

DEPARTMENT OF MANAGED HEALTH CARE

FINAL STATEMENT OF REASONS

Methodology for Determining Average Contracted Rate and Default Rate

Title 28, Sections 1300.71 and 1300.71.31

Control No. 2017-5223

Updated Informative Digest

There have been no changes in applicable laws or to the effect of the proposed regulation from the laws and effects described in the original Notice of Proposed Regulatory Action.

Update of Information Contained in the Initial Statement of Reasons

Regarding proposed Rule 1300.71.31(c)(8), the DMHC has included language compliant with Health and Safety Code (HSC) section 1371.31(a)(3)(A), specifying that the methodology shall take into account information from the independent dispute resolution process (IDRP). Language in proposed (c)(8) states that information shall be included “as applicable” because information from IDRP is currently unavailable. The other information required to be included in the standardized ACR methodology (e.g., provider type) pursuant to proposed (c)(3), must be concluded “at a minimum” because it is always available. This is in contrast to information from the IDRP, which is not currently available because, to date, there have been no final IDRP decisions. Thus, information from IDRP does not yet exist.

The DMHC made the following non-substantive amendments:

- The DMHC has made non-substantive edits to the text of Rule 1300.71.31 including correcting numbering, correcting underlining and capitalization of first letters in the title of regulation, and adding in “Knox-Keene Act” for consistency and clarity.
- The DMHC has added a single letter “s” in 1300.71.31(c)(4) as a non-substantive grammatical amendment. The sentence should have read (see highlight):

(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 “TC” (technical component). For the purpose of this Rule, a modifier is a code applied to the service code that make the service description more specific and

may adjust the reimbursement rate or affect the processing or payment of the code billed.

The addition of the letter “s” does not change the meaning or substance of the provision.

The DMHC made the following substantive amendments to the proposed Rules after the 1st comment period:

Rule 1300.71:

- The DMHC amended Rule 1300.71, subdivision (a)(8), by adding new subparagraphs (U) and (V) to specify and clarify that a pattern of failure to comply with HSC section 1371.31 and the proposed Rule 1300.71.31, as described, constitutes an unjust payment pattern. Referencing the proposed Rule in the existing Claims Settlement Practice Rule will clarify the DMHC’s authority to enforce compliance with the proposed Rule. Historically, enforcing the prohibition on unfair payment patterns has been challenging, so clarity regarding authority and bases for enforcement actions is necessary to ensure compliance, and fair payment of noncontracting individual health professionals. Similarly, the DMHC amended subdivision (s)(2) by adding references to HSC section 1371.31 and proposed Rule 1300.71.31 to clarify that violation of these new sections may constitute a basis for disciplinary action against the plan. The DMHC also made conforming amendments to Rule 1300.71’s note regarding authority and reference.

Rule 1300.71.31:

- In proposed Rule 1300.71.31, the DMHC made amendments to subdivision (a)(3), which defines “geographic region” for the purpose of clarity. The DMHC’s amended language is clearer than the originally proposed language, and will help stakeholders understand that the same definition of “geographic region” applies regardless of whether the default reimbursement rate is based on the Medicare rate or the average contracted rate (ACR).
- The DMHC deleted formerly proposed (a)(4), which would have defined “integrated health system.” Initially, that had been proposed to specify the relevant “model” for the purpose of HSC section 1371.31(a)(3)(C), which requires relevant payors to use a database to determine their ACR, as specified. However, public comments indicated that the proposed definition could be interpreted too broadly, such that it could encompass health plans beyond what the Legislature intended for HSC section 1371.31(a)(3)(C). It is not the DMHC’s intent to adopt an overly broad definition. Accordingly, the DMHC proposes in the final text to take a less prescriptive approach to clarifying and implementing HSC section 1371.31(a)(3)(C). Rather than defining the relevant health plan model that is subject to HSC section 1371.31(a)(3)(C), the proposed Rule now

requires relevant payors to include in their policies and procedures an explanation and justification of the determination that, based on the payor's model, the payor does not pay a statistically significant number or dollar amount of claims covered under section 1371.9 of the Knox-Keene Act (i.e., why it is a payor subject to HSC section 1371.31(a)(3)(C)), as well as other relevant information specified in proposed subdivision (f)(2). This approach will ensure that the relatively few, relevant payors provide the DMHC a reasoned analysis based on facts explaining why they are subject to HSC section 1371.31(a)(3)(C). This effectuates the Legislature's intent that only payors that, based on their model, do not pay a statistically significant number or dollar amount of claims for services covered under Section 1371, refer to the statistically credible database, as required by HSC section 1371.31(a)(3)(C).

