

DEPARTMENT OF MANAGED HEALTH CARE
Average Contracted Rate Methodology and Default Rate (2017-5223)
Responses to Comments for
Comment Period #2, May 3, 2018 – May 18, 2018

#	FROM	COMMENT	DEPARTMENT RESPONSE
1-1	Bob Achermann California Radiological Society	<p>We appreciate the opportunity to submit comments on behalf of our 1,200 physician members. Our members are diagnostic and interventional radiologists and radiation oncologists. Many of them are hospital based and have a strong interest in the regulations to implement AB 72 and out of network physicians.</p> <p>We are supportive of the DMHC efforts to revise the draft regulations and only have comments on the following specific provisions;</p>	No specific change requested. Thank you for your comment.
1-2	Bob Achermann California Radiological Society	<p>Section 1300.71 Claims Settlement Practices</p> <p>We strongly support the change to include plan specific conduct in the scope of the definition of "demonstrable and unjust payment pattern" or "unfair payment pattern. Under this section such conduct would include (1) a pattern of failure to pay noncontracting health professionals the reimbursement described in 1300.71.31, and (2) pattern of failure -to determine the average contracted rate for health care services. We also supportive of the inclusion of a plan's failure to comply with sections 1371.31 and 1300.71.31 as possible grounds for disciplinary action. These safeguards will help ensure that payors comply with disclosure of Average Contracted Rate and proper interim payments to physicians and maintaining their financial viability.</p>	No specific change requested. Thank you for your comment.
1-3	Bob Achermann	Section 1300.71.31 Methodology for Determining Average Contracted Rate; Default Reimbursement	DECLINED. This comment is irrelevant, as it pertains to the text proposed in the first

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	<p>California Radiological Society</p>	<p>Rate, subdivision (a) Definitions, "Average contracted rate"</p> <p>We are concerned that this section defines the applicable calendar year in subdivision (a) (1) as the two years prior to the year in which the service was rendered. Health and Safety Code section 1371.31(a) (2) (A) (I) states that by 7/1/17 plans and delegated entities are to provide the ACR data for the most frequently provided applicable services in each geographic region for the calendar year 2015. We hear complaints from some of our members that some plans are not negotiating in good faith and simply rely on AB 72 rates. Such practices could unfairly impact the actual contracted rates and contradicts the specific mandate of AB 72 by not being reflected of pre-AB 72 average rates. The average contracted rate should reflect 2015 data then modified by the CI for Medical Care Services for three years, 2016-18, when determining the 2019 ACR.</p> <p>Irrespective of the applicable calendar year the regulation definition should specifically reflect that the ACR is adjusted by the CPI for Medical Care Services to reflect the current rates.</p>	<p>comment period.</p> <p>The DMHC has determined the requested change is not necessary to effectuate the purpose of 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 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.</p> <p>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 "...<u>until</u> the standardized methodology under paragraph (3) is specified..." (emphasis added).</p>
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1-4	<p>Bob Achermann</p> <p>California Radiological Society</p>	<p>"Integrated health system" section 1371.31(a) (3) (C), subdivision (d)</p> <p>We support the changes made in this section to require plans to file policies and procedures that clarify how under the payor's model what database is used, how the percentile was derived or other methodology to determine the average contracted rate, and how the plan determined that they did not pay a statistically significant number or dollar amount of claims under 1371.9. A DMHC audit of this process could also help ensure credibility with the process.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Regarding audits: HSC section 1371.31(a)(3)(D) states 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.</p>
1-5	<p>Bob Achermann</p> <p>California Radiological Society</p>	<p>Subdivision (f) Filing Requirements</p> <p>We would request that DMHC require plans to submit their Average Contracted Rates on an annual basis. Since DMHC is required to specify a standardized methodology by 1/1/19 we would also recommend that plans be required to promptly file within 90 to 120 days from when the regulations are final. If plans are allowed a longer time to file plans might be out of compliance for a prolonged period and impacting some physician practices.</p> <p>We appreciate the ongoing efforts of the DMHC to craft the appropriate regulatory structure for these two key elements of AB 72. We are pleased to be able to provide comments during that process.</p>	<p>DECLINED. This comment is irrelevant, as it pertains to the proposed text in the first comment period.</p> <p>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. 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. Requiring an annual filing would be unduly burdensome to the industry. Again, consistent with HSC</p>

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			<p>section 1371.31(a)(3)(D), the DMHC shall review the information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to HSC section 1382.</p> <p>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.</p>
2-6	<p>Bob Achermann</p> <p>California Society of Pathologists</p>	<p>We appreciate the opportunity to submit comments on behalf of our 600 pathologist members. Our members provide anatomic and clinical pathology services. They practice in both hospital and freestanding clinical laboratories. They can be impacted by AB 72 in either setting.</p> <p>We are supportive of the DMHC efforts to revise the draft regulations and would respectfully submit comments on the following provisions;</p>	<p>No specific change requested. Thank you for your comment.</p>
2-7	<p>Bob Achermann</p> <p>California Society of Pathologists</p>	<p>Section 1300.71 Claims Settlement Practices</p> <p>We strongly support the change to include plan specific conduct in the scope of the definition of "demonstrable</p>	<p>No specific change requested. Thank you for your comment.</p>

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		<p>and unjust payment pattern" or "unfair payment pattern. Under this section such conduct would include (1) a pattern of failure to pay noncontracting health professionals the reimbursement described in 1300.71.31, and (2) pattern of failure to determine the average contracted rate for health care services. We also supportive of the inclusion of a plan's failure to comply with sections 1371.31 and 1300.71.31 as possible grounds for disciplinary action. These safeguards will help ensure that payors comply with disclosure of Average Contracted Rate and proper interim payments to physicians and maintaining their financial viability.</p>	
2-8	<p>Bob Achermann California Society of Pathologists</p>	<p>Section 1300.71.31 Methodology for Determining Average Contracted Rate; Default Reimbursement Rate, subdivision (a) Definitions, "Average contracted rate"</p> <p>We are concerned that this section defines the applicable calendar year in subdivision (a) (1) as the two years prior to the year in which the service was rendered. Health and Safety Code section 1371.31(a) (2) (A) (1) states that by 7/1/17 plans and delegated entities are to provide the ACR data for the most frequently provided applicable services in each geographic region for the for the calendar year 2015. We hear complaints from some of our members that some plans are not negotiating in good faith and simply rely on AB 72 rates. Such practices could unfairly impact the actual contracted rates and contradicts the specific mandate of AB 72 by not being reflected of pre-AB 72 average rates. The average contracted rate should</p>	<p>DECLINED. This comment is irrelevant, as it pertains to the proposed text from the first comment period.</p> <p>Please see the response to comment # 1-3.</p>

