



# California Medical Association

*Physicians dedicated to the health of Californians*

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September 22, 2017

Mary Watanabe, Deputy Director, Health Policy & Stakeholder Relations  
Department of Managed Health Care  
980 9<sup>th</sup> 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 methodology on July 21, 2017, a copy of which is attached for reference. The Department, at its September 12, 2017 stakeholder meeting, provided an outline of its regulatory proposal for the standardized ACR methodology. Addressed herein are CMA’s comments to the Department’s outlined regulatory proposal.

### **Average Contracted Rate**

#### **Applicable Calendar Year**

Health & Safety Code §1371.31(a)(3)(A), which directs the Department to develop a standardized methodology for determining ACR by 2019, does not specify what calendar year is to be used in the standardized methodology. In the definition of ACR presented at the stakeholder meeting, the Department defines 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.

Health & Safety Code §1371.31(a)(2)(A)(i) specifies that by July 1, 2017, each health care service plan and its delegated entities shall provide to the Department data listing its ACR for the plan for services most frequently subject to Section 1371.9 in each geographic region in which the services are rendered *for the calendar year 2015*. The Legislature’s intent in using 2015 rates in Health & Safety Code §1371.31(a)(2)(A)(i) was to capture a snapshot of the market prior to the passage of A.B. 72 in 2016. CMA has conveyed to the Department reports we have heard of plans failing to

negotiate contracts in good faith and/or closing their panels entirely, which has affected the stability of contracted commercial rates, beginning in 2016. CMA is further concerned that All Plan Letter 17-009, which permits certain payors to receive an exemption from the Health & Safety Code § 1371.31(a)(2)(A) filing requirements and to reimburse physicians at 125% of the Medicare rate for services subject to A.B. 72, may serve to further skew the market for years 2017 forward. 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 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.

### **ACR Calculation**

Weighted Average: CMA strongly supports the Department's use of an ACR methodology that takes into account the volume of claims paid at a specific contracted rate, as this is the only way to accurately measure what is actually being paid for services in the market. 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. Incorporating the volume of services provided under each contract into the calculation also weights against higher and lower outlier contracted rates.

Weighting by Volume of Services: While CMA supports the approach delineated by the Department generally, we urge that the ACR calculation include the total number of all paid *services or procedures*, rather than paid claims. There is a slight distinction between paid services or procedures and paid claims - a claim could include multiple services or procedures. Counting a claim once even if it contains multiple services or procedures, could skew the ACR for a service. As such, CMA urges the Department to clarify that total number of paid claims includes all the services or procedures within the claim with the specified procedure code.

Allowed Amount: CMA strongly supports the Department's use of the allowed amount in the ACR calculation. The allowed amount reflects the physician's full contracted rate, because it includes the total paid by the plan plus the amount of any patient cost-sharing. Including the physician's full contracted rate in the ACR calculation will result in an accurate measure of the ACR.

Commercial Rates Only: CMA urges the Department to specify what products do not constitute "commercial contracts" when calculating the ACR. Health & Safety Code §1371.9 only applies to services provided to patients enrolled in products regulated by the Department of Managed Health Care and specifically excludes Medi-Cal products. Accordingly, CMA strongly recommends that the Department specify that, in calculating their ACRs, 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.

## **Services with Modified Payments**

In order to accurately reflect contracted commercial rates when determining the ACR, the full and actual contracted rates should be used in the ACR calculation, and not rates that have been adjusted by a modifier or for any other reason. As such, CMA supports the Department's use of "unmodified health care service codes." However, we urge the Department to clarify that the term "unmodified health care services codes" means rates that have not been adjusted by a modifier or for any other reason. "Unmodified health care services codes" could be mistakenly understood to mean that only services for which modifiers are not used are to be included in the ACR calculation.

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. We believe the Department tried to capture this concept, however, we urge the Department to clarify this further in its draft regulations. For instance, the Department may state that payors must calculate the ACR using the full contracted rates before any payment rules or adjustments are applied that would affect the contracted rate. When processing claims, payors may then apply any payment rules or adjustments, including modifiers, to the ACR when reimbursing the noncontracting physician.

