AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

April 17, 2020

Mary Watanabe
Acting Deputy Director
Department of Managed Healthcare
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Sacramento, CA 95814
Sent via email

Re: Temporary Extension of RBO and Provider Group Reporting/Compliance Deadlines

Dear Mary:

Thank you for the issuance of the Department's APL 20-015 concerning temporary extension of plan deadlines, dated April 13, 2020 (attached). As you know, APG's members have reporting and compliance deadlines that are processed through the health plans, as well as directly reported to the Department. Our members are currently involved in the front lines of the COVID-19 pandemic in their clinics and in hospitals. We anticipate disruption in the normal business processes to last through the remainder of 2020.

We are writing to clarify the scope of APL 20-015. It does not appear from the language that the Department's extension of several deadlines would also be applicable to the contracted delegated physician groups that deliver care within health plan networks. Because our membership has clinical as well as administrative functions, their need for similar temporary extensions is even greater than health plans.

Capitated/delegated groups are functioning as best they can in a chaotic environment. Administrative functions have been relocated over the past few weeks, however clinical staff must continue to function in person for all emergent and urgent health care delivery services. Some organizations have had to furlough personnel. Most of our members have rallied to deploy telehealth to thousands of practices across California within a matter of a few weeks, changing the patterns of care delivery that will necessitate later financial reconciliation. Our members also anticipate disputes with some health plans over material risk-shifting that has occurred without prior notice and opportunity to negotiate in compliance with contractual provisions and the Provider Bill of Rights. Plan-level assistance has been offered in some limited cases, but it is drying-up as plans consider their own potential losses from employer terminations of coverage.

While capitated payments have continued, plans have waived patient cost-sharing, which is not revenue for the plan, but for the provider rendering the direct service. We agree that barriers to access should be removed where possible, to facilitate COVID screening and testing. But

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several plans have gone well beyond that policy, without prior consultation with their provider networks. Some plans, such as Blue Shield and Health Net have indicated that some arrangement concerning this lost provider revenue will be determined in the future. Other plans, notably Anthem, have done so without prior notice in violation of the Provider Bill of Rights and indicated that no compensation will be forthcoming. APG members are continuing to sub-capitate their idle specialty practices, as well as PCPs, and are advancing additional financial support where necessary. Such advances will deplete reserves for any future surge of non-COVID services after the emergency abates.

Many practices have also been unable to collect any copays for non-COVID-related telehealth due to the haste in which visits have been provided under platforms that do not support billing. Here again, our members report that several plans are waiving copays for any telehealth services, without prior notice or consultation with their contracted network providers. Our groups will have to track encounters as best as possible and try to reconcile payments after the fact.

We cite these problems over health plan copay waiver policies because the broad scope of this cost shift will take months to reconcile and will impact RBO reporting accuracy. In addition to this problem, as employers shed more employees health plans will experience a loss of premium revenue. This process also involves significant risk shifting of losses to provider groups. As the employer-sponsored coverage terminates risk-bearing groups will experience significant retroactive capitation deductions after services have been rendered beginning 30, 60 and 90 days out. Individual employees often choose to elect COBRA, but do not pay the premium unless they require services. This results in further retroactive capitation deductions by plans after the risk-bearing group for these individuals. A plan would bear the loss of 15 cents on the premium dollar while providers would bear an 85-cent loss under these circumstances. These impacts will hit our members months later and will force restatements of financial position.

Compliance with normal Department and plan audit schedules will therefore be difficult to meet until full reconciliations can be performed and revised audit standards developed that recognize the unprecedented situation faced during the COVID-19 pandemic. We urge the Department to undertake the revision of audit content as soon as possible. In our discussions with DHCS, we recognize that this may require an Executive Order and/or legislative approval.

This is a list compiled by our membership of the common reporting and compliance functions that we request be extended/relaxed during the pendency of the emergency, as the Department has done for similar functions with its regulated plans:

1. Authorization Turn Around Times and Documentation - remove requirements or extend, without penalty, the standard authorization turnaround times by 72 hours. Relax the collection of documentation, except in cases of denial. This will free up staff resources spent on gathering information where an approval decision within benefit limits can be make more quickly. While our membership has demonstrated continued compliance with existing timelines due to the drop in usual patient volume, they anticipate that the April and May surge will impact turnaround times.

2. Claims Payments - extend, without interest penalty, timely payment of claims:
    a. Commercial - 180 calendar days
    b. ERISA - 60 calendar days to deny; 60 business days to pay
    c. Medi-Cal -180 calendar days to pay

3. Misdirected Claims - extend, without penalty, timeline for forwarding misdirected claims:
    a. 120 calendar days

4. Notification of Claims Appeal - extend, without penalty, timeline for sending appeal notice:
    a. 120 calendar days

5. Notification of Receipt of Claim - extend, without penalty, timeline for notice of receipt of claim:
    a. Electronically 20 calendar days
    b. Paper 60 calendar days

6. Encounter Data Submission - encounter data submission timelines should also be extended to match the prior claims payment deadline extension requested above.
    a. Commercial - 180 calendar days from date claim was paid
    b. ERISA - 60 calendar days from when claim was paid
    c. Medi-Cal - 180 calendar days from when claim was paid

7. Expedited credentialing - Allow delegated groups to create an expedited credentialing process, similar to Medicare, to allow non-contracted physicians or physicians who are already in the process of becoming credentialed to join the payors' networks.

8. DMHC RBO audits – Postpone any scheduled audits to no earlier than 6 months after the emergency has been rescinded.

9. RBO Financial Reporting – Postpone financial reporting to no earlier than 6 months after the emergency has been rescinded. Many of our members will need to reconcile plan payments and non-payment for services, disputed cost-shifting, and breach of plan-provider contracts. It

now appears that the complexity of various plan positions on covered services, cost-shifting, and the impact of federal financial support programs will make accurate reporting impossible. Allowing later restatements will just result in our membership incurring duplicative compliance costs.

10. Delegation Oversight Audits – NCQA requires health plans to perform audits of delegated organizations every 12 months. We are uncertain whether DMHC has a role in this process, however, to the extent that it does, it would be very helpful to allow extensions of up to 120 days beyond the 12 month time limit for any audit that must be conducted during calendar year 2020. Many plan audits are currently scheduled during the August and September months this year. That is during the anticipated time when our members will be addressing pent-up demand for non-COVID-19 services.

11. Claims Timely Filing - extend, without penalty, timely filing for fee for service claims. Our members will need to track services performed under telehealth, compile claims and reconcile them prior to submission to payers. Many will not be able to do so until the emergency has been rescinded:

a. Commercial - extend to 365 days
b. Medi-Cal - extend to 365 business days

APG and its members appreciate the Department's consideration of these requests. Please let us know whether you may require further information and/or discussion.

Respectfully submitted,

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