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ALL PLAN LETTER

DATE: August 12, 2026

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

FROM: Sarah Ream
Chief Counsel

SUBJECT: APL 26-012 - Additional guidance regarding billing and payment requirements for COVID-19 testing

The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide further guidance regarding health plan reimbursement for COVID-19 testing.

Note: This APL applies solely to single-virus COVID-19 tests across different testing modalities (e.g., PCR, antigen, point-of-care), and does not govern reimbursement for broader respiratory panel testing that may include COVID-19 testing, unless the cost for the COVID-19 test is clearly broken out and identified in the claim submitted to the health plan.

I. Clarification regarding delegation of risk for COVID-19 testing or vaccinations

On January 15, 2026, the DMHC issued APL 26-002. Section I of the APL, titled "Delegation of risk for COVID-19 testing or vaccinations," clarified that, for purposes of shifting risk for COVID-19 testing or vaccinations, the DMHC considers any type of risk shifting from a plan to a provider to be a form of risk delegation. Prior to shifting the risk for COVID-19 testing or vaccinations from the plan to the provider, the plan must first have negotiated with the provider specifically regarding shifting COVID-19 testing or vaccinations risk and the provider must have agreed to accept that risk.

The DMHC clarifies that Section I of APL 26-002 applies prospectively from January 15, 2026, the date the DMHC issued the APL. The DMHC does not expect health plans to reopen, based on APL 26-002, delegation agreements with providers entered into prior

[1] This All Plan Letter does not apply to Medi-Care Advantage health plan products or to Medi-Cal Managed Care products. This APL does apply to restricted and limited health plans to the extent the health plan has been delegated responsibility for COVID-19 testing and/or vaccinations.

to January 15, 2026, unless the terms of the delegation of risk do not specifically reference COVID-19 testing or vaccinations and the plan and provider are not in agreement that the provision encompasses COVID-19 testing or vaccinations.

The DMHC also does not expect plans to reopen, based on APL 26-002, claims a plan paid prior to January 15, 2026, where the provider expressly agreed in writing (e.g., via contractual compromise, settlement agreement) to accept the amount paid as full compensation for COVID-19 testing or vaccination services provided.

II. Plans may not refuse to reimburse, or reduce reimbursement to, a provider solely on the grounds that the provider collected the specimen for a COVID-19 test and also performed the test or on the grounds that the provider used contracted staff to perform some or all the COVID-19 testing services.

California Health and Safety Code section 1342.2 requires plans to reimburse providers for the costs of COVID-19 testing and for the "health care services related to" such testing. Plans must reimburse providers, including laboratory providers, for those services at the greater of either a specifically negotiated[2] rate agreed to by the provider or at a rate that is at least 125% of the rate Medicare reimburses for the service in the geographic location where the service was delivered.

Section 1342.2, subdivision (a), defines "services related to COVID-19" testing expansively. Such services include "provider office visits for the purpose of receiving testing, products related to testing, the administration of testing, and items and services furnished to an enrollee as part of testing." Plans must reimburse for these services regardless of whether one provider delivered all the services attendant to administering a COVID-19 test (i.e., the provider collected the sample and performed the test) or one provider collected the sample and another provider performed the test. Plans may not limit reimbursement to a provider to only a portion of the services the provider delivered if (1) the provider or its subcontractor who performed the services for which the provider seeks compensation holds the necessary licenses, credential, etc. to perform the services, (2) the services were actually performed, and (3) other grounds for denying or reducing payment do not exist. Likewise, a plan may not deny payment for all or a portion of the services solely on the grounds that the medical personnel who performed some or all the services were contracted by the provider (e.g., contracted nursing staff), so long as the plan is not double billed for the services.

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

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[2] The DMHC considers the rate to have been "negotiated" by the plan and provider only if the provider has expressly agreed in writing to accept the rate as payment for the specified services. If, in the absence of a negotiated rate, a plan sends payment to a provider that is less than 125% of what Medicare would pay for the service, the DMHC would not consider the plan to have complied with the requirements of Health and Safety Code section 1342.2.