DEPARTMENT OF MANAGED HEALTH CARE
Average Contracted Rate Methodology and Default Rate (2017-5223)
Responses to Comments for
Comment Period #1, February 2, 2018 – March 19, 2018

#	FROM	COMMENT	DEPARTMENT RESPONSE
1-1	Jeff Poage, MD California Society of Anesthesiologists (CSA)	The California Society of Anesthesiologists (CSA) appreciates the opportunity to comment on the Department of Managed Health Care's (DMHC) draft comments on the continued implementation of AB 72, in particular the development of the Average Contracted Rate (ACR) methodology and the default rate. CSA represents more than 3,000 physician anesthesiologists who believe that patients should not be in the middle of balance billing situations when physicians are unable to come to contract terms with health care service plans and any entity to which a plan delegates responsibility for payment of claims (hereafter collectively "plans"). We aim to provide the best care and coverage for our patients and appreciate DMHC's concern that anesthesia services are available and accessible and that AB 72 does not jeopardize our ability to come to fair contract terms with our plan partners. The development of the ACR is a critical component of achieving the goals of AB 72 and there must be a fair balance struck in these regulations. While our chief concerns continue to focus on the misapplication of the definition of the Anesthesia Conversion Factor, we also believe that DMHC should adhere to a claims-volume weighted methodology for the ACR. We also firmly believe that AB 72, and its precursor, AB 533 have provided plans with cover to stop negotiating provider contracts in good faith. DMHC must provide a fair	Thank you for your comment. No specific change requested. Please see the response to comment # 1-5 regarding the concern about application of the anesthesia conversion factor, and the response to comment # 1-2 regarding the concern about the applicable calendar year.

		starting point for what year is appropriate in terms of using payor or claims data in the ACR calculation.	
1-2	Jeff Poage, MD California Society of Anesthesiologists (CSA)	**1300.71.31(a)(1)/ "Applicable Calendar Year":** When defining the ACR, DMHC must provide a neutral starting point in time for when plans have provided payor data. The legislative process that led to the passage of AB 72 was acrimonious. Even before the bill was signed, the legislation created a situation where plans in different parts of the state refused to renegotiate contracts in good faith. This was CSA's chief concern as the bill moved through the Legislature and has been born out in reality, even prior to the effective date of any of the provisions of the legislation. Just these cases provide CSA with great concern that the trend will continue, and we ask DMHC to implement this bill in a way that assures access to care and maintains robust provider networks. 2015 was the last year payors could not use legislation as a cover for how they negotiate contracts or how they pay out claims to provider groups. Then pursuant to the applicable calendar year established, CSA strongly urges DMHC to include in the definition that the ACR is to be adjusted by the CPI for the Medical Care Services to reflect current rates.	DECLINED. The DMHC determined the requested change is not necessary to effectuate the statute, Health and Safety Code section (HSC) 1371.31. Under the statute, the 2015 base year and the CPI are not required to apply after promulgation of this proposed regulation. The DMHC has made the policy determination that permanently including the CPI inflator in the ACR methodology would put undue upward pressure on contracted reimbursement rates, in a manner that is potentially out of step with actual market trends. Increasing health care costs was not the intent of the Legislature when enacting AB 72. Additionally, the retrospective base year under the proposed Rule is consistent with the approach under the statute. For use in the year 2017, HSC section 1371.31(a)(2)(A) required payors to develop an interim average contracted rate (ACR) based on rates from calendar year 2015. Thus, using a base year of two years prior is consistent with the approach under the statute. Again, HSC section 1371.31 subdivision (a)(2)(B) provides for application of the CPI inflator only "…until the standardized methodology under paragraph

			(3) is specified…" (emphasis added).
1-3	Jeff Poage, MD California Society of Anesthesiologists (CSA)	**1300.71.31(c)(1):** CSA strongly supports the definition of "Average Contracted Rate" as the claims-volume weighted average of the contracted commercial rates paid by the payor. Health and Safety Code §1371.31(a)(1) defines the ACR as, "the average of the contracted commercial rates paid." A claims-volume weighted average is the only way to accurately measure what is actually being paid for services in the market. As DMHC explains, this approach avoids unduly weighting the average in favor of low-volume contracts. If payors were to calculate their ACR by only taking into account each contract for a particular service, contracts with several individual physicians, that together account for a small volume of patient services, could greatly outweigh a contract with one large group of physicians, which accounts for a substantial volume of patients services. Hence, taking into account the volume of claims the payor paid at a specific contracted rate is the only accurate way to represent what is actually being paid for services in the market. Incorporating the volume of claims provided under each contract into the calculation also ensures that higher and lower outlier rates will not skew the average.	Thank you for your comment. No change requested.
1-4	Jeff Poage, MD California Society of Anesthesiologists (CSA)	**1300.71.31(c)(5):** In order to ensure that it is clear the appropriate adjustments are just those listed, and no others. We suggest the following language: *"Once the average contracted rate is determined under this subdivision (c) and is found to be the appropriate default reimbursement according to Health and Safety*	Partially accepted, partially declined. PARTIALLY ACCEPTED: The DMHC added a reference to payment of the average contracted rate (ACR) in compliance with the statute (HSC

		Code 1371.31(a) (1), the payor may adjust the rate when it reimburses the noncontracting individual health professional to take into account relevant payment modifiers and other health care service-specific or claim-specific factors in compliance with the Knox-Keene Act that affect the amount for reimbursement of the health care services rendered by the contracting individual health professional."	section 1371.31(a)(1)) to clarify what law governs determination of the appropriate default reimbursement rate. The DMHC also changed "shall adjust" to "may adjust" to clarify that adjustment for relevant payment modifiers is required only as is appropriate for a particular claim. PARTIALLY DECLINED: The commenter's stated goal is to "ensure that it is clear the appropriate adjustments are just those listed, and no others." However, the DMHC declines to expressly limit adjustment factors to those listed in the Rule as requested because doing so would be too prescriptive. Rather, it is appropriate to allow for claim reimbursement adjustment as otherwise permissible under the Knox-Keene Act.
1-5	Jeff Poage, MD California Society of Anesthesiologists (CSA)	**1300.71.31(c)(6):** Specifically, we maintain concerns that the Anesthesia Conversion Factor (ACF), which is present in every commercial contract between anesthesia groups and health plans, continues to appear in DMHC's draft regulations as if it is not common or widely understood in our contracts. We have provided DMHC with definitions and information on the ACF in our July 14, 2017 and November 22, 2017 letters, as well as specifically defining it in an email to DMHC staff on June 13, 2017. In this draft of the proposed regulations, as well as the worksheets provided to health plans during the summer of 2017, the ACF is referred to as an "if applicable" component of contract negotiation and reimbursement. This is not acceptable for anesthesia contracts. Language that supposes the applicability of	Partially accepted, partially declined. PARTIALLY ACCEPTED: To clarify the role of anesthesia conversion factors and reimbursement adjustment factors typically applicable in the context of anesthesia services, the DMHC struck "if applicable" and added reference to RVG base units to proposed rule 1300.71.31, subdivision (c)(6). PARTIALLY DECLINED: Although the DMHC agrees with the commenter that it is appropriate to clarify the Rule by adding the reference to

		the ACF could allow health plans to treat this longstanding formula as optional and the values negotiable, which would erode years of negotiations, group agreements, and network adequacy for patients. The following language should be used instead: *(i)The payor shall use the anesthesia conversion factor ("ACF") set forth in the payor's provider contracts instead of an "allowed amount" to complete the calculat ion pursuantto subdivision (c)(1).* *(ii)The average contracted rate for services within subdivision (c)(6)(i) above shall be determined by multiplying the ACF by the sum of RVG base units, time units, and physical status modifier.*	relative value guide (RVG) base units, the DMHC declines to re-word proposed subdivision (c)(6)(ii) (revised (c)(6)(B)) in the manner suggested by the commenter. Rather, the DMHC believes it is appropriate to continue to reference the sum of RVG base unit/time unit/physical status modifiers as an adjustment factor under proposed subdivision (c)(5). Those factors are generally claim-specific and should therefore be applied at the time of reimbursement, pursuant to subdivision (c)(5).
1-6	Jeff Poage, MD California Society of Anesthesiologists (CSA)	**1300.71.31(e)(2):** We support the following language: *"The payor shall indicate on claims payment documents whether it used the average contracted rate or 125 percent of the Medicare rate for payment of the default reimbursement rate."* Thank you for considering our points.	DECLINED. Reimbursement pursuant to the relevant statutes may be the ACR or 125% of the applicable Medicare rate, or it may be another agreed-upon amount, or it may be an amount paid pursuant to the evidence of coverage (EOC) (see HSC sections 1371.31(a)-(b) and 1371.9(c)). Therefore, the language suggested by the commenter is not appropriate and does not accurately state the law.
2-7	Catrina Reyes, Esq. California Medical	On behalf of our more than 43,000 physician and medical student members, the California Medical Association (hereinafter "CMA") would like to thank	Thank you for your comment. No change requested.