- In proposed subdivision (a)(4), the DMHC clarified the definition of "Medicare rate" by striking "125 percent." This amendment was necessary because the originally proposed language could have been misinterpreted to require a default reimbursement rate that is inconsistent with HSC section 1371.31(a). This is because proposed subdivision (a)(2) defines "default reimbursement rate" as the greater of the ACR or 125 percent of the Medicare rate. As noted in public comments, it was necessary to clarify subdivision (a)(4) by striking "125 percent" so that the default reimbursement rate would not appear to be based on 125 percent of 125 percent of the rate Medicare reimburses.
- The DMHC struck formerly proposed subdivision (a)(9), defining "statistically significant." The term statistically significant is relevant to determining which payors shall refer to a statistically credible database to determine their ACR, as required by HSC section 1371.31(a)(3)(C). However, based on public comments and as noted above in connection with formerly proposed subdivision (a)(4), the DMHC has determined it is necessary and appropriate to take a less prescriptive approach to the implementation of that statute. Accordingly, the final proposed rule now requires a relevant payor to include in its policies and procedures an explanation and justification of the determination that, based on the payor's model, the payor does not pay a statistically significant number or dollar amount of claims covered under section 1371.9 of the Knox-Keene Act (see proposed subdivision (f)(2)). This approach will ensure that the relatively few, relevant payors provide the DMHC a reasoned analysis based on facts explaining why they are subject to HSC section 1371.31(a)(3)(C). This effectuates the Legislature's intent that only payors that, based on their model, do not pay a statistically significant number or dollar amount of claims for services covered under Section 1371, refer to the statistically credible database, as required by HSC section 1371.31(a)(3)(C).
- The DMHC renumbered the remaining subparagraphs of subdivision (a) to account for the deletion of formerly proposed subdivision (a)(4) and (a)(9).

- In proposed subdivision (b), the DMHC added that payors shall comply with subdivision (e) for “all” health care services subject to section 1371.9. This addition clarified that although the proposed rule’s methodology is mandatory only for the services “most frequently” subject to section 1371.9, payment of the default reimbursement rate is mandatory for all such services (unless the parties have reached a separate reimbursement agreement, pursuant to HSC section 1371.31(a)(1)).
- In proposed subdivision (b)(1), the DMHC added the word “or” clarify that subparagraphs (1) and (2) are alternatives, and a payor shall comply with one or the other, depending on whether the service at issue is “most frequently” subject to HSC section 1371.9.
- The DMHC relocated formerly proposed subdivision (b)(3) to (c)(8), because information from the independent dispute resolution process is a statutorily required consideration under the proposed rule’s standardized methodology, which is described in subdivision (c). It was therefore appropriate to move that provision to subdivision (c).
- The DMHC has amended subdivision (c) to specify that the rate equation is for the allowed amount for the health care service code for *each* contract times the number of claims paid at *each* allowed amount. This edit was necessary to more clearly represent how the rate is calculated as already demonstrated within the example in this subdivision.
- The DMHC amended (c)(3) for greater clarity and consistency with HSC section 1371.31(a)(3)(A), which requires the DMHC’s standardized methodology to “take into account” the specified factors.
- In subdivision (c)(4), the DMHC clarified what CPT code modifiers should be calculated as separate ACRs by changing the reference to code “27” to code “TC,” which is the appropriate code for “technical component.” The DMHC also added language to clarify the meaning of a CPT code “modifier,” to ensure that payors correctly calculate the base ACR using unmodified health care service codes. This clarification will ensure that payors do not calculate an ACR based on modified codes, which could then be subject to further, duplicative modification at the time of reimbursement, pursuant to proposed subdivision (c)(5).
- In subdivision (c)(5), the DMHC added language to clarify that when the ACR is the appropriate default reimbursement rate “pursuant to subdivision (a)(1) of section 1371.31 of the Knox-Keene Act,” the payor “may” adjust the rate, as specified. Adding the statutory reference clarifies what law governs the payment of the default reimbursement rate. Additionally, changing “shall” to “may” clarifies that adjustment under subdivision (c)(5) is not mandatory in every case; it need only be done as appropriate for a particular claim.

