

From: DMHC Licensing eFiling

Subject: APL 20-033 – Implementation of Emergency Regulation Regarding COVID-19 Diagnostic Testing

Date: Friday September 18, 2020 3:02 PM

Attachments: APL 20-033 – Implementation of COVID-19 Testing (9.18.20).pdf

Dear Health Plan Representative:

Please see the attached APL 20-033 in regards to the implementation of emergency regulation regarding COVID-19 diagnostic testing.

Thank you.



Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: September 18, 2020

TO: All Full-Service Commercial Health Care Service Plans

FROM: Sarah Ream
Acting General Counsel

SUBJECT: APL 20-033 – Implementation of Emergency Regulation Regarding COVID-19 Diagnostic Testing

On July 17, 2020, the Department of Managed Health Care's (DMHC's) emergency regulation regarding COVID-19 diagnostic testing took effect.¹ The DMHC has received a number of questions from stakeholders regarding the emergency regulation. This All Plan Letter (APL) addresses those questions.

1. How does the emergency regulation fit with the COVID-19 testing guidance issued by the California Department of Public Health (CDPH)?

Although the DMHC's regulation and the CDPH guidance both address COVID-19 testing, and should generally be construed consistently,² those two documents are directed at different audiences and address different questions. The emergency regulation applies to full-service commercial health care service plans, including restricted health plans, and specifies when a health plan must cover testing for COVID-19. In contrast, CDPH's guidance is directed to public health officials and providers, such as hospitals, health care providers, and laboratories, and addresses how they should prioritize testing.

¹ The emergency regulation is codified in California Code of Regulations, title 28, section 1300.67.01.

² For example, the DMHC's emergency regulation defines "essential worker" to include "[a] person working in the emergency services sector who has frequent interactions with the public or with people who may have COVID-19 or have been exposed to SARS-CoV-2." For purposes of the DMHC's emergency regulation, "emergency services sector" should be construed consistent with the CDPH guidance, which can be found at this [link](#).

2. If a health plan offers an enrollee who is an “essential worker” (as defined in the emergency regulation) a testing appointment that is within 48 hours of the enrollee’s request, but the testing provider decides a test is not appropriate for the enrollee, has the health plan met its obligation under the emergency regulation to provide a testing appointment?

Yes. For the purpose of the emergency regulation, a testing appointment is one where the enrollee may receive a diagnostic test, based on the judgment of the testing provider. The emergency regulation requires plans to offer an asymptomatic enrollee an appointment with a contracted testing provider that will occur within 48 hours of the enrollee’s request, if the enrollee is an “essential worker” as defined by the emergency regulation. If the enrollee is not an “essential worker” (as defined in the emergency regulation) the plan must offer an appointment that will occur within 96 hours of the enrollee’s request.

If the plan has otherwise complied with its obligations under the emergency regulation, but the testing provider determines that testing is not appropriate for the enrollee at that time, the health plan will still be in compliance with its obligations under the emergency regulation with respect to the enrollee’s request for testing.

The testing provider’s determination that the enrollee does not need a COVID-19 test at that time does not constitute utilization management on the part of the health plan. The emergency regulation does not limit the testing provider’s ability to seek information from the enrollee and determine the need for testing, based on appropriate local, state and federal standards.

3. Are health plans required to offer an appointment for diagnostic testing, even after the enrollee has received a previous testing appointment?

Yes. If an enrollee seeks an appointment for a diagnostic test, the health plan must offer an appointment in accordance with the requirements in the emergency regulation and as explained by Question 2 of this APL. The testing provider may determine, based on local, state or federal guidance or other appropriate standards, that testing is or is not appropriate for the enrollee at that time.

4. Are plans required to cover the cost of the testing appointment, even if the enrollee’s provider decides to not perform or order a COVID-19 test?

Yes. The emergency regulation requires plans to cover “diagnostic testing” for COVID-19. The regulation defines diagnostic testing to include “items and services related to the diagnostic testing for COVID-19 and the administration of such tests.” An enrollee’s appointment to get tested for COVID-19 is related to the testing and administration of the test. If, at the appointment, the provider determines a diagnostic test is not appropriate at that time, the appointment was nonetheless related to testing and administration of a COVID-19 test and, thus, must be covered by the health plan.

5. Does the emergency regulation apply to COVID-19 testing that occurred before the effective date of the emergency regulation (July 17, 2020)?

No, the emergency regulation is prospective and applies only to testing occurring on or after July 17, 2020.

6. When does the emergency regulation expire?

The emergency regulation expires May 14, 2021 and will no longer be in effect after that date unless the DMHC has completed formal rulemaking by that date. This expiration date is based on the 180-day effective period for an emergency regulation, as extended pursuant to Executive Orders N-40-20 and N-66-20.

7. The emergency regulation prohibits health plans from delegating financial risk for COVID-19 diagnostic testing to contracted providers, unless the parties have negotiated and agreed upon a new provision of their contract. Does this prohibition apply to all COVID-19 diagnostic testing or only to testing of asymptomatic “essential workers”?

The prohibition on delegating financial risk unless the parties have negotiated and agreed upon a new provision of their contract applies to all COVID-19 diagnostic testing, regardless of whether the enrollee is asymptomatic or has symptoms of or known/suspected exposure to COVID-19, and regardless of whether the enrollee is an “essential worker” as defined by the emergency regulation.

8. Are health plans required to cover serological tests used to detect antibodies against the SARS-CoV-virus (the virus that causes COVID-19)?

The emergency regulation does not specifically refer to serological tests. Rather, the regulation requires plans to cover “diagnostic testing” as that term is defined in the regulation. The regulation’s definition of “diagnostic testing” mirrors the definitions used in the federal Families First Coronavirus Response Act and the CARES Act. Those definitions look to whether the U.S. Food and Drug Administration (FDA) has approved, authorized or cleared a test. To date, while the FDA has authorized two COVID-19 serology tests, the FDA cautions against using serology tests to diagnose an active COVID-19 infection. Accordingly, health plans currently do not have to cover serological tests for COVID-19 antibodies because such testing is not diagnostic.

9. How should providers report on the claim form whether COVID-19 testing was for symptomatic enrollees and testing of asymptomatic “essential workers” and asymptomatic enrollees who are not “essential workers.”

The emergency regulation provides that plans may not ask for additional proof that an enrollee is an “essential worker” (as defined in the emergency regulation) beyond the provider’s or enrollee’s statement that the enrollee is such an “essential worker.” The DMHC understands that coding for billing purposes in this instance may be difficult, as

there are no generally accepted codes to identify an enrollee as being “an essential worker” as defined in the regulation. However, the DMHC does not have specific guidance regarding coding. The DMHC recommends health plans and providers work together to determine the most efficient way to accurately code for these services.

10. What should a health plan do if it has difficulty finding enrollees appointments with available testing providers³ within the timeframes required in the regulation?

An enrollee may go to any available testing provider if the plan fails to secure an appointment for the enrollee within the applicable timeframes. If a health plan is encountering difficulty securing appointments within the timeframes specified, the health plan should first consult with its contracted providers to determine if more appointments can be made available. The health plan should also consider contracting with additional testing providers. However, if the plan believes the difficulty is due to a general shortage of testing availability, the health plan should contact its assigned reviewer in the DMHC’s Office of Plan Licensing. The DMHC will provide health plans guidance on what information the plan must provide to the assigned reviewer, in the case of a general shortage of testing availability.

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

³ The regulation defines the term “testing provider” as “any professional person, health facility or other person or institution licensed or authorized by the state to deliver or furnish COVID-19 diagnostic tests.”