	Association (CMA)	you for considering comments on the Department of Managed Health Care's (hereinafter "the Department") proposed regulations to implement Assembly Bill 72, codified at Health & Safety Code §§1371.30, 1371.31, and 1371.9. Health & Safety Code § 1371.31(a)(3)(A) requires the Department to specify by January 1, 2019 a methodology that plans and delegated entities (hereinafter "payors") shall use to determine the average contracted rates (hereinafter "ACR") for services most frequently subject to Health & Safety Code §1371.9. As the Department indicated in its Initial Statement of Reasons, the regulations address the problem of ambiguity in key terms and phrases used in Health & Safety Code § 1371.31. CMA supports the Department's efforts to provide clarity for complying entities, which will ensure that payors do not apply widely varying interpretations of the law and that there is uniformity in the payment methodology.	
2-8	Catrina Reyes, Esq. California Medical Association (CMA)	**Section 1300.71. Claims Settlement Practices** **Subdivision (a)(8) Definition of "Demonstrable and Unjust Payment Pattern" or "Unfair Payment Pattern"** CMA urges the Department to include in the definition of "demonstrable and unjust payment pattern" or "unfair payment pattern" failure to use the ACR methodology described in section 1300.71.31 and failure to pay the Default Reimbursement Rate described in section 1300.71.31 and required by Health & Safety Code § 1371.31(a)(1). It is CMA's	ACCEPTED. The DMHC agrees that a pattern of failure to pay noncontracting individual health professionals the reimbursement described in section 1300.71.31 and required pursuant to section 1371.31 for health care services subject to section 1371.9, and a pattern of failure to determine the ACR for health care services subject to section 1371.9 in a manner consistent with section 1300.71.31, may constitute an unjust payment pattern.

		understanding that when the Department adopted the definition to clarify the meaning of unfair payment practices, the Department reasoned that timely and accurate reimbursement of provider claims are necessary to ensure a stable and financially viable health care delivery system. Moreover, unreasonable delays by payors to settle provider claims results in unnecessary expenditure of personnel time and energy by providers in their repeated attempts to get claims paid. These resources would be better spent on providing quality health care services to patients. This same reasoning applies when payors fail to use the required ACR methodology and/or fail to pay the Default Reimbursement Rate, therefore the definition of "demonstrable and unjust payment pattern" or "unfair payment pattern" should be expanded to include failure to use the ACR methodology described in section 1300.71.31 and failure to pay the Default Reimbursement Rate also described in section 1300.71.31 and required by Health & Safety Code § 1371.31(a)(1).	Accordingly, the proposed rule includes new subdivisions (8)(U)-(V). The DMHC also updated the authority and reference note for Rule 1300.71, consistent with these amendments.
2-9	Catrina Reyes, Esq. California Medical Association (CMA)	**Subdivision (s)(2) Review and Enforcement** Given that compliance by payors with the required ACR methodology and correctly paying the Default Reimbursement Rate is necessary to ensure a stable and financially viable health care delivery system, the regulations must provide for the review and enforcement by the Department of these requirements as set forth in Health & Safety Code §1371.31. As such, CMA urges the Department to include section 1371.31 of the Health & Safety Code in the enumerated sections in subdivision (s)(2) to ensure that failure of a plan to comply with the	ACCEPTED. The DMHC has made the proposed amendment to the regulation.

		requirements of Health & Safety Code §1371.31 may constitute a basis for disciplinary action against the plan.	
2-10	Catrina Reyes, Esq. California Medical Association (CMA)	**Section 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate** **Subdivision (a) Definitions** (1) "Average contracted rate" *Average Contracted Rate.* CMA strongly supports the definition of "average contracted rate" as the claims-volume weighted average of the contracted commercial rates paid by the payor. Health & Safety Code §1371.31(a)(1) defines the ACR as, "the average of the contracted commercial rates *paid*" [emphasis added]. A claims-volume weighted average is the only way to accurately measure what is actually being *paid* for services in the market. As the Department explains, this approach avoids unduly weighting the average in favor of low-volume contracts. If payors were to calculate their ACR by only taking into account each contract for a particular service, contracts with several individual physicians, that together account for a small volume of patient services, could greatly outweigh a contract with one large group of physicians, which accounts for a substantial volume of patient services. Hence, taking into account the volume of claims the payor paid at a specific contracted rate is the only way to represent what is actually being paid for services in the market. Incorporating the volume of claims provided under each contract into the calculation also ensures that higher and lower outlier contracted rates will not skew the average.	Thank you for your comment. No change requested.
2-11	Catrina Reyes, Esq. California Medical	*Applicable Calendar Year.* Health & Safety Code §1371.31(a)(3)(A), which directs the Department to develop a standardized methodology for determining ACR by 2019, does not specify what calendar year is	No specific change requested. See response to comment 1-2.

	Association (CMA)	to be used in the standardized methodology. As such, the proposed regulations define in subdivision (a)(1) the applicable calendar year as the "two years prior to the year in which the health care service was rendered." CMA has several concerns with this definition of applicable calendar year.	
2-12	Catrina Reyes, Esq. California Medical Association (CMA)	Health & Safety Code §1371.31(a)(2)(A)(i) specifies that by July 1, 2017, each health care service plan and its delegated entities shall provide to the Department data listing its ACR for the plan for services most frequently subject to Section 1371.9 in each geographic region in which the services are rendered *for the calendar year 2015*. The Legislature's intent in using 2015 rates in Health & Safety Code §1371.31(a)(2)(A)(i) was to capture a snapshot of the market prior to the passage of A.B. 72 in 2016. CMA has conveyed to the Department reports we have heard of several plans failing to negotiate contracts in good faith and/or closing their panels entirely, which has affected the stability of contracted commercial rates beginning in 2016, as well as the stability of provider networks. In order to preserve the contracted commercial rates prior to A.B. 72 and to avoid network destabilization via rate manipulation, CMA urges the Department to require payors to instead use contracted rate data from calendar year 2015 and adjust it by the CPI for Medical Care Services for three years (CY 2016, CY 2017, and CY 2018) when determining the 2019 ACR and then adjust it annually for the subsequent years.	DECLINED. See response to comment 1-2. The DMHC will continue to monitor complaints received regarding non-compliance with the Knox-Keene Act and take further action when appropriate.
2-13	Catrina Reyes, Esq. California Medical Association (CMA)	Whatever applicable calendar year the Department establishes, CMA strongly urges the Department to include in the definition that the ACR is to be adjusted by the CPI for Medical Care Services to reflect current rates. The 2017 ACR submissions required by Health &	DECLINED. See response to comment 1-2.

		Safety Code §1371.31(a)(2) are adjusted annually by the CPI for Medical Care Services, which demonstrates the Legislature's intention that reimbursement should reflect current market rates. In addition, adjusting the ACR by the CPI for Medical Care Services to reflect current rates ensures an accurate comparison with the Medicare rate given that the Medicare rate has been defined as the rate in place in the year in which the health care service was rendered.	
2-14	Catrina Reyes, Esq. California Medical Association (CMA)	(3) "Geographic region" Subdivision (a)(3) of the proposed regulations define "geographic region" as having the meaning described in subdivision (a)(6) of section 1371.31 of the Knox-Keene Act, for both the default reimbursement rate based on the Medicare rate and average contracted rate. For clarity, CMA suggests the following substitute language for subdivision (a)(3): "'Geographic region' has the meaning described in subdivision (a)(6) of section 1371.31 of the Knox-Keene Act, whether the default reimbursement rate is based on the Medicare rate or the average contracted rate."	ACCEPTED. The DMHC has made the amendment to subdivision (a)(3).
2-15	Catrina Reyes, Esq. California Medical Association (CMA)	In addition, CMA urges the Department to include in the definition that the reimbursement rate is based on the geographic region in which the services were rendered as specified in Health & Safety Code §1371.31(a)(1). In situations where a service is initiated in one region and completed in another, in the case of laboratory work, for example, there may be misunderstandings as to which region to base the reimbursement rate. Specifying this in the definition avoids this misunderstanding and ensures uniformity in the payment methodology.	DECLINED. HSC section 1371.31(a) specifies that the default rate is based on the geographic region in which services were rendered. Adding CMA's requested language would be duplicative of the statute and is not necessary.
2-16	Catrina Reyes, Esq. California Medical Association (CMA)	(4) "Integrated health system" As explained further below under subdivision (d), the definition of Integrated Health System lacks authority,	ACCEPTED. The DMHC struck the proposed definition of "integrated health system" and made

		consistency, and clarity. The definition focuses on a delivery system organizational model as opposed to a payment system model as limited by the statute, thereby capturing any network of providers that coordinates services, including most delegated entities. Accordingly, the definition is too broad and therefore enlarges the scope of the narrow exemption in Health & Safety Code §1371.31(a)(3)(C).	conforming changes to proposed subdivision (d)-(e), for greater clarity and consistency with HSC section 1371.31(a)(3)(C).
2-17	Catrina Reyes, Esq. California Medical Association (CMA)	(5) "Medicare rate" CMA strongly supports the Department specifying that the calendar year in which the health care service was rendered applies for payments using the Medicare fee-for-service rate. As the Department explains, basing reimbursement on the year in which the health care service was rendered is consistent with how Medicare pays claims. Moreover, this is consistent with the Legislature's intention that payments subject to Health & Safety Code §1371.31(a)(1) should reflect current rates.	Thank you for your comment. No change requested.
2-18	Catrina Reyes, Esq. California Medical Association (CMA)	CMA strongly opposes the use of the reimbursement rate paid to providers participating in Medicare ("par" rate) for determining the Medicare rate. Medicare participating physicians are reimbursed at a lower rate because they enjoy the benefits of contracting such as increased volume of patients and referrals from the payor. Physicians subject to the provisions of Health & Safety Code §§1371.31 and 1371.9 will *not* receive the benefits of contracting. Accordingly, CMA urges the Department to use the Medicare "limiting charge" for nonparticipating providers in the Department's definition of the Medicare rate.	DECLINED. The DMHC considered using the "non-participating" ("non-par") Medicare rate as the baseline for the Medicare alternative for the default reimbursement rate, rather that the "participating" Medicare rate. However, the DMHC has rejected the non-par approach because it is not analogous to the other default reimbursement rate alternative: the ACR. The ACR is the average of contracted rates, which is more akin to "participating" Medicare rates. Thus, a better comparison for the ACR is the "participating" Medicare rate.

