaccines, and Therapeutics After the End of the Federal Public Health Emergency

For the first six months after the federal public health emergency expires, plan must continue to reimburse providers for COVID-19 tests, vaccines, and therapeutics at either the contracted rate agreed to by the plan and provider or, if the plan and provider have not agreed upon a rate, then at "an amount that is reasonable." The DMHC currently defines "an amount that is reasonable" for purposes of COVID-19 testing, vaccinations, and therapeutics as an amount that is at least 125% of the amount Medicare reimburses on a fee-for-service basis for same or similar services in the general geographic region in which the service was rendered or delivered. If no Medicare reimbursement rate exists for a COVID test or combination of tests, plans shall reimburse out-of-network providers based on the plans' standard fee schedule for the same or similar tests. For purposes of this APL, "125% of the amount Medicare reimburses" shall not include bonus payments or additional payments for the use of specialized equipment or expedited processing.

Beginning six months after the federal public health emergency expires, reimbursement for COVID-19 testing, vaccinations, and therapeutics will be "in an amount that is reasonable" if the plan reimburses the provider at least 100% of the amount Medicare reimburses on a fee-for-service basis for same or similar in the general geographic region in which the service was rendered or delivered, consistent with aforementioned

[2] Health and Safety Code section 1342.2(h)(3).

limitations on applicable bonus payments and extra payments. Beginning six months after the federal public health emergency ends, the guidance in this paragraph supersedes the reimbursement guidance contained in APL 22-014. The Department may also issue further direction and guidance to health plans regarding what notice health plans must provide to enrollees regarding the end of the federal public health emergency.

Commercial health plans shall continue to reimburse providers according to applicable timeframes set forth in Health and Safety Code section 1371 after the public health emergency expires.

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