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		<p>reflect 2015 data then modified by the CPI for Medical Care Services for three years, 2016-18, when determining the 2019 ACR.</p> <p>Irrespective of the applicable calendar year the regulation definition should specifically reflect that the ACR is adjusted by the CPI for Medical Care Services to reflect the current rates.</p>	
2-9	<p>Bob Achermann</p> <p>California Society of Pathologists</p>	<p>"Integrated health system" section 1371.31(a) (3) (C), subdivision (d)</p> <p>We support the changes made in this section to require plans to file policies and procedures that clarify how under the payer's model what database is used, how the percentile was derived or other methodology to determine the average contracted rate, and how the plan determined that they did not pay a statistically significant number or dollar amount of claims under 1371.9. A DMHC audit of this process could also help ensure credibility with the process.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Regarding audits: HSC section 1371.31(a)(3)(D) states 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.</p>
2-10	<p>Bob Achermann</p> <p>California Society of Pathologists</p>	<p>Subdivision (f) Filing Requirements</p> <p>We would request that DMHC require plans to submit their Average Contracted Rates on an annual basis. Since DMHC is required to specify a standardized methodology by 1/1/19 we would also recommend that plans be required to promptly file within 90 to 120 days from when the regulations are final. If plans are allowed a longer time to file plans might be out of compliance for a prolonged period and impacting some physician practices.</p>	<p>DECLINED. This comment is irrelevant, as it pertains to the proposed text from the first comment period.</p> <p>Please see the response to comment # 1-5.</p>
2-11	<p>Bob Achermann</p>	<p>1300.71 (o) (2) (c)- Recognition of Modifiers</p>	<p>DECLINED.</p>

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	<p>California Society of Pathologists</p>	<p>We appreciate the regulation recognition on use of modifiers, which is very common in the billing of pathology services. There is a professional component, -26, and technical component -27, and if a pathology code has no modifier that indicates it is a global charge or claim for the total of the two components. We would suggest the following language: "For the purpose of subdivision (c)(3)(i), when calculating the average contracted rate, the payor shall use unmodified and full contracted allowed amounts, 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)." This clarification is also critical for payors that have payment systems or rules that adjust payments even if the claim did not include a modifier.</p> <p>We appreciate the ongoing efforts of the DMHC to craft the appropriate regulatory structure for these two key elements of AB 72. We are pleased to be able to provide comments during that process.</p>	<p>Thank you for your comment. The proposed Rule, section 1300.71.31(c)(4) states: "(4) For the purpose of subdivision (c)(3)(i) [revised (c)(3)(A)], 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 makes the service description more specific and may adjust the reimbursement rate or affect the processing or payment of the code billed."</p> <p>The DMHC determined it is unnecessary to add ...“and full contracted amounts...” because the current language, “unmodified,” in context with the rest of the provision, is sufficiently clear.</p>
<p>3-12</p>	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>On behalf of our more than 43,000 physician and medical student members, the California Medical Association (hereinafter “CMA”) would like to thank you for considering additional comments on the Department of Managed Health Care’s (hereinafter “the Department”) proposed regulations to implement Assembly Bill 72 (Bonta 2016), 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</p>	<p>No specific change requested. Thank you for your comment.</p>

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		<p>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.</p> <p>CMA appreciates the Department’s efforts to implement A.B. 72 in a manner that ensures that payors do not apply widely varying interpretations of the law and that there is uniformity in the payment methodology. CMA submitted extensive comments during the initial comment period, a copy of which is attached for reference. CMA supported a number of provisions in the initial proposed regulations that have not changed in the revised text and so CMA continues to support these provisions. Addressed here are areas of the revised text that CMA strongly supports as well as those that remain primary concerns for CMA and that CMA urges the Department to reconsider.</p>	
3-13	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>Section 1300.71. Claims Settlement Practices CMA strongly supports the Department’s inclusion of 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 as well as a pattern of failure to determine the average contracted rate for health care services subject to section 1371.9 in a manner consistent with section 1300.71.31 in the definition of “demonstrable and unjust payment pattern” or “unfair payment pattern.” CMA also strongly supports the Department’s inclusion of sections 1371.31 and 1300.71.31 in the enumerated sections in subdivision (s)(2) to ensure that failure of a plan to comply with the</p>	<p>No specific change requested. Thank you for your comment.</p>

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		<p>requirements in sections 1371.31 and 1300.71.31 may constitute a basis for disciplinary action against the plan. Payors' failure to use the required ACR methodology and/or failure to pay the Default Reimbursement Rate impacts the viability of physician practices and results in unnecessary expenditure of personnel time and energy by physicians in their repeated attempts to get claims paid correctly. These resources would be better spent on providing quality health care services to patients. As such, proper enforcement of sections 1371.31 and 1300.71.31 is necessary to ensure a stable and financially viable health care delivery system.</p>	
3-14	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>Section 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate</p> <p>Subdivision (a) Definitions <u>"Average contracted rate"</u></p> <p><i>Applicable Calendar Year.</i> CMA remains concerned that the revised text maintains the definition of applicable calendar year as the "two years prior to the year in which the health care service was rendered." 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 <i>for the calendar year 2015</i>. 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</p>	<p>DECLINED. This comment is irrelevant, as it pertains to the proposed text from the first comment period.</p> <p>Please see the response to comment # 1-3.</p>

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		<p>2016. CMA continues to receive feedback from physician practices, particularly anesthesiology and radiology practices, that plans are failing to negotiate contracts in good faith and/or closing their panels entirely. In some cases, the plan has threatened termination of the contract if the physicians do not agree to a cut in their contracted commercial rates. Physicians report that plans have stated that they will just rely on the A.B. 72 rates for out-of-network fully insured commercial claims. This results in a de facto fee schedule, unstable contracted commercial rates beginning in 2016, and unstable provider networks, all of which were not the intent of the Legislature. In order to preserve the contracted commercial rates prior to A.B. 72 and to avoid network destabilization via rate manipulation, CMA continues to urge the Department to require payors to 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.</p> <p>Whatever applicable calendar year the Department establishes, CMA continues to strongly urge 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 & 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. No other payments, commercial or public, are paid based on</p>	
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		prior years' rates. In fact, the Department defined the Medicare rate as the rate in place in the year in which the health care service was rendered. As such, adjusting the ACR by the CPI for Medical Care Services to reflect current rates is in line with industry standard and it 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.	
3-15	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p><u>"Integrated health system"</u></p> <p>CMA strongly supports the Department striking the definition of Integrated Health System in the revised text as the definition was too broad and would have enlarged the scope of the narrow exemption in Health & Safety Code §1371.31(a)(3)(C).</p>	No specific change requested. Thank you for your comment.
3-16	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p><u>"Medicare rate"</u></p> <p>CMA continues to support 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) reflect current rates.</p>	No specific change requested. Thank you for your comment.
3-17	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p>CMA, however, remains strongly opposed to 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</p>	<p>DECLINED.</p> <p>The DMHC considered using the "non-participating" (non-par) Medicare rate as the baseline for the Medicare alternative for the default reimbursement rate, rather than the</p>

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		the payor. Physicians subject to the provisions of Health & Safety Code §§1371.31 and 1371.9 will <i>not</i> receive the benefits of contracting. Accordingly, CMA continues to urge the Department to use the Medicare “limiting charge” for nonparticipating providers in the Department’s definition of the Medicare rate.	“participating” (par) 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.
3-18	Catrina Reyes, Esq. California Medical Association	CMA understands the Department’s position 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 # 3-17. Additionally, HSC section 1371.31(a)(3)(C) applies only to specified, narrow circumstances, and does not generally govern payment of the default reimbursement rate.
3-19	Catrina Reyes, Esq. California Medical Association	<u>“Services most frequently subject to section 1371.9”</u> Although CMA supports the concept of the definition of "services most frequently subject to section 1371.9," CMA continues to urge 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	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 HSC section 1371.31.