2-19	Catrina Reyes, Esq. California Medical Association (CMA)	CMA understands that the "par" Medicare rate allows for a comparison to the ACR given that contracted rates are used in the ACR calculation. However, when a statistically credible database is used to determine the ACR, the Legislature made clear that the database must reflect "rates paid to noncontracting individual health professionals," as specified in Health & Safety Code §1371.31(a)(3)(C). In this case, the ACR is based on "rates paid to noncontracting individual health professionals," making the use of the Medicare nonparticipating "limiting charge" necessary for an appropriate comparison.	DECLINED. Please see the DMHC response to comment 2-18. Additionally, it should be noted that HSC section 1371.31(a)(3)(C) applies only to specified, narrow circumstances, and does not generally govern payment of the default reimbursement rate.
2-20	Catrina Reyes, Esq. California Medical Association (CMA)	<u>(7) "Services most frequently subject to section 1371.9"</u> CMA supports the concept of the definition of "services most frequently subject to section 1371.9." Nonetheless, CMA urges the Department to define the term as at least the top 80 percent of services subject to Health & Safety Code § 1371.9 within each category of services instead of across all service categories. The Department's proposed definition may capture a more limited set of services that may not reflect the span of services across categories and specialties that are most frequently subject to Health & Safety Code § 1371.9. For instance, simply due to the frequency of use of a particular service, that service may comprise the top 80 percent of the payor's statewide claims volume for services subject to Health & Safety Code § 1371.9, and services in other categories that are also frequently subject to Health & Safety Code § 1371.9 would not be captured under the Department's proposed definition. CMA recognizes the Department's concerns that a category-based approach could exclude some of the services most frequently subject to Health & Safety Code § 1371.9. However, if the categories of services used is comprehensive, such	DECLINED. The DMHC considered defining the term "most frequently subject to section 1371.9" according to the top specified percentage of AB 72 claims within broad service categories (e.g., anesthesia services), instead of across all service categories. However, the DMHC determined that a category-based approach could exclude some of the more frequently-claimed health care service codes, which is inconsistent with Health and Safety Code section 1371.31. However, we note that this proposed Rule expressly allows payors to employ the Rule's standardized methodology for any service subject to HSC section 1371.9. Additionally, for any services that are less frequently subject to section 1371.9, the payor's methodology shall be a reasonable method of determining the average contracted

		as Current Procedural Terminology ("CPT") code sections, i.e. evaluation and management, anesthesia, surgery, radiology, pathology and laboratory, and medicine, a majority of the services most frequently subject to Health & Safety Code § 1371.9 should be captured. In addition, the Department will be better able to assess network adequacy by specialty and payor under this approach.	commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year (see proposed Rule 1300.71.31(b)(2)).
2-21	Catrina Reyes, Esq. California Medical Association (CMA)	<u>(8) "Services subject to section 1371.9"</u> In subdivision (a)(8), the definition of "services subject to section 1371.9" includes nonemergency health care services provided to the enrollee by a noncontracting individual health professional as a result of covered health care services received at a contracting health facility. CMA understands that the Department is clarifying that A.B. 72 applies to some noncontracted services that are not rendered in the contracted health facility as provided for in Health & Safety Code § 1371.9(a)(1). The example provided by the Department in its Initial Statement of Reasons is when an enrollee has blood drawn at an in-network facility but it is sent for processing to an out-of-network lab and the resulting report is read by a noncontracting pathologist, the pathology services would be subject to section 1371.9 because they were "a result of" a service rendered at an in-network facility. CMA is concerned that without further clarification and limitation in the regulations of the kinds of services not rendered in the contracted health facility that would be subject to section 1371.9, the definition in the proposed regulations may be misinterpreted to include a broad range of services not intended or envisioned to be subject to section 1371.9. For instance, follow-up visits with a noncontracting individual health professional may arguably occur "as a result of covered health care	DECLINED. The language of the proposed Rule regarding health services "as a result of" covered health services at a contracting health facility is consistent with the language of HSC section 1371.31. To avoid an overly rigid definition, the DMHC declines to expressly describe which services may or may not be the "result of" such covered services.

		services received at a contracting health facility," however, these services were not intended to be subject to section 1371.9. As such, CMA urges the Department to provide further clarification and limitation in the regulations of the kinds of services not rendered in the contracted health facility that would be subject to section 1371.9.	
2-22	Catrina Reyes, Esq. California Medical Association (CMA)	**Subdivision (b)** <u>Subdivision (b)(2)</u> CMA strongly supports the inclusion in the regulations that for services not frequently subject to 1371.9 and therefore not subject to the standardized methodology, the payor may use the standardized methodology to determine the ACR, but if the payor uses a different methodology, that different methodology shall be a reasonable method. However, CMA urges the Department to also include in subdivision (b) that unless otherwise agreed to by the noncontracting individual health profession and the payor, the payor *must pay* the noncontracting individual health profession the "default reimbursement rate" for *all* health care services subject to Health and Safety Code section 1371.9 and not only for those "most frequently" subject to 1371.9 as provided for in Health & Safety Code § 1371.31(a)(1). Though this clarification is in subdivision (e)(1), also including it in subdivision (b) will help further clarify the confusion on this issue given that payors may mistakenly think that for services for which the standardized methodology does not apply, payors are not required to make payments pursuant to Health & Safety Code §1371.31(a)(1).	Partially accepted and partially declined. PARTIALLY DECLINED: The Rule's requirement to pay the default rate already uses the mandatory word "shall." Subdivision (b) states that for services subject to 1371.9, "payors <u>shall</u> comply with subdivision (e)" (regarding payment of the default rate) and, for services most frequently subject to section 1371.9, <u>shall</u> use the methodology described in the Rule. (Underline added.) PARTIALLY ACCEPTED: The DMHC agrees that subdivision (b)'s introductory provision should be clarified to apply to "all" services subject to 1371.9. In a similar clarifying amendment, the DMHC added to proposed Rule 1300.71.31(e)(1) that, absent other agreement, payors shall reimburse the default reimbursement rate for "all" services subject to HSC section 1371.9.
2-23	Catrina Reyes, Esq.	In addition, CMA urges the Department to specify that the Department will audit the proper use of the	DECLINED.

	California Medical Association (CMA)	standardized methodology as well as the payments made according to Health & Safety Code § 1371.31(a)(1) to ensure that payors are complying with the standardized methodology set forth in regulations and the payment requirements in Health & Safety Code § 1371.31(a)(1).	This proposed change would be duplicative of the statute, which states in HSC section 1371.31(a)(3)(D) that the DMHC shall review information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to Section 1382.
2-24	Catrina Reyes, Esq. California Medical Association (CMA)	<u>Subdivision (b)(3)</u> Subdivision (b)(3) provides that, "payors shall include information from the independent dispute resolution process pursuant to section 1371.30 of the Act, as applicable." However, the Department does not specify how or where payors are to include this information. As such, CMA urges the Department to provide further clarification on this requirement. Though no information is currently available from the independent dispute resolution process, the Department can still provide some guidance to payors on how the information is to be included when developing the ACR. For instance, the Department can specify that the payment amounts determined as a result of the independent dispute resolution process should be included annually in the ACR calculation as well as provide guidance on how these payments are to be weighted in the ACR calculation. Finally, CMA urges the Department to audit and approve how the information from the independent dispute resolution process is used by payors in the calculation of the ACR.	DECLINED. The inclusion of information from the independent dispute resolution process (IDRP) is consistent with HSC section 1371.31(a)(3)(A). The DMHC declines to impose a prescriptive standard regarding the use of this information at this time beyond what is already included in the statute. Regarding the proposal to audit the use of the IDRP information, please see the response to comment # 2-23. Note, in response to comment #5-68, below, this formerly proposed subdivision (b)(3) was relocated to proposed subdivision (c)(8).
2-25	Catrina Reyes, Esq. California Medical Association (CMA)	**Subdivision (c) Methodology for Determining the Average Contracted Rate** <u>Subdivision (c)(1)</u> CMA strongly supports the methodology for determining the ACR outlined in subdivision (c)(1). As explained	Thank you for your comment. No specific change requested. However, the commenter noted that the patient cost sharing must be included to reflect the actual contracted rate. The DMHC agrees that the provider's full contracted rate includes the portion paid by the health plan and the patient's share of cost. The

