California Medical Association
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Mary Watanabe, Deputy Director, Health Policy & Stakeholder Relations
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Sent via email to mary.watanabe@dmhc.ca.gov

RE: Comments on Standardized ACR Methodology

Dear Ms. Watanabe:

On behalf of our more than 43,000 physician and medical student members, the California Medical Association (CMA) would like to thank you for considering stakeholder input on the efforts of the Department of Managed Health Care (hereinafter "the Department") to implement Assembly Bill 72, codified at Health & Safety Code §§1371.30, 1371.31, and 1371.9.

Health and Safety Code § 1371.31(a)(3)(A) requires the Department to specify by January 1, 2019 a methodology that plans and delegated entities shall use to determine the average contracted rates (ACR) for services most frequently subject to Health & Safety Code §1371.9. CMA submitted extensive comments related to the development of the ACR on March 3, 2017, a copy of which is attached for reference. At the Department's June 26, 2017 public meeting, the Department raised a number of additional considerations for the standardized ACR methodology as well as the Medicare rate which we address herein. Our comments regarding the Department's independent dispute resolution process (IDRP) proposal are outlined in a separate letter.

As A.B. 72 will have significant impacts on physicians and reimbursement is nuanced depending on specialty, CMA urges the Department to convene a provider stakeholder or workgroup meeting, where physicians and other providers can voice concerns. Moreover, we urge the Department to audit the out-of-network payments to ensure that plans are complying with the interim payment rules.

Average Contracted Rate

ACR Calculation

Health & Safety Code §1371.31(a)(1) defines ACR as the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. In order to accurately reflect an "average" of the rates, the average must account for the volume of services the plan paid at a specific contracted rate because this is the only way to measure what is actually being paid for those services in the market. If plans calculate their

ACR by only taking into account each contract for a particular service, the result would be an ACR that is not an accurate measure of the average rate being paid, which is entirely contrary to the intent of A.B. 72. Contracts with several individual physicians, that together account for a small volume of patient services, can greatly outweigh a contract with one large group of physicians, which accounts for a substantial volume of patient services. Incorporating the volume of services provided under each contract into the calculation also weights against higher and lower outlier contracted rates. The intent of establishing an accurate ACR in the law was to encourage contracting between providers and plans and to not destabilize provider networks by incentivizing health plans to terminate existing contracts, which will further narrow provider networks and patient access to care.

Payment and Claims Data

Claim Amount

CMA urges the Department to specify that the "claim amount" that should be included in the ACR calculation should be the allowed amount, which includes the total paid by the plan plus the amount of any patient cost-sharing. Patient cost-sharing must be included to reflect the actual contracted rate. A physician's full contracted rate includes the portion paid by the plan *and* the patient's share of the costs. Therefore, excluding the patient's cost-sharing in the ACR calculation would not reflect the physician's full contracted rate and would be an inaccurate measure of the ACR.

Disputed and Denied Payments

CMA urges the Department to require plans to use payments in their final disposition when calculating the ACR as these reflect the actual rates paid. Disputed payments are usually underpaid claims and thus do not reflect the full contracted commercial rates. In addition, denied services should be excluded from the ACR calculation as nothing was paid for these services. Health & Safety Code §1371.31(a)(1) defines ACR as the average of the contracted commercial rates *paid* by the health plan or delegated entity for the same or similar services in the geographic region. Given that nothing was *paid* for these services they are outside of the definition of the ACR.

Services with Modified Payments

In order to accurately reflect contracted commercial rates when determining the ACR, CMA urges the Department to require the plans to use the full and actual contracted rates and not rates that have been adjusted by a modifier or for any other reason. 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. Similarly, modifier -50 (bilateral procedure) adjusts payments as the procedure for the second side is paid at 50 percent of the contracted rate. Note, however, that a plan's payment system may adjust payments even if the claim did not include a modifier.

As the payment rates for procedures that have been adjusted due to a modifier or other reasons do not reflect the actual contracted commercial rates, using this amount would not be an accurate reflection of the contracted commercial rates resulting in a skewed ACR. Calculating the ACR using the full and actual contracted rates does not mean payments based on the ACR cannot still be adjusted or modified based on the plan's payment policies. However, for purposes of the ACR calculation, the full and actual contracted rate should be used to accurately reflect the contracted commercial rates.