- In subdivision (c)(6)(A), the DMHC struck the introductory language “if applicable” because the DMHC understands that anesthesia conversion factors are standard contract elements within the health coverage industry, and it would be confusing and inaccurate to suggest that a payor’s contracts may lack that information.
- In subdivision (c)(6)(B), the DMHC clarified that the relevant “base units” are those set by the American Society of Anesthesiologists Relative Value Guide (RVG). This change ensures that anesthesiology services are adjusted by the sum of those base units and the other specified adjustment factors, consistent with standard industry practice.
- In subdivision (c)(7)(A), the DMHC clarified that “bundled payments” should be excluded from the calculation of the ACR. This is consistent with the exclusion of case rates and global rates, which are rates applicable to a course of treatment. Similar to those, bundled payments are for a collection of services and cannot feasibly be separated into per-service rates, and their inclusion would therefore be inconsistent with HSC section 1371.31, which bases the ACR on rates paid for services. The DMHC also clarified that a payor “shall” include CPT codes in which a global rate is embedded “the American Medical Association CPT code description.” This change clarified that including claims related to such codes is mandatory, and clarified what standard governs whether a code is, in fact, embedded with a global rate.
- In subdivision (c)(7)(B), the DMHC added language to clarify that payors should not exclude from the ACR calculation fee-for-service payments made by a payor who *receives* capitation. Without this clarification, delegated entities would effectively be carved out of the proposed Rule, which would be inconsistent with HSC section 1371.31(c).
- The DMHC added new subdivision (c)(7)(E) to clarify that claims paid under secondary payment rates pursuant to coordination of benefits clauses shall be excluded from calculation of the ACR. Secondary payments do not reflect full commercial rates paid, consistent with HSC section 1371.31(a), and must therefore be excluded from the calculation of the ACR.
- The DMHC struck the originally proposed subdivision (d) and replaced it with a new proposed subdivision (d) to implement HSC section 1371.31(a)(3)(C) in a manner that is less prescriptive, more clear, and more consistent with the purpose of that statute. As noted above in regard to formerly proposed subdivisions (a)(4) (previously defining integrated health system) and (a)(9) (previously defining statistically significant), the DMHC now proposes to require the few relevant payors who are subject to HSC section 1371.31(a)(3)(C) to use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region to determine an

ACR required pursuant to this Rule and section 1371.31 of the Knox-Keene Act. This approach is consistent with HSC section 1371.31(a)(3)(C) and addresses stakeholder concerns that the originally proposed language appeared to enlarge the scope of HSC section 1371.31(a)(3)(C), which was not the DMHC's intent. Additionally, the amended proposed rule clarifies that this subdivision (d) applies notwithstanding any other provision of this Rule, which is necessary to clarify that the described payors should consult a database to determine their ACR, rather than use the methodology required in subdivision (b) and described in subdivision (c).

- In subdivision (e), the DMHC clarified that unless otherwise agreed by the payor and the noncontracting individual health professional, and except as provided in subdivision (b) of HSC section 1371.31, the payor shall reimburse the noncontracting individual health professional, for "all" services subject to HSC section 1371.9, the default reimbursement rate. This has been a point of confusion among some stakeholders, due to the fact that the standardized methodology described in subdivision (c) is mandatory only for services "most frequently" subject to section 1371.9 (see proposed Rule 1300.71.31(b)(1)). Similar to the DMHC's amendment to subdivision (b)'s introductory sentence, this addition of the word "all" is necessary to clarify that, while the ACR methodology may vary, the default reimbursement rate is required for all relevant services.
- As described in connection with the amendments to formerly proposed subdivisions (a)(4) and (a)(9) and proposed subdivision (d), the DMHC now proposes to implement HSC section 1371.31(a)(3)(C) in a manner that is less prescriptive, more clear, and more consistent with that statute. In subdivision (f)(2), the DMHC clarifies and specifies what information a relevant payor must file in order to substantiate that the payor is, indeed, subject to HSC section 1371.31(a)(3)(C).
- Specifically, proposed subdivision (f)(2)(A) now requires those relevant payors to include in their policies and procedures an explanation and justification of the determination that, based on the payor's model, the payor does not pay a statistically significant number or dollar amount of claims covered under HSC section 1371.9 (i.e., why it is a payor subject to HSC section 1371.31(a)(3)(C)), as well as other relevant information specified in proposed subdivision (f)(2). This approach will ensure that the relatively few, relevant payors provide the DMHC a reasoned analysis based on facts explaining why they are subject to HSC section 1371.31(a)(3)(C). This effectuates the Legislature's intent that only payors that, based on their model, do not pay a statistically significant number or dollar amount of claims for services covered under Section 1371.9, refer to the statistically credible database, as required by HSC section 1371.31(a)(3)(C).
- Proposed subdivision (f)(2)(B) requires a relevant payor's policies and procedures to include information regarding which database relevant payors use to determine their ACR. This information is necessary to implement HSC section

1371.31(a)(3)(C), which requires a relevant payor to “...demonstrate to the department that it has access to a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region...”