		above, a claims-volume weighted average is the only way to accurately measure what is actually being paid for services in the market. In addition, CMA strongly supports the specification that the calculation is to be done for each health care service procedure code. This ensures that the ACR is the average of the contracted commercial rates for the "same or similar service" as required in Health & Safety Code § 1371.31(a)(1). Given that rates for health care services vary greatly depending on the nature and complexity of the service, using a broad definition of "same or similar service" could result in the contracted commercial rates for simple services, for which there is a greater volume of these services, outweighing the contracted commercial rate for complex services. Accordingly, CMA strongly supports the specification in the methodology that the calculation is to be done for each health care service procedure code or CPT code. Finally, CMA strongly supports the use of the allowed amount in the calculation, which includes the total paid by the payor plus the amount of any patient cost-sharing. Patient cost- sharing must be included to reflect the actual contracted rate. A physician's full contracted rate includes the portion paid by the plan *and* the patient's share of the costs.	proposed Rule 1300.71.31(c)(4)-(5) specify that the payor shall use unmodified health care service codes to calculate the ACR, and that modifiers and other claim-specific factors may be applied to adjust the ACR at the time of reimbursement. The DMHC believes these provisions accurately convey that the ACR is based on allowed amounts, including cost sharing.
2-26	Catrina Reyes, Esq. California Medical Association (CMA)	<u>Subdivision (c)(3)</u> Subdivision (c)(3) states that payors shall consider each combination of the enumerated factors. The use of the term "consider" suggests that it is not a mandatory provision. Health & Safety Code § 1371.31(a)(3) provides that the methodology *shall* take into account, *at a minimum*, the specialty of the individual health professional and the geographic region in which the services are rendered. CMA urges the Department to clarify that if the payor's contracted commercial rates for	Partially declined and partially accepted. PARTIALY DECLINED: Proposed subdivision (c)(3) already contains the word "shall," which indicates a mandatory action. The DMHC declines to use the word "must." PARTIALLY ACCEPTED:

		services vary based on each of the enumerated factors, then the payor *must* calculate the ACR separately for each of these factors. If a payor contracts at different rates based on provider and/or specialty type, payors *must* calculate the ACR for the different provider and/or specialty types separately. Combining contracted commercial rates for physicians and non-physicians, for example, would skew the overall ACR as the contracted rates for these provider types may be significantly different. Moreover, the New York Attorney General, in its 2008 fraud investigation and settlement regarding use of the Ingenix database by many health plans to determine out-of-network reimbursement rates, identified the conflation of physician and non-physician payments as one of the practices that led to its enforcement action regarding the validity of the data. Additionally, if a payor pays different rates to physicians based on the type of facility where the services are provided, payors *must* calculate the ACR for the facility types separately. Combining contracted commercial rates for hospitals and ambulatory surgery centers, for example, could again skew the ACR.	To clarify this provision, instead of stating that payors shall "consider" factors, the proposed Rule now states payors shall calculate and "take into account" each combination of the factors, which is consistent with the language in HSC section 1371.31.
2-27	Catrina Reyes, Esq. California Medical Association (CMA)	<u>Subdivision (c)(4)</u> CMA strongly supports the requirement that payors use "unmodified health care service codes" to calculate the ACR as rates for services that have been adjusted due to a modifier or other reasons do not reflect the actual contracted commercial rates resulting in a skewed ACR. For example, modifier -51 (multiple surgery reduction) is used when more than one surgical procedure is performed at the same session by the same physician. Codes billed with modifier -51 are subject to significant reductions in payment in that the most complex procedure is paid at 100 percent, but the second most complex procedure is typically paid at 50 percent of the	Thank you for your comment. No change requested.

		contracted rate, and the third most complex procedure is typically paid at 25 percent of the contracted rate. Payments can be reduced even further depending on the payor's specific rules.	
2-28	Catrina Reyes, Esq. California Medical Association (CMA)	To avoid varying interpretations of the term "unmodified" and to ensure uniformity in the payment methodology, CMA urges the Department to clarify that "unmodified" means that payors must use the full and actual contracted rates and not rates that have been adjusted by a modifier or other factors. This clarification is especially critical for payors that have payment systems that adjust payments even if the claim did not include a modifier.	Partially declined and partially accepted PARTIALLY DECLINED: The DMHC declines to adopt the exact language suggested by the commenter because the commenter's proposed language is ambiguous and confusing, but agrees that it is valuable to clarify the meaning of "unmodified." PARTIALLY ACCEPTED. The DMHC has proposed amended language to clarify that, for the purpose of this proposed Rule, a modifier is a code applied to the service code that makes the service description more specific and may adjust the reimbursement rate or affect the processing or payment of the code billed.
2-29	Catrina Reyes, Esq. California Medical Association (CMA)	CMA also supports the exception in subdivision (c)(4) for modifiers "26" (professional component) and "27" (technical component). CMA urges that the contracted commercial rates used in the ACR calculation be accurately reflected by not only using the full and actual contracted rate, but by also using contracted rates that reflect the physician's services. Using a payment rate that includes modifier "26" (professional component) is appropriate when determining the ACR because it reflects the contracted rate for just the physician's	Thank you for your comment. No change requested. Note that, consistent with comment # 4-59, below, the DMHC made a clarifying change to its reference to the "technical component" modifier, identifying that modifier as "TC" rather than "27."

		services.	
2-30	Catrina Reyes, Esq. California Medical Association (CMA)	Subdivision (c)(5) CMA understands this subdivision to mean that relevant modifiers or payors' payment policies may still be applied at the time of reimbursement to the noncontracting physician, however, to ensure clarity, CMA suggests the following substitute language: "Once the average contracted rate is determined under this subdivision (c) and is found to be the appropriate default reimbursement rate according to Health & Safety Code 1371.31(a)(1), the payor may adjust the rate when it reimburses the noncontracting individual health professional to take into account relevant payment modifiers and other health care service-specific or claim-specific factors in compliance with the Knox-Keene Act that affect the amount for reimbursement of the health care services rendered by contracting individual health professionals."	Partially accepted, partially declined. Please see DMHC response to comment # 1-4, which suggested identical language for proposed Rule 1300.71.31, subdivision (c)(5).
2-31	Catrina Reyes, Esq. California Medical Association (CMA)	Subdivision (c)(6) CMA urges the Department to strike "if applicable" in subdivision (c)(6)(i). Given that the anesthesia conversion factor is included in every single commercial contract, the applicability is never in question. Including the language "if applicable" in the regulations could result in payors treating this longstanding formula as optional and the values negotiable, which would erode years of negotiations, group agreements, and network adequacy for patients. In addition, CMA urges the Department to include the then current American Society of Anesthesiologists Relative Value Guide ("RVG") in the definition. The RVG provides clarity to the definition of each specific factor and is used by virtually every anesthesia group when negotiating contracts. Accordingly, CMA suggests the following substitute	Partially accepted and partially declined. Please see DMHC response to comment # 1-5, which suggested identical language for proposed Rule 1300.71.31, subdivision (c)(6).

		language for subdivision (c)(6): "(i) The payor shall use the anesthesia conversion factor ("ACF") set forth in the payor's provider contracts instead of an "allowed amount" to complete the calculation pursuant to subdivision (c)(1). (ii)The average contracted rate for services within subdivision (c)(6)(i) above shall be determined by multiplying the ACF by the sum of RVG base units, time units, and physical status modifier."	
2-32	Catrina Reyes, Esq. California Medical Association (CMA)	<u>Subdivision (c)(7)</u> *Case Rates and Global Rates.* CMA supports the exclusion of case rates and global rates from the ACR calculation. However, for clarity, CMA suggests the following language with regards to CPT codes in which a global rate is embedded: "Case rates and global rates shall be excluded, except that the payor must include the Current Procedural Terminology ("CPT") code in which a global rate is embedded per the American Medical Association CPT code description."	Partially accepted and partially declined. PARTIALLY ACCEPTED: The DMHC agrees that it would be helpful to clarify proposed subdivision (c)(7) by specifying that the relevant standard for determining whether a particular code has an embedded global rate is the American Medical Association CPT code description. PARTIALLY DECLINED: The DMHC did not adopt the exact language suggested by the commenter but, as noted above, the DMHC made a clarifying change as suggested (e.g. the DMHC used the word "shall" rather than "must", in accordance with standard regulation drafting protocols).
2-33	Catrina Reyes, Esq.	*Capitated Payments.* CMA urges the Department to specify that capitated payments made to a delegated entity from which subsequently fee-for-service	Partially accepted and partially declined.