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		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 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.	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 and, for any other services that are less frequently subject to section 1371.9, the payor’s 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 (see proposed Rule 1300.71.31(b)(2)).
3-20	Catrina Reyes, Esq. California Medical Association	Subdivision (b) CMA strongly supports the Department’s clarification that the payor must pay the noncontracting individual health profession the “default reimbursement rate” for <i>all</i> 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).	No specific change requested. Thank you for your comment.
3-21	Catrina Reyes, Esq. California Medical Association	CMA continues to urge the Department to specify that the Department will audit the proper use of the standardized methodology as well as the payments made according to Health & Safety Code §1371.31(a)(1)	DECLINED. This proposed change would be duplicative of the statute, which states in HSC section

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		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). Some large plans are currently not paying physicians according to the requirements in Health & Safety Code § 1371.31(a)(1) but instead either paying less than 125 percent of the amount Medicare reimburses or paying nothing at all and assigning an incorrect amount to the patient cost-share. As such, CMA urges the Department to specify that the Department will audit payors to ensure compliance with the law.	1371.31(a)(3)(D) the DMHC shall review information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to HSC section 1382.
3-22	Catrina Reyes, Esq. California Medical Association	Subdivision (c) Methodology for Determining the Average Contracted Rate <u>Subdivision (c)(3)</u> CMA strongly supports the Department changing the term “considering” in subdivision (c)(3) to “taking into account” to align with the mandatory language in Health & Safety Code § 1371.31(a)(3). However, to ensure a clear understanding of the requirement, CMA suggests the following language: “In calculating the rate described in subdivision (c)(1), the payor shall take into account each combination of these factors, at a minimum.”	DECLINED. The proposed language states that payors “shall” calculate the ACR taking into account each combination of factors. Therefore, the proposed Rule already employs mandatory language and the proposed change is unnecessary.
3-23	Catrina Reyes, Esq. California Medical Association	<u>Subdivision (c)(4)</u> CMA continues to strongly support the requirement that payors use “unmodified health care service codes” to calculate the ACR as services that have been adjusted due to a modifier or other reasons do not reflect the actual contracted commercial rates resulting in a skewed	DECLINED. Please see the DMHC response to comment # 2-11. Further, the language of the proposed Rule, requiring use of “unmodified” health care

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		<p>ACR. CMA also strongly supports the Department’s efforts to clarify the requirement. However, CMA is still concerned that payors may apply varying interpretations of subdivision (c)(4). Without further clarification, payors may misinterpret subdivision (c)(4) to mean that they should exclude any claims data from the ACR calculation if it includes modifiers rather than including the claims data, but at the full contracted rate, prior to any payment adjustments. Accordingly, CMA suggests the following language: “When calculating the average contracted rate under this subdivision (c), the payor shall use unmodified and full contracted allowed amounts, 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).”</p> <p>This clarification is also critical for payors that have payment systems or rules that adjust payments even if the claim did not include a modifier. For example, modifier -51 identifies when multiple procedures have been performed and most payors’ claims systems apply a minimum of a 50 percent reduction in payment. However, most payors’ claims systems also automatically identify when multiple procedures have been performed, even when modifier -51 was not appended, and apply the 50 percent reduction. The above suggested language will address both potential misinterpretations.</p>	<p>service codes, precludes a payor from calculating the ACR using a code adjusted for the multiple procedure code, or other modifiers, in the manner described by the commenter. Therefore, further clarification is unnecessary.</p>
3-24	<p>Catrina Reyes, Esq. California Medical</p>	<p><u>Subdivision (c)(5)</u> CMA supports the Department’s clarification regarding</p>	<p>DECLINED. The proposed Rule, in section</p>

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	Association	the appropriate default rate as well as the change in the term “shall” to “may” to ensure that payors do not misunderstand subdivision (c)(5) to be a mandatory provision. However, CMA urges the Department to also change the term “shall” to “may” in the last sentence of subdivision (c)(5) as follows: “Appropriate reimbursement may shall account for relevant payment modifiers and other health care service- or claim-specific factors in compliance with the Knox-Keene Act that affect the amount for reimbursement of health care services rendered by contracting individual health professionals.” Again, to ensure that payors do not misunderstand subdivision (c)(5) to be a mandatory provision.	1300.71.31(c)(5), pertains to “relevant” payment modifiers, adjusting reimbursement “as appropriate.” This language clearly conveys that a claim needs to be adjusted pursuant to this subdivision only when it is appropriate to do so. Therefore, the proposed change is unnecessary.
3-25	Catrina Reyes, Esq. California Medical Association	<u>Subdivision (c)(6)</u> CMA supports the changes made to the provisions for anesthesia services. This will ensure that the longstanding practice of using an anesthesia conversion factor is preserved even for payments pursuant to Health & Safety Code § 1371.31(a)(1).	No specific change requested. Thank you for your comment.
3-26	Catrina Reyes, Esq. California Medical Association	<u>Subdivision (c)(7)</u> CMA strongly supports the Department’s additions and clarifications to claims that shall be excluded from the average contracted rate calculation. However, CMA continues to urge the Department to clarify the following: <i>Claims Not in Final Disposition Status.</i> CMA supports the exclusion of claims not in final disposition status from the ACR calculation. However, CMA recommends that the Department clarify that the total amount paid for	DECLINED. The proposed Rule is sufficiently clear in its exclusion of “claims not in final disposition status.” The term cannot be reasonably interpreted to mean a claim that was once disputed, but is now in final disposition status.

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		settled claims, including the original payment amount and any additional (or final) amount, 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.	
3-27	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p>Subdivision (d)</p> <p>CMA strongly supports the Department’s substantial revisions to subdivision (d) of the proposed regulations. The initial proposed regulations lacked clarity, was inconsistent with the intent of the statute, and was over broad. CMA supports the Department’s approach to instead require payors to file policies and procedures with the Department that include: 1) explanations and justifications 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; 2) information regarding which database is used for the determination of an ACR; 3) certification that the database is statistically credible; and 4) explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database. In addition, CMA fully supports the Department’s description of a statistically credible database to be a nonprofit database that is unaffiliated with a payor. This approach would conceivably preserve the narrow exemption in Health & Safety Code §1371.31(a)(3)(C) and preclude the default reimbursement rate from being negatively skewed based</p>	No specific change requested. Thank you for your comment.

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		on the choice of database and the percentile or amount used in the database.	
3-28	Catrina Reyes, Esq. California Medical Association	CMA urges the Department to clarify that the description of a statistically credible database also applies to subdivision (d). Accordingly, CMA suggests the following addition: “For the purpose of subdivisions <u>(d)</u> and <u>(f)(2)</u> , a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.” In addition, to reinforce the Department’s approach, we urge the Department to specify that the Department will audit these filings to confirm that the payor in fact does not pay a statistically significant number or dollar amount of claims for services covered under Health & Safety Code § 1371.9 and to ensure that the default reimbursement rate is not being negatively skewed.	DECLINED. Proposed Rule 1300.71.31(f)(3) clarifies what constitutes a “statistically credible database” for the purpose of subdivision (f)(2), which references subdivision (d). Therefore, the current proposed language is sufficiently clear that subdivision (f)(3) clarifies the meaning of “statistically credible database” for the purpose of both subdivisions (d) and (f)(2).
3-29	Catrina Reyes, Esq. California Medical Association	Subdivision (f) Filing Requirements In order for the Department to ensure compliance with the standardized methodology set forth in regulations and with the payment requirements in Health & Safety Code § 1371.31(a)(1), CMA continues to urge 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 again 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,	DECLINED. This comment is irrelevant, as it pertains to the proposed text from the first comment period. 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. 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. An annual