- Proposed subdivision (f)(2)(C) requires a relevant payor’s policies and procedures to include certification that the database is statistically credible. The DMHC does not propose to be prescriptive about the form of this certification. However, attestation from an appropriate individual with relevant expertise that the database is statistically credible is necessary to implement HSC section 1371.31(a)(3)(C), which requires the payor to “demonstrate” access to a statistically credible database.
- Proposed subdivision (f)(2)(D) requires a relevant payor’s policies and procedures to include explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database. This provision is necessary to implement HSC section 1371.31(a)(3)(C), which requires relevant payors to “...use that database to determine an [ACR] required pursuant to paragraph (1)....” of HSC section 1371.31(a). The DMHC does not propose a prescriptive rule for how a relevant payor must use the database to determine the ACR for the purpose of the default reimbursement rate. However, relevant payors must explain and justify their chosen methodology for using the database so that the DMHC has the information necessary to ensure that it comports with HSC section 1371.31.
- Proposed subdivision (f)(3) clarifies that, for the purpose of subdivision (f)(2), a “statistically credible database” shall be a nonprofit database that is unaffiliated with a payor. This provision clarifies, implements, and makes specific HSC section 1371.31(a)(3)(C), which requires relevant payors to use a “statistically credible database” to determine their ACR, as specified. Proposed Rule 1300.71.31(f)(3) is necessary to implement that statute in a manner that ensures the credibility, fairness, and impartiality of the database used for the relatively few payors subject to HSC section 1371.31(a)(3)(C).

The DMHC has determined that allowing an applicable payor to use of its own in-house database would not ensure impartiality and soundness of the rates. Such a database would not be meaningfully reviewable by the DMHC, and thus it would fail to effectuate the Legislature’s intent to ensure fair reimbursement of noncontracting providers, pursuant to HSC section 1371.31. Additionally, the DMHC has made the policy determination that use of a for-profit database also raises concerns regarding the impartiality of the data, because a for-profit company may have a profit motive to create a database that is attractive to payors, meaning it may report rate data that that tends to result in artificially lower reimbursement, inconsistent with the meaning of ACR pursuant to HSC section 1371.31.

In contrast, the DMHC believes that use of a nonprofit database will act as a safeguard to help ensure that the data is collated and displayed in a manner that is not influenced by profit motives of interested parties. Use of a nonprofit database is intended to ensure fair reimbursement of noncontracted providers. However, the proposed rule does not expressly limit those applicable payors to using FAIR Health; if other appropriate options are available, then applicable payors may consult those other appropriate databases.

- Proposed subdivision (g) clarifies that the Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act, including section 1394. Similar to the proposed amendments to Rule 1300.71, this proposed subdivision (g) is necessary to clarify the DMHC's ability to enforce compliance with the proposed Rule, consistent with its existing authority.

Update of Material Relied Upon

No material other than the public comments, the Notice of Proposed Regulatory Action, the 15-day Comment Period documents, the Final Statement of Reasons, and the Final Text of the Regulations have been added to the rulemaking file since the time the rulemaking record was opened, and no additional material has been relied upon.

Mandate on Local School Agencies and School Districts

The DMHC has determined that the proposed regulation will not impose a mandate on local school agencies or school districts.

Comparable Federal Law

The DMHC has reviewed federal law and determined that there is no comparable federal law for this regulation.

Alternatives to the Proposed Regulation

As discussed in the Initial Statement of Reasons, the DMHC considered various alternatives to the proposed regulation during the informal rulemaking process. Further, the DMHC determined during the rulemaking process that the alternatives considered would not be more effective in carrying out the purposes for which the regulation is proposed, would not be as effective and less burdensome to health plans and providers, and would not be more cost-effective in implementing the requirements of Health and Safety Code sections 1371.9 and 1371.31.

Summary of and Responses to Comments

The DMHC's summary and responses to comments received are contained in tabs H and L of the rulemaking record.