	California Medical Association (CMA)	payments are made by the delegated entity are not excluded. In other words, a fee-for-service payment made by a delegated entity should not be excluded because it originated as a capitated payment from a health plan or another delegated entity. Without such clarification, CMA is concerned that the exclusion of "capitated payments" from the ACR calculation could lead to the exclusion of most downstream fee-for-service payments in contravention of Health & Safety Code §1371.31(c). In addition, CMA urges the Department to clarify that all types of compensation for all products including but not limited to incentive payments and bonus payments should be included in the ACR calculation as these are part of the contracted rate.	PARTIALLY ACCEPTED: The DMHC agrees that the proposed Rule is not intended to exclude payments from capitated payors who pay claims for health care services subject to HSC section 1371.9 on a fee-for-service basis. Accordingly, the DMHC amended the proposed Rule to clarify subdivision (c)(7)(ii) (revised (c)(7)(B)) by noting that the exclusion of claims paid pursuant to capitation does not include fee-for-service payments made by a payor who receives capitation from another entity. PARTIALLY DECLINED: The DMHC declines to include specific language regarding incentive payments and bonus payments. Pursuant to proposed subdivision (c)(1), the ACR is calculated based on the allowed contracted amount.
2-34	Catrina Reyes, Esq. California Medical Association (CMA)	*Denied Claims.* CMA supports the exclusion of denied claims from the ACR calculation as nothing was paid for these services. Health & Safety Code §1371.31(a)(1) defines ACR as the average of the contracted commercial rates *paid* by the health plan or delegated entity for the same or similar services in the geographic region. Given that nothing was *paid* for these services they are outside of the definition of the ACR.	Thank you for your comment. No change requested.
2-35	Catrina Reyes, Esq. California Medical	*Claims Not in Final Disposition Status.* CMA supports the exclusion of claims not in final disposition status from the ACR calculation. However,	DECLINED. The DMHC believes that the proposed Rule is

	Association (CMA)	CMA recommends that the Department clarify that final amounts paid by the payor are to be included in the ACR calculation. CMA is concerned that payors will misunderstand this exclusion to mean that any disputed claim is to be excluded, including those that have been settled and where a final amount has been paid.	sufficiently clear in its exclusion of "claims not in final disposition status." The DMHC does not believe the term may be reasonably interpreted to mean a claim that was once disputed, but is now in final disposition status.
2-36	Catrina Reyes, Esq. California Medical Association (CMA)	*Bundled Payments.* CMA urges the Department to exclude bundled payments from the ACR calculation. As there is no basis upon which payors can identify the exact payment amount made to a provider for a particular service in a bundled payment, we urge the Department to exclude bundled payments from the ACR calculation.	ACCEPTED. Please see the amended language in proposed Rule 1300.71.31(c)(7)(i) (revised (c)(7)(A)).
2-37	Catrina Reyes, Esq. California Medical Association (CMA)	*Memorandums of Understanding (MOUs) or Single Case Agreements (SCAs)*. CMA urges the Department to exclude Memorandums of Understanding (MOUs) or single case agreements (SCAs) from the ACR calculation. MOUs and SCAs are agreements between a noncontracting physician and a payor for the provision of specific pre-defined services for one patient for one date of service or range of service dates. Health & Safety Code §1371.31(a)(1) defines ACR as the average of the *contracted* commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. As these are one-time, limited agreements with *noncontracting* physicians these are not considered contracted rates. Therefore, we urge the Department to exclude MOUs and SCAs from the ACR calculation.	DECLINED. The language of the statute as detailed by the commenter as well as the proposed Rule are sufficiently clear that MOUs or SCAs may not be in the calculation, so the suggested change is unnecessary.
2-38	Catrina Reyes, Esq. California Medical Association (CMA)	*Secondary Payments.* CMA urges the Department to exclude secondary payments from the ACR calculation. Payors use different methods when they calculate secondary payments in coordination of benefit s cenarios. Under one method, the primary payor pays	ACCEPTED. Please see the amendment to proposed Rule 1300.71.31(c)(7)(v) (revised (c)(7)(E)).

		the contracted rate and the secondary payor generally pays the balance of the allowed amount. For example, if the allowed amount for the primary payor is $100 and the primary payor pays $80 and the patient has a 20% cost-sharing obligation, the secondary payor could pay up to the $20 balance. Under a different coordination of benefits method, if the primary payor's contracted rate is more than the secondary payor's contracted rate then the secondary payor makes no payment and the physician is contractually required to write off the balance owed. For example, if the allowed amount for the primary payor is $100 and the primary payor pays $80, but the contracted rate with the secondary payor is $75, the secondary payor pays nothing and the doctor is required to write off the amount of the patient's 20% cost-sharing obligation. As illustrated, secondary payments in coordination of benefit scenarios are either zero dollar amounts or a fraction of the contracted commercial rates and therefore do not reflect the actual contracted commercial rates. Accordingly, including this amount in the ACR calculation would result in an inaccurate reflection of the contracted commercial rates.	
2-39	Catrina Reyes, Esq. California Medical Association (CMA)	*Non-Commercial Rates.* Although the definition and methodology for the ACR in the proposed regulations specifies that it is a claims-volume weighted average of the "contracted commercial rates," for clarity, CMA urges the Department to explicitly state what products do not constitute "contracted commercial rates" when calculating the ACR. Health & Safety Code § 1371.9 only applies to services provided to patients enrolled in products regulated by the Department and specifically excludes Medi-Cal products. Accordingly, CMA strongly recommends that the Department specify that, in calculating the ACR, payors may not include rate information for products not regulated by	DECLINED. The DMHC does not believe the term "commercial" rate can reasonably be interpreted to mean rates paid under the Medi-Cal or Medicare programs, neither of which is a commercial product. Additionally, the DMHC believes that the statute and proposed Rule are sufficiently clear that ACR means the average of the contracted commercial rates paid by the payor for the same or similar services in the

		the Department including Medicare products, Medi-Cal products, out-of-state products, self-insured employer products, or other products regulated by federal law.	geographic region, so the suggested change is unnecessary.
2-40	Catrina Reyes, Esq. California Medical Association (CMA)	**Subdivision (d)** Subdivision (d) of the proposed regulations lacks clarity, is inconsistent with the intent of the statute, and is over broad. Subdivision (d) lacks clarity in that, on its face, it can be reasonably and logically interpreted at least two different ways. 1 CCR § 16(a)(1). Simply reading subdivisions (d)(1) and (d)(2) would suggest that if the payor operates an Integrated Health System, they are deemed to not pay a statistically significant number or dollar amount of claims for services subject to Health & Safety Code §1371.9 and therefore the payor shall demonstrate access to and use a statistically credible database. If subdivision (d)(1) is read in conjunction with the first part of subdivision (d), it would appear that it is a two-part determination. Payors must first determine whether it paid a statistically significant number or dollar amount of claims for services subject to Health & Safety Code §1371.9. If so, subdivision (d) would apply and if the payor is also an Integrated Health System, then the payor shall demonstrate access to and use a statistically credible database. These are at least the two different ways subdivision (d) can be interpreted therefore rendering this subdivision unclear.	No specific change requested. Note, however, the DMHC struck and redrafted proposed Rule 1300.71.31(d) for greater clarity and alignment with HSC section 1371.31(a)(3)(C).
2-41	Catrina Reyes, Esq. California Medical Association (CMA)	In addition, because the definition of Integrated Health System is too broad it enlarges the scope of the narrow exemption in Health & Safety Code §1371.31(a)(3)(C). The definition of Integrated Health System focuses on a delivery system organizational model as opposed to a payment system model, thereby capturing any network of providers that coordinates services,	No specific change requested. Note, however, the DMHC struck and redrafted proposed Rule 1300.71.31(d) for greater clarity and alignment with HSC section 1371.31(a)(3)(C). Similarly, as noted in

		including most delegated entities. This is not consistent with Health & Safety Code §1371.31(a)(3)(C). Government Code § 11342.2 provides that, "[w]henever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute." The exemption in Health & Safety Code §1371.31(a)(3)(C) was intended for payors that are unable to calculate an ACR due to their payment model. For instance, health plans that operate closed health systems have salaried physicians and/or pay on a fully capitated basis and thus do not have contracted rates for a particular service for which to use in the ACR calculation. These plans, therefore, must use a database to determine the ACR for purposes of payment under Health & Safety Code §1371.31(a)(1). The exemption was not intended to exempt payors that have the data to calculate an ACR. A broad definition of Integrated Health System would exempt payors that have the data to calculate an ACR thereby contravening the narrow exemption provided for in Health & Safety Code §1371.31(a)(3)(C).	response to comment #2-16, the DMHC also struck the initially proposed definition of "integrated health system" (formerly proposed subdivision (a)(4)).
2-42	Catrina Reyes, Esq. California Medical Association (CMA)	Finally, subdivision (d)(2) provides no guidance on what qualifies as a statistically credible database or how payors are to use the database for purposes of payment of the default reimbursement rate. CMA is concerned that payors will negatively skew the default reimbursement rate based on the choice of database and the percentile or amount used in the database. To avoid widely varying definitions of a statistically credible database, and to ensure compliance with the law and uniformity in a payment methodology, CMA strongly urges the Department to specify that the	DECLINED: The DMHC declines to specify payors subject to HSC section 1371.31(a)(3)(C), which are therefore subject to the proposed Rule 1300.71.31, subdivisions (d) and (f)(2)-(3), must use the 80th percentile of the FAIR Health database. The DMHC believes mandating use of the 80th percentile is unduly prescriptive. Instead, as noted below in regard to comment

		database to be used by payors is FAIR Health and the amount to be used for purposes of payment of the default reimbursement rate is the 80th percentile of the FAIR Health allowed amount. Many plans currently use FAIR Health data, as such, there is nothing novel about using the data from FAIR Health. Moreover, the FAIR Health database is often identified as the most comprehensive and reliable source for independent data. Specifying the use of FAIR Health will avoid the same issues that resulted in the New York Attorney General's fraud investigation and settlement regarding use by many health plans of the Ingenix database, which contained faulty and manipulated data. The 80th percentile is appropriate, because though when FAIR Health compiles it data, it automatically employs an outlier methodology to detect and remove data entries that represent invalid data, removing those in the top 20th percentile will eliminate outlier charges even further. As a result, the data that would be used for purposes of payment of the default reimbursement rate would be representative of the costs of providing the services and outliers would have no effect on the resulting data.	# 2-43, relevant payors must explain and justify the percentile or other methodology they employ to determine the ACR using the database.
2-43	Catrina Reyes, Esq. California Medical Association (CMA)	Should the Department decline to specify a database for use by all payors, CMA recommends that the Department at a minimum require the database to be maintained by a nonprofit organization not affiliated with a health plan, and require payors to file with the Department the database used, to certify that it is statistically credible, and to indicate the reasons for the determination of the percentile or other amount used for purposes of payment of the default reimbursement rate.	ACCEPTED. The DMHC redrafted proposed subdivision (d) for greater clarify and alignment with HSC section 1371.31(a)(3)(C). Additionally, the DMHC adopted several of the commenter's suggested clarifications regarding an appropriate statistically credible database. Please see proposed Rule 1300.71.31(f)(2)-(3), which, among other provisions, requires applicable payors to demonstrate in its policies