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		<p>2019, payments will have been made incorrectly for several months. Health & Safety Code §1371.31(a)(3)(D) specifies 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 is 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.</p>	<p>filing would be unduly burdensome on the industry. Again, consistent with HSC section 1371.31(a)(3)(D), the DMHC shall review the information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to HSC section 1382.</p> <p>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.</p>
3-30	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>Subdivision (g) Enforcement</p> <p>CMA supports the Department's addition of subdivision (g) in the revised text to reinforce the Department's enforcement authority to ensure payors' compliance with the standardized methodology set forth in regulations and with the payment requirements in Health & Safety Code § 1371.31(a)(1). Again, however, CMA would like to stress that enforcement of these regulations and the statute will be challenging without audits of the proper use of the standardized methodology, of the payments made according to Health & Safety Code</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Regarding audits: HSC section 1371.31(a)(3)(D) states that the DMHC shall review information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to HSC section 1382.</p>

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		§1371.31(a)(1), and of payor filings as well as without payors filing their average contracted rates with the Department for approval on an annual basis.	
3-31	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p>Thank you for the opportunity to provide comments regarding the revised text for the proposed standardized ACR methodology, which will have a considerable impact on physicians, patients, and payors 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 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.</p>	<p>No specific change requested. Thank you for your comment.</p>
3-32	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p> <p>(This comment letter dated 3/19 was also submitted during 1st comment period so comments 3-32 through 3-70 are identical to comments 2-7 through 2-45 from 1st comment chart)</p>	<p>On behalf of our more than 43,000 physician and medical student members, the California Medical Association (hereinafter “CMA”) would like to thank 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.</p> <p>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</p>	<p>This comment is irrelevant, as it pertains to the proposed text from the first comment period.</p>

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		<p>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.</p>	
3-33	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>Section 1300.71. Claims Settlement Practices</p> <p>Subdivision (a)(8) Definition of “Demonstrable and Unjust Payment Pattern” or “Unfair Payment Pattern”</p> <p>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 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</p>	<p>This comment is irrelevant, as it pertains to the proposed text from the first comment period.</p>

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		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).	
3-34	Catrina Reyes, Esq. California Medical Association	<p>Subdivision (s)(2) Review and Enforcement</p> <p>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 requirements of Health & Safety Code §1371.31 may constitute a basis for disciplinary action against the plan.</p>	This comment is irrelevant, as it pertains to the text from the first comment period.
3-35	Catrina Reyes, Esq. California Medical Association	<p>Section 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate</p> <p>Subdivision (a) Definitions (1) <u>“Average contracted rate”</u></p> <p><i>Average Contracted Rate.</i> 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 <i>paid</i>” [emphasis added]. A claims-volume weighted average is the only way to accurately measure what is actually being <i>paid</i> for services in the market. As the Department explains, this</p>	This comment is irrelevant, as it pertains to the text from the first comment period.

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		<p>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.</p>	
3-36	<p>Catrina Reyes, Esq. California Medical Association</p>	<p><i>Applicable Calendar Year.</i> 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 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.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>
3-37	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>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 <i>for the calendar year 2015</i>. 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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		<p>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.</p>	
3-38	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>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 & 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.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>
3-39	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>(3) <u>“Geographic region”</u></p> <p>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’</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		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.”	
3-40	Catrina Reyes, Esq. California Medical Association	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.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-41	Catrina Reyes, Esq. California Medical Association	(4) <u>“Integrated health system”</u> As explained further below under subdivision (d), the definition of Integrated Health System lacks authority, 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).	This comment is irrelevant, as it pertains to the text from the first comment period.
3-42	Catrina Reyes, Esq. California Medical Association	(5) <u>“Medicare rate”</u> 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	This comment is irrelevant, as it pertains to the text from the first comment period.

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		Health & Safety Code §1371.31(a)(1) should reflect current rates.	
3-43	Catrina Reyes, Esq. California Medical Association	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 <i>not</i> 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.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-44	Catrina Reyes, Esq. California Medical Association	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.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-45	Catrina Reyes, Esq. California Medical Association	<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	This comment is irrelevant, as it pertains to the text from the first comment period.

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		<p>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 3-46 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 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.</p>	
3-46	<p>Catrina Reyes, Esq. California Medical Association</p>	<p><u>(8) “Services subject to section 1371.9”</u></p> <p>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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		<p>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 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.</p>	
3-47	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>Subdivision (b)</p> <p><u>Subdivision (b)(2)</u></p> <p>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 <i>must pay</i> the noncontracting individual health profession the “default reimbursement rate” for <i>all</i> health care services subject</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		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).	
3-48	Catrina Reyes, Esq. California Medical Association	In addition, CMA urges the Department to specify that the Department will audit the proper use of the 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 comment is irrelevant, as it pertains to the text from the first comment period.
3-49	Catrina Reyes, Esq. California Medical Association	<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	This comment is irrelevant, as it pertains to the text from the first comment period.

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		audit and approve how the information from the independent dispute resolution process is used by payors in the calculation of the ACR.	
3-50	Catrina Reyes, Esq. California Medical Association	<p>Subdivision (c) Methodology for Determining the Average Contracted Rate</p> <p><u>Subdivision (c)(1)</u></p> <p>CMA strongly supports the methodology for determining the ACR outlined in subdivision (c)(1). As explained 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 <i>and</i> the patient’s share of the costs.</p>	This comment is irrelevant, as it pertains to the text from the first comment period.
3-51	Catrina Reyes, Esq.	<u>Subdivision (c)(3)</u>	This comment is irrelevant, as it pertains to the

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	California Medical Association	<p>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 <i>shall</i> take into account, <i>at a minimum</i>, 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 services vary based on each of the enumerated factors, then the payor <i>must</i> calculate the ACR separately for each of these factors. If a payor contracts at different rates based on provider and/or specialty type, payors <i>must</i> 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 <i>must</i> 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.</p>	text from the first comment period.
3-52	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p><u>Subdivision (c)(4)</u></p> <p>CMA strongly supports the requirement that payors use “unmodified health care service codes” to calculate the</p>	This comment is irrelevant, as it pertains to the text from the first comment period.

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		<p>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 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.</p>	
3-53	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>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.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>
3-54	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>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 services.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>
3-55	<p>Catrina Reyes, Esq.</p>	<p><u>Subdivision (c)(5)</u></p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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	California Medical Association	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."	
3-56	Catrina Reyes, Esq. California Medical Association	<p><u>Subdivision (c)(6)</u></p> <p>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 language for subdivision (c)(6):</p> <p>"(i) The payor shall use the anesthesia conversion</p>	This comment is irrelevant, as it pertains to the text from the first comment period.

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		<p>factor (“ACF”) set forth in the payor’s provider contracts instead of an “allowed amount” to complete the calculation pursuant to subdivision (c)(1).</p> <p>(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.”</p>	
3-57	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p><u>Subdivision (c)(7)</u></p> <p><i>Case Rates and Global Rates.</i> 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.”</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>
3-58	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p><i>Capitated Payments.</i> CMA urges the Department to specify that capitated payments made to a delegated entity from which subsequently fee-for-service 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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		ACR calculation as these are part of the contracted rate.	
3-59	Catrina Reyes, Esq. California Medical Association	<i>Denied Claims.</i> 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 <i>paid</i> by the health plan or delegated entity for the same or similar services in the geographic region. Given that nothing was <i>paid</i> for these services they are outside of the definition of the ACR.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-60	Catrina Reyes, Esq. California Medical Association	<i>Claims Not in Final Disposition Status.</i> CMA supports the exclusion of claims not in final disposition status from the ACR calculation. However, 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.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-61	Catrina Reyes, Esq. California Medical Association	<i>Bundled Payments.</i> 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.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-62	Catrina Reyes, Esq. California Medical Association	<i>Memorandums of Understanding (MOUs) or Single Case Agreements (SCAs).</i> 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 &	This comment is irrelevant, as it pertains to the text from the first comment period.