Global Payments

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. Some payments are for a global charge and require a modifier to distinguish the physician's services. Many radiology services, for example, are described by a single or global CPT code, but are comprised of two distinct portions: a professional component and a technical component. The professional component includes the physician's services and the technical component includes the provision of all equipment, supplies, personnel, and costs related to the performance of the service. Contracted rates for the technical component are paid to the facility or practice responsible for these costs. To claim only the professional portion of a service, modifier -26 (professional component) is appended to the CPT code. In this instance, using a payment rate that includes modifier -26 is appropriate when determining the ACR because it reflects the contracted rate for just the physician's services.

Payments for Anesthesia Services

Payments for anesthesia services are calculated differently from other services. Virtually all anesthesia services are paid under a formula that includes base units, time units, a physical status modifier for the patient, and an anesthesia conversion factor, expressed in dollars per unit. The formula is as follows:

(Base Units + Time Units + Physical Status Modifier) x Anesthesia Conversion Factor = Reimbursement Rate

The base units, time units, and physical status modifiers are all standard measures and unique to anesthesia services. The base units are measurements published by the American Society of Anesthesiologists annually and correspond to the complexity and intensity of the anesthesia service. The time unit is a measurement of each 15-minute interval, or fraction thereof, during which anesthesia services are performed. Physical status modifiers commonly known as P-modifiers help to distinguish between levels of complexity in providing anesthesia services comparative to patient health circumstances. Because of different levels of complexity in providing anesthesia to patients of varying health states, use of a P-modifier can sometimes add an additional base unit (or units) when reported.

In the standardized ACR methodology for anesthesia services, we urge the Department to require plans to use the anesthesia conversion factor formula expressed in dollars per unit when determining the contracted commercial rates to be included in the ACR calculation. This is the

most widely accepted method for setting rates for anesthesia services and is used in virtually every contract for anesthesia services because it includes the unique components of anesthesia delivery.

Payments for Different Provider and Facility Types

If a plan contracts at different rates based on provider type, CMA urges the Department to require the plans to calculate the ACR for the different provider 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 plan pays different rates to physicians based on the type of facility where the services are provided, combining contracted commercial rates for hospitals and ambulatory surgery centers, for example, could again skew the ACR. Thus, CMA urges the Department to specify that if plans' contracted rates for services vary based on facility type, then those ACRs should be reported separately by facility type.

Capitated and Sub-Capitated Payments

CMA urges the Department to require plans to convert capitated and sub-capitated payments into a fee-for-service equivalent and provide the methodology on how the payments were converted. In addition, all types of compensation for all products including but not limited to incentive payments and bonus payments should be included in the fee-for-service conversions as these are part of the contracted rate.

Bundled Payments

Bundled payment programs generally make one payment for a group of services to a single entity, traditionally a hospital, which then allocates the money among the participating providers. As there is no basis upon which plans 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.

Services Paid at a Case Rate

Case rates are payments designed around a continuum of care for a specific condition that could include a range of services. Hence, it may be difficult to determine the commercial contracted rate for a particular service that is part of the case rate. As such, we suggest the Department exclude case rates from the ACR calculation. However, if data is available that allows for the conversion of case rates into a fee-for-service equivalent, we suggest the Department require plans to convert case rates into a fee-for-service equivalent and provide the methodology on how the payments were converted.

MOUs or Single Case Agreements

A Memorandum of Understanding or single case agreement is an agreement between a non-contracting physician and a plan for the provision of specific pre-defined services for one patient for one date of service or range of service dates. Health & Safety Code §1371.31(a)(1) defines ACR as the average of the *contracted* commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. As these are one-time, limited agreements for *non-contracting* physicians these are not considered contracted rates. Moreover, these non-contracting physicians do not enjoy the benefits of contracting such as increased volume of patients and being listed in the plan's provider directory. Therefore, we urge the Department to exclude single case agreements from the ACR calculation.