			and procedures access to and use of a statistically credible database pursuant to subdivision (d), including (i) an explanation and justification of the determination that the payor is, in fact, subject to HSC section 1371.31(a)(3)(C); (ii) information on which database is being used; (iii) certification that the database is statistically credible; and (iv) explanation and justification of the percentile or other methodology used to determine the ACR using the database. Finally, the DMHC specified that the relevant database shall be a nonprofit that is unaffiliated with a payor.
2-44	Catrina Reyes, Esq. California Medical Association (CMA)	**Subdivision (e)(2)** For clarity, CMA suggests the following substitute language for subdivision (e)(2), "The payor shall indicate on claims payment documents whether it used the average contracted rate or 125 percent of the Medicare rate for payment of the default reimbursement rate."	DECLINED. Please see the DMHC's response to comment # 1-6, which suggested identical language.
2-45	Catrina Reyes, Esq. California Medical Association (CMA)	**Subdivision (f) Filing Requirements** To facilitate the Department's ability to ensure compliance with the standardized methodology set forth in regulations and with the payment requirements in Health & Safety Code	DECLINED. The DMHC made the policy decision not to require annual approval of a payor's ACR, which is consistent with HSC section 1371.31, which does not require such annual approval.

		§1371.31(a)(1), CMA urges the Department to require payors to file their average contracted rates with the Department for approval on an annual basis. In addition, given that the Department shall specify a standardized methodology by January 1, 2019, we urge the Department to set the filing deadline to the Department's first annual plan filing on March 31 or within 90 days of the publication of the final regulations, whichever is earlier. CMA is concerned that if the payors' policies and procedures are not compliant with the standardized methodology set forth in regulations and the filing deadline is not until August 15, 2019, payments will have been made incorrectly for several months. Health & Safety Code § 1371.31(a)(3)(D) does specify that the Department shall review the required information filed as part of its examination of fiscal and administrative affairs. The first annual plan filing on March 31 would be part of the Department's examination of fiscal and administrative affairs. Moreover, delaying the filing of the information will mean that the Department will not be able to determine payors' compliance with the standardized methodology in a timely manner. Thank you for the opportunity to provide comments regarding the proposed standardized ACR methodology, which will have a considerable impact on physicians, patients, and health plans in California in coming years. We appreciate your consideration of our input on how to best address the many nuances of the law as well as our	The DMHC has determined that the proposed Rule's provisions requiring filing of a payor's policies and procedures used to determine ACRs, in conjunction with the DMHC's periodic audits pursuant to HSC section 1382, are sufficient to ensure that payors employ a compliant ACR methodology resulting in appropriate default reimbursement. The DMHC believes that requiring an annual filing would be unduly burdensome on the industry and overly prescriptive. Again, consistent with HSC section 1371.31(a)(3)(D), the DMHC will review the information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to HSC section 1382. The DMHC also declines to impose the suggested filing deadline. Instead, the Rule imposes a filing deadline that will give payors sufficient time to develop and document compliant policies and procedures, and requires submission in accordance with the existing deadline for certain quarterly financial filings required by existing law. The DMHC believes that this will promote efficiency and reduce the burden of those impacted by the proposed regulation.

		clarifications to ensure a uniform understanding of the regulations. We look forward to working with the Department and other stakeholders to ensure it achieves its objectives.	
3-46	Ann Tran-Lien, JD Cathy Atkins, JD California Association of Marriage and Family Therapists (CAMFT)	On behalf of our 31,000 members, the California Association of Marriage and Family Therapists ("CAMFT") thanks the Department for the opportunity to express our comments regarding the proposed rulemaking on the Methodology for Determining Average Contracted Rate; Default Reimbursement Rate. CAMFT represents the interests of mental health professionals of various disciplines. CAMFT respectfully requests the regulations provide a mechanism which requires, or which would ensure that an out-of-network provider subject to the regulations be informed that, if he or she did not enter into an agreement with the insurance company, prior to rendering services, the fee for his or her services is limited to a "default" rate. This applies to services which are rendered at the contracted facility, or, which occur outside of the facility, if they were rendered "as a result" of those (in hospital) services. We appreciate your consideration of our comments.	Thank you for your comment. However, the suggestion to require or provide notice of the law to noncontracting individual health professionals is outside the scope of HSC section 1371.31 and this regulation package. As required by law, this proposed regulation is located on the Department's website at www.dmhc.ca.gov and was also sent to our list serve for notification regarding the pending regulation.
4-47	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	The California Association of Health Plans (CAHP) represents 49 public and private health care service plans that collectively provide coverage to over 25 million Californians. ACLHIC is a state trade association representing many of the largest life and health insurers doing business in California. We write today to submit our associations' comments to the proposed rule published February 2nd, which specifies a standardized methodology that health care service plans and their delegated entities are to use to compute the average contracted rate (ACR) for health care services subject to AB 72's balance billing protection, starting January 1, 2019. In general, the proposed rule appears to be well-informed by stakeholder input from the Department's public meeting on this issue last year. We provide below additional considerations and recommendations on behalf of our members to achieve a sound ACR methodology that is in line with the intent of AB 72.	Thank you for your comment. No change requested.

4-48	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	• *1300.71.31 (a)(1)"Average contracted rate" means the claims-volume weighted average of the contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year, for services most frequently subject to section 1371.9 of the Knox-Keene Act. The applicable calendar year is two years prior to the year in which the health care service was rendered.* We support this approach of basing ACR on the calendar year two years prior to that in which the health care service was rendered. However, as further detailed below under the next bullet, if the ACR is based on two years prior, then so should the Medicare fee.	No change requested. Please see the DMHC response to comment # 4-51 regarding the concern about the Medicare base year.
4-49	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	Other stakeholders have raised an alternative proposal to adjust the ACR annually from a base year of 2015 commercial rates. We do not believe that approach would be sound and furthermore, would be difficult to operationalize. Plans' average contracted rates may in some cases trend down year-over-year because plans contract with providers at rates that are competitive in the market. The proposed approach to use rates from two years prior in the calculation of the ACR allows health plans to ensure coverage remains affordable to enrollees. There are also logistical concerns in maintaining a set 2015 base year. For example, due to coding changes over time, Plans would need to create complex crosswalks to determine ACR and address the issue of obsolete coding.	No change requested.
4-50	Wendy Soe, California Assc. Of Health Plans (CAHP)	Additionally, we ask that the Department confirm carriers offering multiple products (e.g. HMO and PPO) are able to factor in the various offerings in the calculation of an ACR. This approach will reduce administrative complexity and provide a more robust data set for the	DECLINED. The DMHC declines to specify that carriers offering multiple products are able to factor in the various offerings in the calculation of an

	Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	ACR analysis.	ACR because this change is unnecessary. There is nothing in the proposed Rule preventing payors from calculating the ACR for all commercial product lines.
4-51	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	• *1300.71.31 (a)(5): "Medicare rate" means 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar health care services in the geographic region in which the health care services were rendered, for the calendar year in which the health care services were rendered, on a "par" basis. "Par" basis means the reimbursement rate paid to health care service providers participating in the Medicare program by accepting Medicare assignment.* If the ACR is based on commercial reimbursement rates from two years prior, then so should the Medicare rate the ACR is contrasted against. For example, if the 2019 ACR rate is based on 2017 contracted commercial rates, the assessment for default reimbursement should be a comparison of the averaged 2017 commercial rates, against 125% of the 2017 Medicare rate, for a particular billing code. There are several reasons for this.	DECLINED. The DMHC declines to define Medicare rate retrospectively. The DMHC made this policy decision because using the year in which the health care service was rendered is consistent with Medicare payment, and makes sense in light of the fact that the rate effective in the year in which the service was rendered will typically be available, and does not depend on collating a previous year's data (which, in contrast, is a concern for the ACR alternative). The DMHC believes that this consistency within the industry to use the year in which health care services are rendered will prevent confusion and ensure consistent application of the data when determining a rate.
4-52	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health	First, billing codes change year-over-year. There is a possibility that a code that existed in 2017 has been eliminated by 2019, or that new codes are created in 2019, with no comparable code in 2017. Using the same base year for both sides of the default reimbursement rate equation is the most operationally viable.	DECLINED. Please see the DMHC's response to comment #4-51. With respect to the commenter's note about the potential unavailability of billing codes, the DMHC expects that a Medicare rate for a