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		<p>Safety Code §1371.31(a)(1) defines ACR as the average of the <i>contracted</i> 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 <i>noncontracting</i> physicians these are not considered contracted rates. Therefore, we urge the Department to exclude MOUs and SCAs from the ACR calculation.</p>	
3-63	<p>Catrina Reyes, Esq. California Medical Association</p>	<p><i>Secondary Payments.</i> 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 scenarios. Under one method, the primary payor pays 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.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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3-64	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p><i>Non-Commercial Rates.</i> 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 the Department including Medicare products, Medi-Cal products, out-of-state products, self-insured employer products, or other products regulated by federal law.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>
3-65	<p>Catrina Reyes, Esq.</p> <p>California Medical Association</p>	<p>Subdivision (d)</p> <p>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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		<p>§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.</p>	
3-66	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>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, including most delegated entities. This is not consistent with Health & Safety Code §1371.31(a)(3)(C). Government Code § 11342.2 provides that, “[w]henver 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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		<p>contravening the narrow exemption provided for in Health & Safety Code §1371.31(a)(3)(C).</p>	
3-67	<p>Catrina Reyes, Esq. California Medical Association</p>	<p>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 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.</p> <p>The 80th percentile is appropriate, because though when FAIR Health compiles its 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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		resulting data.	
3-68	Catrina Reyes, Esq. California Medical Association	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.	This comment is irrelevant, as it pertains to the text from the first comment period.
3-69	Catrina Reyes, Esq. California Medical Association	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.”	This comment is irrelevant, as it pertains to the text from the first comment period.
3-70	Catrina Reyes, Esq. California Medical Association	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 §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	This comment is irrelevant, as it pertains to the text from the first comment period.

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		<p>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.</p> <p>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 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.</p>	
4-71	<p>Jeff Poage, MD</p> <p>California Society of Anesthesiologists</p>	<p>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</p>	<p>No specific change requested. Thank you for your comment.</p>

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		<p>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.</p> <p>The development of the ACR is a critical component of achieving the goals of AB 72 and it appears in the latest draft of these regulations that DMHC has come a long way in addressing certain components that would have put healthcare providers at a disadvantage in negotiating contracts with plans. Specifically, CSA has advocated for the mandatory inclusion of the Anesthesia Conversion Factor (ACF), which is now clearly delineated in the second comment period of these regulations, and we are thankful to DMHC for this enumeration. We applaud this development in the regulation, as well as on certain other components, but do express some concerns on others, listed below.</p>	
4-72	<p>Jeff Poage, MD</p> <p>California Society of Anesthesiologists</p>	<p>Support <u>Section 1300.71 regarding claim settlement practices</u> CSA strongly supports DMHC’s inclusion in the definition of a “demonstrable and unjust payment pattern” at section 1300.71(a)(8)(U) “a pattern of failure to pay noncontracting individual health professionals the reimbursement described in section 1300.71.31 and</p>	<p>No specific change requested. Thank you for your comment.</p>

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		required pursuant to section 1371.31.” CSA also strongly supports the Department’s inclusion of references to sections 1371.31 and 1300.71.31 at section 1300.71(s)(2) to ensure that failure of a plan to comply with the requirements in sections 1371.31 and 1300.71.31 may constitute a basis for disciplinary action against the plan. Payors’ failure to use the required ACR methodology and/or failure to pay the Default Reimbursement Rate impacts the viability of physician practices and results in unnecessary expenditure of personnel time and energy by physicians in their repeated attempts to get claims paid correctly. These resources would be better spent on providing quality health care services to patients. As such, proper enforcement of sections 1371.31 and 1300.71.31 is necessary to ensure a stable and financially viable health care delivery system.	
4-73	Jeff Poage, MD California Society of Anesthesiologists	<u>Section 1300.71.31 (c)(6) regarding the Anesthesia Conversion Factor (ACF)</u> CSA is very appreciative of DMHC’s acknowledgement that the ACF is a standard component of anesthesia contracts and has included of the American Society of Anesthesiologists Relative Value Guide base units, time units, and physical status modifier. These inclusions will ensure that the longstanding practice of using an ACF is the norm even in out of network payments.	No specific change requested. Thank you for your comment.
4-74	Jeff Poage, MD California Society of Anesthesiologists	<u>Section 1300.71.31 (d) regarding a rates database</u> CSA fully supports the Department’s definition of a statistically credible database to be a nonprofit database that is unaffiliated with a payor. This approach would conceivably preserve the narrow exemption in Health & Safety Code § 1371.31(a)(3)(C) and preclude the default	No specific change requested. Thank you for your comment.

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		reimbursement rate from being negatively skewed based on the choice of database and the percentile or amount used in the database.	
4-75	<p>Jeff Poage, MD</p> <p>California Society of Anesthesiologists</p>	<p>Remaining Concerns <u>Section 1300.71.31 (a) regarding the methodology for determining ACR and the default reimbursement rate</u> CSA has seen patterns of behavior change between health plans and our physician anesthesiologist members attempting to negotiate contracts since the passage of AB 72. DMHC continues to define the applicable calendar year as “two years prior to the year in which the health care service was rendered.” However, AB 72 used 2015 as the benchmark year by which services would be measured. 2015 was the last year before conversations regarding out of network payments occurred, which would lead one to believe that neither plans nor providers could alter behavior or negotiations to build a more favorable rate setting atmosphere. Our members have in fact seen plans modify and threaten to terminate contracts subsequent to the passage of AB 72, and as a result, we believe the applicable calendar year should be 2015 and adjusted by the Consumer Price Index for Medical Care Services for three years (2016, 2017, and 2018) when determining the 2019 ACR and then adjusted accordingly.</p> <p>Additionally, we encourage DMHC to include in the definition that the ACR is to be adjusted by the CPI for Medical Care Services to reflect current rates. The Legislature made clear their intent that reimbursement should reflect actual market trends.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p> <p>.</p> <p>Please see the DMHC response to comment #1-3.</p>

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4-76	<p>Jeff Poage, MD</p> <p>California Society of Anesthesiologists</p>	<p><u>Section 1300.71.31 (f) regarding filing requirements</u></p> <p>As we embark on a standardized way of dealing with out of network payments, CSA urges DMHC to require payors to file their average contracted rates with DMHC for approval on an annual basis. Considering that DMHC is required to review this information, this seems like a sensible means of ensuring adequate payments and trends or unintended consequences of implementing these measures. Thank you for considering our points.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p> <p>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. 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. Requiring an annual filing would be unduly burdensome to the industry. Again, consistent with HSC section 1371.31(a)(3)(D), the DMHC shall review the information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to HSC section 1382.</p>
5-77	<p>Deborah Espinal</p> <p>Kaiser Foundation Health Plan</p>	<p>On behalf of Kaiser Foundation Health Plan, Inc. (“the Plan”), The Permanente Medical Group (“TPMG”), and the Southern California Permanente Medical Group (“SCPMG”) (collectively “Kaiser Permanente”), I am submitting comments regarding the revised draft of the Average Contracted Rate Methodology and Default Rate proposed regulations. Throughout California, the Plan contracts with Kaiser Foundation Hospitals to provide</p>	<p>No specific change requested. Thank you for your comment.</p>