## **Distinct ACRs**

We support the Department's proposal to calculate distinct ACRs when a plan contracts at different rates based on provider or specialty type, or based on the type of facility where the services are provided. However, the Department specified that payors need only consider these factors. CMA strongly urges the Department to make this mandatory for the standardized ACR methodology. Health & Safety Code §1371.31(a)(3)(A) provides that the standardized ACR methodology *shall* take into account, amongst other things, the specialty of the individual health professional. 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.

## **Exclusions**

Capitated Payments: We support the Department's exclusion of certain rates and claims from the ACR calculation, namely case rates, denied claims, and claims not in their final disposition. However, CMA has concerns with excluding all capitated payments from the ACR calculation. 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). Note that all types of compensation for all

products including but not limited to incentive payments and bonus payments should be included in the ACR calculation as these are part of the contracted rate.

**Bundled Payments:** The Department's regulatory proposal for the standardized ACR methodology does not exclude bundled payments from the ACR calculation. 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.

**Memorandums of Understanding (MOUs) or Single Case Agreements (SCAs):** The Department's regulatory proposal for the standardized ACR does not exclude Memorandums of Understanding (MOUs) or single case agreements (SCAs). MOUs and SCAs are agreements between a non-contracting physician and a payor for the provision of specific pre-defined services for one patient for one date of service or range of service dates. Health & Safety Code §1371.31(a)(1) defines ACR as the average of the *contracted* commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region. As these are one-time, limited agreements for *non-contracting* physicians these are not considered contracted rates. Therefore, we urge the Department to also exclude MOUs and SCAs from the ACR calculation.

### **Services Most Frequently Subject**

In the Department's regulatory proposal, "[s]ervices most frequently subject to Health & Safety Code §1371.9" is defined as, "health care services that, when added together, comprise at least 80 percent of the payor's statewide claims volume for health care services subject to Health & Safety Code §1371.9 in the applicable calendar year." We urge the Department to clarify this definition to mean the top 80 percent of codes based on utilization. We further urge the Department to provide an explanation stating that it is then these services that are subject to the standardized ACR methodology.

### **Information to Take into Account**

Health & Safety Code §1371.31(a)(3)(A) provides that the standardized ACR methodology shall take into account, amongst other things, information from the independent dispute resolution process (IDRP). The Department's regulatory proposal failed to specify if or how it would consider the IDRP information. Accordingly, in formulating the standardized ACR methodology, we urge the Department to specify that information from the IDRP will be taken into account.

### **Medicare Rate**

In the Department's regulatory proposal, the Department defined the Medicare Rate as "125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar health care services in the geographic region in which the health care services were rendered, for the calendar year in which the health care service was rendered, on a 'par' basis. 'Par' basis means the reimbursement rate paid to health care service providers participating in the Medicare program by accepting Medicare assignment." CMA strongly supports the Department's use of the calendar

year in which the health care service was rendered for payments using the Medicare fee-for-service rate. However, CMA strongly opposes the use of “par” basis. Medicare 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, physicians subject to the provisions of A.B. 72 will not receive the benefits of contracting. Accordingly, CMA urges the Department to use the Medicare limiting charge for nonparticipating providers in the Department’s definition of the Medicare rate.

### **Audits of Payments**

CMA has shared with the Department several reports we received of plans not paying non-contracting physicians according to the payment rules required by Health & Safety Code §1371.31(a)(1). As such, we urge the Department to audit the out-of-network payments to ensure that payors are complying with the statutory payment rules and to take appropriate corrective and/or enforcement action should it identify payors that are out of compliance with the law.

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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](mailto:creyes@cmanet.org) should you require any clarification or additional information regarding CMA’s comments.

Respectfully submitted,



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Attachment: CMA Comments – DMHC Standardized ACR Methodology - 072117