	Insurance Co. (ACLHIC)		"same or similar" service will be available to facilitate the required comparison of Medicare rate and ACR, consistent with HSC section 1371.31(a)(1).
4-53	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	Second, Plans need to be able to program the default reimbursement rate for both the ACR and the Medicare rate well in advance each year. Using the "calendar year in which a service was rendered" for the Medicare rate makes it challenging for payors to automate claims processing. Additionally, Medicare sometimes releases fees late or does so retroactively. Using Medicare rates from two calendar year prior will help to limit such volatility.	DECLINED. Please see the DMHC's response to comment #4-51.
4-54	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	● *1300.71.31 (a)(8): "Services subject to 1371.9" are nonemergency health care services provided to an enrollee by a noncontracting individual health professional at a contracting health facility where the enrollee received covered health care services, or nonemergency health care services provided to the enrollee by a noncontracting individual health professional as a result of covered health care services received at a contracting health facility.* In the "Statement of Reasons" accompanying the proposed regulations, an example of "as a result of covered health care services received at a contracting health facility" is provided as: For example, if an enrollee has blood drawn at an in-network facility but it is sent for processing to an out-of-network lab and the resulting report is read by a noncontracting	DECLINED. The language of the proposed Rule (*amended* regulation subdivision (a)(7)) regarding services received "as a result of" covered health services at a contracting health facility is consistent with the language of HSC section 1371.31. To avoid an overly rigid definition, the DMHC declines to expressly describe which services may or may not be the "result of" such covered services.

		pathologist, the pathology services would be subject to Health and Safety Code section 1371.9 because they were "a result of" a service rendered at an in-network facility. This example is helpful in understanding the intent of the law; however, it may be helpful to also provide an example of when this provision would not apply so that stakeholders are clear as to its intended scope. For instance, we do not believe that services received after a patient is discharged from the in-network facility would fall under the scope of this provision.	
4-55	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	• *1300.71.31 (a)(9) "Statistically significant" means five or more claims for services subject to section 1371.9 for the applicable calendar year, as defined in subdivision (a)(1) of this Rule.* The proposed definition does not meet accepted principles of statistics. Typically, statistical significance is expressed as a percentage because significance levels depend very much on the sample size. An arbitrary value of "five" claims does not provide an accurate picture of statistical significance because 5 out of 50 claims hold a much different weight than 5 out of 5,000 claims. We recommend revising the definition to state "five <u>percent</u> or more of claims". The use of a percentage would calibrate statistical significance for all health plans, both large and small.	Partially accepted and partially declined. PARTIALLY ACCEPTED: The DMHC struck the proposed definition of "statistically significant" in formerly proposed Rule 1300.71.31(a)(9). PARTIALLY DECLINED: The DMHC declines to include a specific definition of the term "statistically significant," which appears in HSC section 1371.31(a)(3)(C). Instead, the DMHC proposes to take a nonprescriptive approach, and require the payor to provide relevant information to explain and justify its status as a payor subject to HSC section 1371.31(a)(3)(C) (see proposed Rule 1300.71.31 (f)(2)-(3)).
4-56	Wendy Soe,	• *1300.71.31 (b)(3)Payors shall include information*	DECLINED.

	California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	*from the independent dispute resolution process pursuant to section 1371.30 of the Act, as applicable.* It is not clear how and how frequently information from the IDRP should be included into the reimbursement. We recommend further specification in the regulations on how IDRP should factor into the default rate.	The inclusion of information from the independent dispute resolution process (IDRP) is consistent with HSC section 1371.31(a)(3)(A). The DMHC declines to impose a prescriptive standard regarding the use of this information at this time. Regarding the proposal to audit the use of the IDRP information, please see the response to comment # 2-23. Note, in response to comment #5-68, this formerly proposed subdivision (b)(3) was relocated to proposed subdivision (c)(8).
4-57	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	• *1300.71.31 (c)(1)Methodology for determining the average contracted rate. Except as specified in subdivision (c)(6), for each health care service procedure code for services most frequently subject to section 1371.9 of the Knox Keene Act, the payor shall calculate the claims volume-weighted mean rate:* *Rate = sum of [the allowed amount for the health service code under a contract x number of claims paid at that allowed amount] / Total number of claims paid for that code across all commercial contracts.* To account for scenarios where there are multiple service units making up one total claim, we would recommend the Department clarify or confirm that "allowed amount" is the dollar amount per service unit. Additionally, in the denominator, "number of claims" should be changed to "number of service units. For example, if a pathologist	DECLINED. The DMHC believes that specifying the standardized ACR methodology as a claims-weighted mean is consistent with HSC section 1371.31, which defines ACR as the average of the contracted commercial "rates paid" by the payor. Since the ACR is based on the rates paid, it is appropriate to calculate the average based on the number of actual claims. However, the DMHC does not expect the allowed amount to be inflated in the manner the commenter suggests. If, as in the commenter's example, a single claim had three billed items for the same service code, the "allowed" amount" for that service should not be tripled.

		was paid $50.00 per CPT code 88312, which is a special stain and interpretation for microorganisms, but that pathologist ran three different tests for the same person to assess for different microorganisms, the total claim might be $150.00. However, that should not be the ACR. The ACR should be based on the $50.00 calculated as the sum of the allowed amount for each service unit ($50 + $50 + $50), divided by the number of service units (3). Otherwise the value would be inflated.	The allowed amount for the service code would still be whatever amount is set forth in the contract.
4-58	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	Artificially inflating the ACR could adversely impact contracting—specialists may choose to terminate contracts if they are able to be paid at the higher ACR as a noncontracting provider.	DECLINED. Please see the DMHC's response to comment # 4-57.
4-59	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	• *1300.71.31 (c)(4)For the purpose of subdivision (c)(3)(i), the payor shall use unmodified health care service codes to calculate the average contracted rate, except that the payor shall calculate separate average contracted rates pursuant to this subdivision (c) only for CPT code modifiers "26" (professional component) and "27" (technical component).* We have received confirmation from a number of plan claims experts that the technical component should be modifier "TC" instead of "27." (CPT book, 2018 edition, Appendix A).	ACCEPTED.
4-60	Wendy Soe, California Assc. Of	**(c)(7)**	DECLINED. As noted in response to other comments, the

	Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	• *1300.71.31 (d) Payors that did not pay a statistically significant number or dollar amount of claims for services subject to section 1371.9 of the Act in the applicable calendar year defined in subdivision (a)(1) of this Rule, <u>or payors operating an integrated health system</u>, shall comply with this subdivision (d).* We strongly recommend the inclusion of the underlined above to ensure this provision is aligned with the intent of AB 72.	DMHC struck the formerly proposed definition of integrated health system from Rule 1300.71.31(a)(4), and re-drafted subdivision (d) for greater clarity and alignment with HSC section 1371.31.
4-61	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co. (ACLHIC)	Additionally, while statistically significant number of claims is defined, statistically significant dollar amount is not. Further, "statistically significant dollar amount" is not included or defined in the statute. This subdivision reinforces our earlier point that statistical significance should be a percentage value, rather than a fixed number.	DECLINED. The DMHC struck the proposed definition of "statistically significant," and re-drafted subdivision (d). Note, however, that statistically significant dollar amount is referenced in HSC section 1371.31(a)(3)(C): "*If, based on the health care service plan's model, a health care service plan does not pay a statistically significant number <u>or dollar amount</u> of claims for services covered under Section 1371.9,* […]" (Emphasis added.)
4-62	Wendy Soe, California Assc. Of Health Plans (CAHP) Steffanie Watkins, Assc. Of California Life & Health Insurance Co.	While (d) states that payors that did not pay a statistically significant number or dollar amount are to comply with (d)(1) and (d)(2), those subdivisions only address rules payors operating as an integrated health system. It is silent on how reimbursement should work for payors that did not pay a statistically significant amount, that are not integrated health systems. Thank you the opportunity for offer comment to these proposed regulations.	No change specifically requested. However, please note that the DMHC has re-drafted proposed Rule 1300.71.31(d) for greater clarity and alignment with HSC section 1371.31(a)(3)(C).

	(ACLHIC)		
5-63	William Barcellona, JD, MHA America's Physician Groups	America's Physician Groups submits the following comments on the draft rule. Section 1300.71.31(a)(4): "Integrated health system" means an organization that, through ownership or formal agreements, vertically and horizontally aligns health care facilities, programs, and services in order to offer a coordinated and full range of health care to a defined geographic population, and that is held responsible clinically and fiscally for the health status of that population. This definition describes virtually any existing full-service health plan and risk bearing organization (taking full risk). It is unclear why this definition is included in the regulation and how it may serve to provide an exception from the required methodology described at page 18 under subsection (d)(2): *(d) Payors that did not pay a statistically significant number or dollar amount of claims for services subject to section 1371.9 of the Act in the applicable calendar year defined in subdivision (a)(1) of this Rule shall comply with this subdivision (d).* *(1) For the purpose of subdivision (a)(3)(C) of section 1371.31 of the Act, a payor does not pay a statistically significant number or dollar amount of claims for services subject to section 1371.9 "based*	No change specifically requested. However, please note that the DMHC struck the proposed definitions of "integrated health system" and "statistically significant," and also re-drafted proposed Rule 1300.71.31(d) for greater clarity and alignment with HSC section 1371.31(a)(3)(C).