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		<p>hospital services to its members and with TPMG and SCPMG to provide medical services to its members in Northern and Southern California, respectively. As multi-specialty group practices, TPMG and SCPMG take direct responsibility for organizing and providing the professional medical care that Plan members receive.</p> <p>The Plan appreciates the Department’s continued efforts in promulgating these regulations which are connected to a long standing complex issue having significant impact to health plans, health plan members, and providers. The following are comments and suggestions made by the Plan. Excerpts from the proposed regulations are included as bold-italic text while the Plan’s recommended changes are included as underlined text. For the text the Plan recommends be stricken, the text is underlined and stricken.</p>	
5-78	<p>Deborah Espinal</p> <p>Kaiser Foundation Health Plan</p>	<p><u>Comment 1</u></p> <p><i>(f) Filing requirements.</i> <i>(1) Payors shall electronically file with the department the policies and procedures used to determine the average contracted rates in compliance with this section by August 15, 2019, and thereafter when the policies and procedures are amended.</i> <i>(2) If applicable, the payor shall demonstrate in its policies and procedures access to and use of a statistically credible database pursuant to subdivision (d) of this Rule including the following information:</i> <i>(i) Explanation and justification of the determination</i></p>	<p>DECLINED.</p> <p>The commenter suggests that the language in proposed Rule 1300.71.31(f)(2)(i) and (iv) (revised (f)(2)(A) and (D), respectively), requiring explanation and “justification” implies that, “plans who can utilize this exception are somehow doing something wrong...”</p> <p>It is not the intent to suggest any wrongdoing on the part of payors with a model that falls under HSC section 1371.31(a)(3)(C) and proposed subdivisions (d) and (f)(2)-(3).</p> <p>Rather, the requirement in proposed</p>

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		<p><i>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></p> <p><i>(ii) Information regarding which database is used for the determination of an ACR;</i></p> <p><i>(iii) Certification that the database is statistically credible; and</i></p> <p><i>(iv) Explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database.</i></p> <p><i>(3) For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.</i></p> <p>The Plan has several concerns with this section.</p> <p>1) The Plan believes it is reasonable for the Department to request explanations for items (i) and (iv), but requiring the Plan to “justify” rather than simply “explain” seems to suggest that plans who can utilize this exception are somehow doing something wrong and therefore they need to justify this. Health and Safety Code Section 1371.31(a)(3)(C) states that health plans using this option are making this decision based on the health plan’s model. For this reason, it would seem reasonable that plans using this option should be able to provide a clear narrative that explains their model for item (i). Similarly, for item (iv), it seems reasonable that the Plan explain how we use the database, e.g., to determine the</p>	<p>subdivision (f)(2)(i) (revised (f)(2)(A)) is intended to ensure that payors adequately describe their model and provide justification (i.e., a reasoned analysis supported by facts) that they are subject to HSC section 1371.31(a)(3)(C). The required explanation and justification is necessary to effectuate the Legislature’s intent that only the statutorily-described payors refer to a database, as specified, to determine the ACR.</p> <p>Similarly, regarding the commenter’s concern about the requirement for “explanation and justification of the percentile or other methodology used to determine the [ACR], using the database, pursuant to proposed Rule 1300.71.31(f)(2)(iv) [revised (f)(2)(D)],” the DMHC intends for applicable payors to describe their methodology for using the database and provide justification (i.e., a reasoned analysis supported by facts) showing that the payor’s methodology effectuates the Legislature’s requirement to, “demonstrate to the [DMHC] that [the payor] has access to a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region” and the requirement to use that database to determine an average contracted rate, consistent with HSC section 1371.31. The explanation and justification of the manner by which these payors use the</p>
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		average contract rate. It is not clear what the Department would expect from the Plan that “justifies” the percentile used by the Plan in reference to the database. If the Department has a specific concern or question related to the health plan’s explanation the Department can submit the question directly to the health plan during the filing process. We believe that health plans that fall under Health and Safety Code Section 1371.31(a)(3)(C) are health plans that have unique characteristics and any justifications used to support the explanation would be best addressed in a question directly to the health plan rather than codified into regulations.	database is necessary to ensure that the DMHC has the information necessary to determine whether such a payor complies with HSC section 1371.31.
5-79	Deborah Espinal Kaiser Foundation Health Plan	2) Item (iii) is problematic because health plans are not able to “certify” that a database is statistically credible. There is no known certification process available to accomplish this. The data is proprietary to the database company and it is unclear if the company would be willing to “certify” this either. We would recommend changing this to requiring the health plan “explain” why the database is statistically credible. This is something health plans are more likely to be able to obtain from the company providing this data.	DECLINED. The DMHC does not intend to prescribe a particular mode for certification that the database is statistically credible. Rather, the payor shall be able to certify the database is statistically credible to meet the purpose of this subdivision of the Rule. The DMHC has made the policy determination that this attestation, in conjunction with the other filing requirements under proposed Rule 1300.71.31(f) and the DMHC’s periodic audits pursuant to HSC section 1382, are sufficient to ensure the credibility of the database and to effectuate the purpose of AB 72 without being unduly burdensome and overly prescriptive for the industry.
5-80	Deborah Espinal	3) Item (3) appears to be a reference to FAIR Health,	DECLINED.

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	<p>Kaiser Foundation Health Plan</p>	<p>which is a nonprofit organization. This language really weds us (and any other health plan that uses a statistically credible database) to FAIR Health in perpetuity. Currently FAIR Health is one of the most prominent companies creating this type of data set. What if in the future new options became available to health plans but the company is not a nonprofit? It is unclear why the profit status of a company should be more significant than the fact that a company is able to create a statistically credible database that is comprehensive and assists the industry with the problems related to provider charges and payments. In addition, if a health plan has robust data of its own, there is no reason why a health plan could not create a statistically credible database by itself, rather than relying on a third-party vendor. For these reasons we recommend the Department may not want to tie a statistically credible database to a nonprofit for all time. This could end up requiring a legislative or regulatory fix in the future.</p>	<p>The DMHC has determined that proposed Rule 1300.71.31(f)(3) is necessary to ensure 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 made the policy determination that use of a for-profit database could also raise potential 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 tends to result in artificially lower reimbursement, inconsistent with the meaning of ACR pursuant to HSC section 1371.31.</p> <p>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 the potential profit motives of interested parties. The required use of a nonprofit database by the DMHC is intended to ensure fair reimbursement</p>
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			<p>of noncontracted providers.</p> <p>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.</p>
5-81	<p>Deborah Espinal</p> <p>Kaiser Foundation Health Plan</p>	<p>Recommended changes:</p> <p>(f) Filing requirements.</p> <p>(1) Payors shall electronically file with the department the policies and procedures used to determine the average contracted rates in compliance with this section by August 15, 2019, and thereafter when the policies and procedures are amended.</p> <p>(2) If applicable, the payor shall demonstrate in its policies and procedures access to and use of a statistically credible database pursuant to subdivision (d) of this Rule including the following information:</p> <p>(i) 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;</p> <p>(ii) Information regarding which database is used for the determination of an ACR;</p> <p>(iii) Certification <u>Explanation for why the database is statistically credible;</u> and</p> <p>(iv) Explanation and <u>justification</u> of the percentile or other methodology used to determine the average contracted rate, using the database.</p> <p>(3) For the purpose of subdivision (f)(2), a statistically</p>	<p>DECLINED.</p> <p>Please see the DMHC response to comment #5-80.</p>