Services Most Frequently Subject

CMA anticipates, based on input from our members, that the categories of services most likely to be subject to Health & Safety Code §1371.9 are pathology, radiology, anesthesiology, hospital inpatient, surgical, and consultative specialty services. We understand a large number of CPT code categories and/or subheadings are implicated by these types of services. However, we urge the Department to ensure that it has broad information on these services in order to accurately and more easily identify which services are most frequently subject to Health & Safety Code §1371.9.

Base Year

Health & Safety Code §1371.31(a)(2)(A)(i) specifies that by July 1, 2017, each health care service plan and its delegated entities shall provide to the Department data listing its ACR for the plan for services most frequently subject to Section 1371.9 in each geographic region in which the services are rendered for the calendar year 2015. Moreover, Health & Safety Code §1371.31(a)(2)(B) provides that for each calendar year after the plan's initial submission of the ACR and until the standardized methodology is specified by the Department, a health care service plan and the plan's delegated entities shall adjust the rate initially established by the Consumer Price Index (CPI) for Medical Care Services, as published by the United States Bureau of Labor Statistics.

Health & Safety Code §1371.31(a)(3)(A), in directing the Department to develop a standardized methodology for determining ACR, does not specify what calendar year is to be used in the standardized methodology. The purpose of using 2015 rates in Health & Safety Code §1371.31(a)(2)(A)(i) was to provide a snapshot of the market prior to A.B. 72. CMA has already heard reports of plans failing to negotiate contracts in good faith and/or closing their panels entirely, which then affects the stability of contracted commercial rates. In order to preserve the contracted commercial rates prior to A.B. 72 and avoid network destabilization via rate manipulation, CMA urges the Department to use 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. However, given the uncertainty in the market due to the passage of A.B. 72, we encourage the Department to revisit this at a future date to assess whether the use of 2015 data adjusted by the CPI for Medical Care Services still accurately and appropriately reflects market rates.

Geographic Region

Health & Safety Code §1371.31(a)(1) defines ACR as the average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. Health & Safety Code §1371.31(a)(6) specifies that for reimbursement based on the Medicare fee-for-service rates, geographic regions shall be the geographic regions specified for physician reimbursement for Medicare fee-for-service by the United States Department of Health and Human Services. There is no specification in this provision, however, on the geographic regions to be used for the ACR. In identifying the geographic regions to be used for the ACR, CMA urges consistency between the Department of Managed Health Care and the Department of Insurance.

At the June 2017 stakeholder meeting, the Department raised the issue of how to determine which geographic region will be used in situations where a service is initiated in one region and completed in another – in the case of laboratory work, for example. CMA recommends that the geographic region for a service should be determined by the address where the service was rendered, even if the service is provided at a non-contracting facility resulting from an in-network facility visit.

Medicare Rate

Health & Safety Code §1371.31(a)(1) specifies that for services subject to §1371.9, "the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered." Medicare reimburses participating and nonparticipating physicians at different rates for services they provide. Nonparticipating physicians are reimbursed at a higher rate because they do not enjoy the benefits of contracting such as increased volume of patients and referrals from the payor. Similarly, the physicians subject to the provisions of A.B. 72 will not receive the benefits of contracting. Accordingly, CMA urges that the Department specify in regulations and guidance that Medicare rate for purposes of Health & Safety Code §1371.31(a)(1) is the Medicare limiting charge for nonparticipating providers.

Health & Safety Code §1371.31(a)(2) specifies that payments made using the ACR should be based on 2015 rates adjusted annually by CPI for Medical Care Services. However, the law is silent as to what year payments made using the Medicare fee-for-service rate should be based on. CMA urges that payments made using the Medicare fee-for-service rate should be based on the amount Medicare reimburses on a fee-for-service basis for the current year. The initial ACR submissions are adjusted annually by the CPI for Medical Care Services, which demonstrates the Legislature's intention that rates should reflect current market rates.

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Thank you for the opportunity to provide input regarding the 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 and look forward to working with the Department and other stakeholders to

ensure it achieves its objectives. I can be reached by phone at (916) 551-2543 or by email at creyes@cmanet.org should you require any clarification or additional information regarding CMA's comments.

Respectfully submitted,

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