		on the health care service plan's model" if the payor operates an integrated health system. *(2) A payor who operates an integrated health system shall demonstrate access to and use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region as the source of rate data for the purpose of payment of the default reimbursement rate in accordance with subdivision (a)(1) of section 1371.31 of the Act and subdivision (e) of this Rule. [Highlights in original.]*	
5-64	William Barcellona, JD, MHA America's Physician Groups	**Section 1300.71.31(a)(5):** "Medicare rate" means 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar health care services in the geographic region in which the health care services were rendered, for the calendar year in which the health care service was rendered, on a "par" basis. "Par" means the reimbursement rate paid to health care service providers participating in the Medicare program by accepting Medicare assignment. There is an ambiguity created between this definition and the "Default reimbursement rate" definition set forth under Section 1300.71.31(a)2), which states "…or 125 percent of the Medicare rate…" Given that subsection (5) sets the "Medicare rate" at 125%, restating another 125% figure is additive, and therefore creates a conflict with the rate set in the underlying statute, AB 72. For clarity, the definition under subsection (5)	ACCEPTED.

		should be "100 percent" and not 125 percent, so long as the 125 percent figure is then maintained in subsection (2).	
5-65	William Barcellona, JD, MHA America's Physician Groups	**Section 1300.71.31(a)(9):** "Statistically significant" means five or more claims for services subject to section 1371.9 for the applicable calendar year, as defined in subdivision (a)(1) of this Rule. If we understand the flow of terminology in this proposed rule, this definition means that there must be five or more claims for "services subject to section 1371.9" which are: *(8) "Services subject to section 1371.9" are nonemergency health care services provided to an enrollee by a noncontracting individual health professional at a contracting health facility where the enrollee received covered health care services, or nonemergency health care services provided to the enrollee by a noncontracting individual health professional as a result of covered health care services received at a contracting health facility.* Then, the percentage threshold for such services is defined as follows: *(7) "Services most frequently subject to section 1371.9" of the Knox-Keene Act means the health*	No change specifically requested. However, please note that the DMHC struck the proposed definitions of "integrated health system" and "statistically significant," and also re-drafted proposed Rule 1300.71.31(d) for greater clarity and alignment with HSC section 1371.31(a)(3)(C).

		care services that, when added together, comprise at least 80 percent of the payor's statewide claims volume for health care services subject to section 1371.9 in the applicable calendar year, as defined in subdivision (a)(1) of this Rule. Therefore, if after compiling 80% of the nonemergency health care services provided to an enrollee by a noncontracting individual health professional as defined under subsection (8) above there are less than 5 claims for a specific health care service code for the applicable calendar year (two years prior to the year in which the service was rendered) then the payment data is not "statistically significant." The methodology for determining the average contracted rate for health care service codes that are not statistically significant is set forth at 1300.71.31(d) at page 18, but it only applies to an "integrated health system." <u>If the payer is not such an entity, the proposed Rule does not provide a methodology at this subsection</u>.	
5-66	William Barcellona, JD, MHA America's Physician Groups	**Section 1300.71.31(b)**: <u>For health care services subject to section 1371.9 of the Knox-Keene Act, payors shall comply with subdivision (e) and do the following:</u> <u>(1) For health care services most frequently subject to 1371.9, payors shall use the methodology described in</u>	No change requested. Please note, however, that the DMHC struck the proposed definition of "statistically significant."

		this Rule to determine the average contracted rate. (2) For health care services that do not fall under subdivision (b)(1), the payor may, but is not required to, use the methodology described in this Rule to determine the average contracted rate. If the payor uses a different methodology, that different methodology shall be a reasonable method of determining the average contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year. (3) Payors shall include information from the independent dispute resolution process pursuant to section 1371.30 of the Act, as applicable. Subsection (b) implies that compliance with subsection (e) (payment of the default payment rate) is primary. Then, either subsection (1) (the Rule methodology set forth under subsection (c)), *OR* (2) a permissive methodology based on a reasonable method. The determination of whether to use (1) or (2) lies with whether the service is one that is "most frequently subject to 1371.9" or if it is not. Pursuant to subsection (a)(9) the later services would be those that only accrue 4 or less times during the "applicable calendar year" *OR* do not fall within the 80% threshold under subsection (7). But in no event could a payer chose to pay less than the	

		implied floor under subdivision (e), the default rate of 125% of the Medicare fee schedule.	
5-67	William Barcellona, JD, MHA America's Physician Groups	It is not clear how the "five or more" test interacts with the 80 percent threshold and whether one or the other metric can be used to determine whether the permissive alternative methodology of subsection (b)(2) is applicable and can be used.	No change requested. The DMHC notes that it struck the definition of "statistically significant" from the proposed Rule. However, the commenter expressed uncertainty regarding the interaction between the threshold for services "most frequently subject to [MFST] section 1371.9" and the threshold for a "statistically significant" number or dollar amount of claims covered under section 1371.9. Although the Rule no longer proposes to define "statistically significant," that threshold remains relevant to determining which payors should consult a database to determine the ACR, as specified under HSC section 1371.31(a)(3)(C). Accordingly, the DMHC notes the following: 1) For services MFST section 1371.9, the payor shall use the proposed Rule's standardized methodology to calculate the ACR. (see proposed Rule 1300.71.31(b)(1)). 2) For other, non-MFST services, the payor shall use another reasonable methodology (see proposed Rule 1300.71.31(b)(2)). 3) Notwithstanding the above, a payor that is subject to HSC section 1371.31(a)(3)(C) (i.e., a payor that, based on the payor's model, does not pay a statistically significant number or

			dollar amount of claims for services covered under Section 1371.9), shall determine the ACR in accordance with proposed Rule 1300.71.31(d). See also proposed subdivision (f)(2)-(3). The DMHC believes that the amended proposed Rule and the statute are sufficiently clear and does not warrant further change regarding the interaction of the noted thresholds.
5-68	William Barcellona, JD, MHA America's Physician Groups	Furthermore, the language at subsection (b)(3) requiring Payors to include "information from the independent dispute resolution process…as applicable" is not clear and it is ambiguous whether this means that such information is intended to modify subsection (1) and/or (2) methodology, because the phrasing of subsection (b) and its three numerical paragraphs is neither set forth in the conjunctive or disjunctive. Proprietary rates should not be made public at any time during this process.	Partially declined, and partially accepted. PARTIALLY DECLINED: The inclusion of information from the independent dispute resolution process (IDRP) is consistent with HSC section 1371.31(a)(3)(A). The DMHC declines to impose a prescriptive standard regarding the use of this information at this time. PARTIALLY ACCEPTED: The DMHC agrees that subdivision (b) must be clarified by adding "or" between (b)(1) and (b)(2) and moved (b)(3) to new subdivision (c)(8), since the requirement to include information from the IDRP is pertinent to the standardized ACR methodology (HSC section 1371.31(a)(3)(A)).

5-69	William Barcellona, JD, MHA America's Physician Groups	**Section 1300.71.31(c)(3):** "The payor shall calculate a rate described in subdivision (c)(1) considering each combination of these factors, at a minimum: (i) Health care service code, including but not limited to Current Procedural Terminology (CPT) codes, (ii) Geographic region, (iii) Provider type and specialty, and, (iv) Facility type. Our APG members have noted that provider type and specialty are already accounted for since most CPT codes are specialty specific. Thus, the minimum mandatory inclusion of element (iii) is likely unnecessary and redundant.	DECLINED. The DMHC believes that a CPT code is not always a perfect indicator of specialty or provider type. Therefore, we propose to keep those factors separate for the purpose of ACR stratification to ensure appropriate calculation of the ACR.
5-70	William Barcellona, JD, MHA America's Physician Groups	**Section 1300.71.31(e)(2): The payor shall indicate on claims payment documents the manner by which the payor satisfied this subdivision (e)** APG agrees that it could be expeditious to require an annotation when payment in an AB 72 situation is made pursuant to the default payment rate of 125% of the Medicare fee schedule. We assume that since the notation requirement is set forth under subsection (e) that it would only be required in a default payment rate application, and not when ACR payment is required under the rule. If the Department intends to require the later notation as well, it would appear this proposed	No specific change requested. The DMHC notes that the default reimbursement rate is the greater of the ACR or 125% of the relevant Medicare rate (see proposed Rule 1300.71.31(a)(2)). In other words, the ACR is the default reimbursement rate, when the ACR is greater than the relevant Medicare rate. The proposed subdivision (e)(2) is intended to require payors to indicate on the payment documents whether a given reimbursement is

		language is unclear and ambiguous.	the ACR, the Medicare rate, or a different agreed-upon rate, so that the DMHC can determine a payor's compliance with the AB 72 default reimbursement rate requirements, either for the purpose of compliance review or enforcement actions. The DMHC has not proposed a prescriptive requirement regarding how a payor must comply with this requirement.
5-71	William Barcellona, JD, MHA America's Physician Groups	Notation on the EOB/remittance advice is difficult since disposition codes are standardized nationally by the Council for Affordable Quality Healthcare, Inc. (CAQH), which means that any proposed changes would need to be approved and made by that entity prior to application. It is unclear whether the Department has addressed this issue with CAQH and if the two organizations have agreed to the necessary modifications. Thank you for the opportunity to comment.	No specific change requested. Please see the DMHC's response to comment number 5-70. Additionally, the DMHC notes that it does not intend to require changes to disposition codes. The DMHC proposes to require some indication of what AB 72 compliant reimbursement rate was paid: ACR, the Medicare rate, or another agreed-upon amount.