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		<p>credible database shall be a nonprofit database that is unaffiliated with a payor.</p> <p>Kaiser Permanente appreciates the opportunity to provide comments on the Average Contracted Rate Methodology and Default Rate regulations.</p>	
6-82	<p>Richard Katz, PT,DPT, MA</p> <p>California Physical Therapy Association</p>	<p>On behalf of the California Physical Therapy Association (CPTA) and its 8,400 members, I would like to thank you for the opportunity to present our questions regarding the proposed modified regulation, Methodology for Determining Average Contracted Rate; Default Reimbursement Rate, amending Sections 1300.71 and adding section 1300.71.31 in title 28, California Code of Regulations. Our participation in rulemaking for the State of California’s consumers of health insurance is an integral part of ensuring access to rehabilitative services.</p> <p>With that said, pursuant to Government Code section 11346.8(c) and California Code of Regulations, Title 1, section 44, we hereby offer the following questions:</p> <p>1. The regulations indicate that the proposed payment methodology (ACR) applies when services are provided by a non-contracted provider at a contracted (in network) facility. Does the ACR apply to services provided by a provider at a non-contracted facility?</p>	<p>No specific change requested.</p> <p>Absent other agreement, payment of the default reimbursement rate, which may be the ACR, is required for “services subject to section 1371.9,” which the proposed Rule defines as, “...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, <u>or</u> 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.” [Emphasis added.]</p> <p>As noted in the Initial Statement of Reasons, this definition clarifies that HSC section 1371.9 applies an either/or, disjunctive test for relevant noncontracted health care services that either occur at a contracted facility where the enrollee received covered health care services, “or” as a result of those health care services received. This provision is necessary to clarify that AB 72 applies to some noncontracted services that</p>

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			are not rendered in the contracted health facility.
6-83	Richard Katz, PT,DPT, MA California Physical Therapy Association	2. Does the payment methodology apply to an individual provider who is not credentialed with a payer within a contracted facility and bills under the facilities tax ID?	No specific change requested. As noted in proposed Rule 1300.71.31(a)(8), HSC section 1371.9(f) contains relevant definitions, including the definition of a “noncontracting individual health professional” who is subject to HSC section 1371.31 and this proposed Rule.
6-84	Richard Katz, PT,DPT, MA California Physical Therapy Association	3. Could a third-party administrator who is contracted with a payer impose their out of network rates on a non-contracted provider as an alternative to the ACR?	No specific change requested. Health plans and delegated entities who are “payors” under HSC section 1371.31 and the proposed Rule must comply with the requirements for reimbursement described in HSC section 1371.31 and this proposed Rule. Payors who use a third-party administrator or similar entity remain responsible for complying with the reimbursement required by these laws.
6-85	Richard Katz, PT,DPT, MA California Physical Therapy Association	4. Would a non-contracted facility be able to balance bill a patient beyond the ACR if those rates are disclosed to a patient if there is an agreement between the patient and the facility?	No specific change requested. This question is outside the scope of this proposed Rule. The DMHC notes that the requirements for effective notice and consent to out-of-network cost sharing are described in HSC section 1371.9(c).
6-86	Richard Katz, PT,DPT, MA California Physical Therapy Association	5. Please clarify how this section applies to physical therapists and what other payment methodologies may be employed. a. This provision further clarifies that, for <i>other</i> services subject to Health and Safety Code section 1371.9, a	No specific change requested. As noted in proposed Rule 1300.71.31(a)(8), HSC section 1371.9(f) contains relevant definitions, including the definition of an

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		<p>payor may use the regulation’s ACR methodology or it may, instead, employ a different methodology. Therefore, this proposed regulation clarifies that the payor has flexibility in how it determines the ACR for services that are not “most frequently subject to” Health and Safety Code section 1371.9.</p> <p>Thank you for your consideration in this matter. We look forward to the Departments response.</p>	<p>“individual health professional” and a “noncontracting individual health professional.”</p>
7-87	<p>Wendy Soe</p> <p>California Association of Health Plans</p>	<p>The California Association of Health Plans (CAHP) submits the following comments to the proposed regulations:</p> <ul style="list-style-type: none"> • <i>1300.71.31 (a)(1) “Average contracted rate” <u>and ACR</u> 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.</i> <p>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 rate.</p>	<p>No specific change requested.</p>
7-88	<p>Wendy Soe</p> <p>California</p>	<p>We also 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</p>	<p>DECLINED.</p> <p>The DMHC declines to specify that carriers</p>

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	Association of Health Plans	ACR. This approach will reduce administrative complexity and provide a more robust data set for the ACR analysis.	offering multiple products are able to factor in the various offerings in the calculation of an ACR because we believe this change is unnecessary. We note that nothing in the proposed Rule prevents payors from calculating the ACR for all commercial product lines.
7-89	Wendy Soe California Association of Health Plans	<ul style="list-style-type: none"> • 1300.71.31 (a)(54): “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. <p>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.</p> <p>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</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p> <p>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.</p> <p>Additionally, with respect to the commenter’s note about the potential unavailability of billing codes, the DMHC expects that a Medicare rate for a “same or similar” service will be available to facilitate the required comparison of</p>

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		base year for both sides of the default reimbursement rate equation is the most operationally viable.	Medicare rate and ACR, consistent with HSC section 1371.31(a)(1), thus making this approach operationally viable.
7-90	Wendy Soe California Association of Health Plans	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 years prior will help to limit such volatility.	This comment is irrelevant, as it pertains to the text from the first comment period.
7-91	Wendy Soe California Association of Health Plans	<ul style="list-style-type: none"> • (7)(8) <i>“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.</i> <p>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 described as such:</p> <p>“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 pathologist, the pathology services would</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p> <p>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 and unnecessary regulatory burden, the DMHC declines to expressly describe which services may or may not be the “result of” such covered services.</p>

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		<p>be subject to Health and Safety Code section 1371.9 because they were “a result of” a service rendered at an in-network facility.”</p> <p>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. We would ask that the Department clarify this in the final rules.</p>	
7-92	<p>Wendy Soe</p> <p>California Association of Health Plans</p>	<ul style="list-style-type: none"> • <i>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:</i> <i>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.</i> <p>To account for scenarios where there are multiple service units making up one total claim, we 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 was paid \$50.00 per CPT code 88312, which is a special</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p> <p>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.</p> <p>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. The allowed amount for the service code would be whatever amount is set forth in the contract.</p>

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		<p>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, dividing by “number of claims” (1) would artificially inflate the value.</p> <p>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.</p>	
7-93	<p>Wendy Soe</p> <p>California Association of Health Plans</p>	<ul style="list-style-type: none"> • <u>1300.71.31(f)(3) For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.</u> <p>We are disappointed to see in (f)(3), a reference to a “nonprofit database” which, at this time, limits options to the FAIR Health database. In stakeholder meetings, many parties, including the health plans expressed reservations with such an arbitrary limit on available options. It is unclear why the profit/nonprofit status of a company should be held in greater esteem than the statistic credibility of the database and the reliability and utility to the industry. More importantly, health plans have robust data of their own that could be relied on for this purpose. We recommend that this language be removed.</p> <p>Thank you the opportunity for offer comment to these</p>	<p>DECLINED.</p> <p>Please see the DMHC response to comment #5-80.</p>

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8-94	<p>William Barcellona, JD, MHA</p> <p>America's Physician Groups</p>	<p>proposed regulations.</p> <p>America's Physician Groups submits the following four comments on the 2nd version of the draft rule.</p> <p>Section 1300.71.31(d) Payors subject to subdivision (a)(3)(C) of section 1371.31 of the Knox- Keene Act shall use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region to determine an average contracted rate required pursuant to this Rule and section 1371.31 of the Knox- Keene Act. This subdivision (d) applies notwithstanding any other provision of this Rule.</p> <p>The reference to subdivision (a)(3)(C) of the statute refers to "a health care service plan's model" as a relevant factor to what type of database it should refer to in determining payments when it does not have a statistically significant number of claims.</p> <p>APG asserts that there is an ambiguity concerning which entities are subject to this subsection, above. Many have opined that the purpose of this reference in the underlying statute is to refer to the Kaiser Permanente system which includes an integrated, exclusive contracted provider network. Any Knox Keene licensed plan, however, could assert that given its "model" it falls under the provisions of (a)(3)(C) since "model" is not defined and lacks clarity. For example, this subsection could apply to a Restricted Knox Keene licensee, or since it is common to apply requirements to "health plans" to their contracted, delegated RBOs, that it could</p>	<p>No specific change requested.</p> <p>It should be noted that the DMHC struck the definition of "integrated health system" from the Rule during the 2nd comment period because of comments indicating confusion that were received from stakeholders.</p> <p>Based on the scope of the stakeholder comments the DMHC received, the DMHC is declining to use a rigid definition for the relevant model, in favor of language that is consistent with HSC 1371.31(a)(3)(C).</p>
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		<p>apply to those entities as well.</p> <p>This ambiguity creates a material concern because the Department has chosen to make it a mandatory requirement for an “(a)(3)(C)” entity to refer to an independent, nonprofit, third party database, as we will discuss further in the next section.</p>	
8-95	<p>William Barcellona, JD, MHA</p> <p>America’s Physician Groups</p>	<p>Section 1300.71.31 (f) Filing requirements. (3) For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.</p> <p>If we are correct in the assumption that the recent addition of the “nonprofit database” language in this version of the draft rule refers to the Fair Health Database, then APG is very disappointed that the Department has now taken this approach. The exclusion of charge-based indices (as is the Fair Health Database) was FUNDAMENTAL to the construction of AB 72 and was agreed to by all stakeholder parties. It should be acceptable for a payer to refer to other claims databases such as Milliman and others that are operated on a “for profit” basis. Such databases are credible and responsible. It is far more important that the database is premised on payments, rather than charges, than whether it is run on a for-profit or not-for-profit basis.</p>	<p>DECLINED.</p> <p>Please see the DMHC’s response to comments # 5-80 and 8-96.</p>
8-96	<p>William Barcellona, JD, MHA</p> <p>America’s Physician Groups</p>	<p>Again, the Fair Health Database is based on <u>charges</u>, <u>not actual payments</u>. Using a charge-based index is inherently inflationary and cannot reflect the average of actual payments. It cannot meet the requirement of AB 72 to ensure payments to non-contracted providers reflect the rates paid in the contracted market. We</p>	<p>DECLINED.</p> <p>Please see the DMHC’s response to comment # 5-80. Regarding the concern that certain databases are based on charges, the DMHC notes that payors may develop their</p>

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		<p>strongly suggest that the Department make the following change to the language of subsection (3):</p> <p>For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor, that is based on actual payment data rather than charge data.</p>	<p>methodology for using a database to reflect rates paid to noncontracting individual health professionals, consistent with HSC section 1371.31(a)(3)(C). Thus, the DMHC has determined that a database such as FAIR Health, in conjunction with a payor’s methodology reportable under proposed Rule 1300.71.31(f)(2)(D), is compliant with HSC section 1371.31(a)(3)(C).</p> <p>That is, the proposed Rule does not require the relatively few payors subject to HSC section 1371.31(a)(3)(C) and proposed Rule 1300.71.31(d) and (f)(2)-(3) to base their determination of ACR on 100% of the rates provided in the database. Rather, HSC section 1371.31(a)(3)(C) requires that applicable payors use the database to determine the ACR. The proposed Rule requires payors to explain and justify the percentile or other methodology the applicable payor used to determine the ACR, using the database. This suggests that the payor may calculate the ACR as a percentage of the rate given in the database. Therefore, because the rates given by a database may be adjusted based on a percentage applied, there should be limited concern that databases that use “charge” data will be inflationary. Based on this fact, the Department is declining to make the proposed change submitted by the commenter.</p>
8-97	William Barcellona,	Section 1300.71.31(c)(3): “ <u>The payor shall calculate a</u>	DECLINED.

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	<p>JD, MHA</p> <p>America's Physician Groups</p>	<p><u>rate described in subdivision (c)(1) considering each combination of these factors, at a minimum:</u></p> <ul style="list-style-type: none"> • <u>Health care service code, including but not limited to Current Procedural Terminology (CPT) codes,</u> • <u>Geographic region,</u> • <u>Provider type and specialty, and,</u> • <u>Facility type.</u> <p>In our previous letter to the Department submitted during the first comment period, we lodged a comment regarding subsection (iii) above: "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." The Department did not change the language cited above in the 2nd draft.</p>	<p>The DMHC believes that CPT code is not always a perfect indicator of specialty or provider type. Therefore, those factors are kept separate for the purpose of ACR stratification to ensure appropriate calculation of the ACR.</p>
<p>8-98</p>	<p>William Barcellona, JD, MHA</p> <p>America's Physician Groups</p>	<p>Since that time, and upon further reflection, we now lodge another comment regarding subsection (i) above; in that requiring payers to use a methodology that requires average contracted rate determinations or references to outside databases for low-volume claims payments to each specific CPT code will result in a cumbersome and administratively burdensome process where the vast majority of payments under AB 72 fall at contracted rates well below the 125% of Medicare floor required under the statute.</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p> <p>Please note, however, that for "low volume" claims, i.e. claims for services that are not "most frequently subject to section 1371.9," payors are generally subject to proposed Rule 1300.71.31(b)(2). That is, the payor may, but is not required to, use the methodology described in this proposed Rule to determine the ACR. If the payor uses a different methodology, that different methodology shall be a reasonable method of determining the ACRs paid by the payor for the same or similar services in the</p>

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			<p>geographic region, in the applicable calendar year.</p> <p>In contrast, applicable payors that are subject to HSC section 1371.31(a)(3)(C) are subject to proposed Rule 1300.71.31(d) and (f)(2)-(3).</p>
8-99	<p>William Barcellona, JD, MHA</p> <p>America’s Physician Groups</p>	<p><u>Section 1300.71.31(e)(2): The payor shall indicate on claims payment documents the manner by which the payor satisfied this subdivision (e)</u></p> <p>In our prior letter during the first comment period, we cited the following point: “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 language is unclear and ambiguous. 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.”</p> <p>We continue to urge the Department to take this point</p>	<p>This comment is irrelevant, as it pertains to the text from the first comment period.</p>

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		<p>into account.</p> <p>Thank you for the opportunity to provide comment. We submit these recommendations respectfully. Please direct any questions concerning this comment letter to the undersigned.</p>	
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