AB 72
Stakeholder Meeting

September 12, 2017
Agenda

1. Welcome and Introductions
2. Overview of AB 72
3. AB 72 Regulation Timeline
4. Review of Standardized Average Contracted Rate Methodology
5. Public Comment
Consumer Participation Program

- Submit a “Petition to Participate in a Proceeding”.
- Issue: “AB 72 Standardized Methodology for Average Contracted Rate”.
- California Department of Managed Health Care > About the DMHC > Opportunities to Participate
Overview of AB 72

Sara Durston, Attorney, Office of Legal Services
Jessica Petersen, Attorney, Office of Legal Services
AB 72 Overview

Effective July 1, 2017:
  • Prohibits Surprise Balance Billing.
  • Establishes a Default Reimbursement Rate.

Effective September 1, 2017:
  • Establishes a binding and mandatory Independent Dispute Resolution Process (IDRP). Access to legal remedies is preserved.

Effective January 1, 2019:
  • Requires the DMHC to finalize regulations establishing a standard Average Contracted Rate (ACR) methodology.
Default Reimbursement Rate

Effective July 1, 2017:
For services rendered subject to Health and Safety Code Section 1371.9, unless otherwise agreed to by the noncontracting health professional and the payor, the payor shall reimburse the **greater** of:

- The Average Contracted Rate (ACR), or
- 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic regions in which the services were rendered.
## Default Reimbursement Rate

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Average Contracted Rate (ACR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2017 – December 31, 2017</td>
<td>ACR based on Calendar Year 2015 rates and filed with the DMHC by July 1, 2017</td>
</tr>
<tr>
<td>January 1, 2018 – December 31, 2018</td>
<td>ACR adjusted by Consumer Price Index for Medical Services</td>
</tr>
<tr>
<td>January 1, 2019 or effective date of reg. - Ongoing</td>
<td>ACR based on the standardized methodology defined in regulations</td>
</tr>
</tbody>
</table>
Standardized Methodology

By January 1, 2019, DMHC is required to develop a standardized methodology for calculating the average contracted rate (ACR) for services most frequently subject to Health and Safety Code Section 1371.9.

- Payors will use this methodology to calculate the average contracted rate for services rendered on or after January 1, 2019 and most frequently subject to Health and Safety Code Section 1371.9.

- Payors may also use this methodology or another reasonable method to determine the Average Contracted Rate for less frequent services subject to Health and Safety Code Section 1371.9.

- Payors are still required to pay the greater of 125% of Medicare or the Average Contracted Rate.
AB 72 Regulation Timeline

Jessica Petersen, Attorney, Office of Legal Services
# Regulation Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder Meeting to Solicit Initial Input on Standardized Average</td>
<td>June 26, 2017</td>
</tr>
<tr>
<td>Contracted Rate Methodology and Independent Dispute Resolution Process</td>
<td></td>
</tr>
<tr>
<td>(IDRP)</td>
<td></td>
</tr>
<tr>
<td>Stakeholder Meeting to Solicit Input on Standardized Average Contracted</td>
<td>September 12, 2017</td>
</tr>
<tr>
<td>Rate Methodology Prior to Rulemaking Process</td>
<td></td>
</tr>
<tr>
<td>Formal Rulemaking Process</td>
<td>October 2017 –</td>
</tr>
<tr>
<td></td>
<td>December 2018</td>
</tr>
<tr>
<td>Regulation Effective</td>
<td>January 1, 2019</td>
</tr>
</tbody>
</table>
Review of Standardized Average Contracted Rate Methodology

Jessica Petersen, Attorney, Office of Legal Services
Definitions

Payor
A health plan or its delegated entity that has the responsibility for payment of a claim for health care services subject to Health and Safety Code Section 1371.9.

Average Contracted Rate (ACR)
The 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. The applicable calendar year is two years prior to the year in which the health care service was rendered.
Definitions

“Services subject to Health and Safety Code Section 1371.9”

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.
“Services most frequently subject to Health and Safety Code Section 1371.9”

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 and Safety Code Section 1371.9 in the applicable calendar year.
Definitions

Statistically Significant
Five or more claims for services subject to Health and Safety Code Section 1371.9 for the applicable calendar year.

Geographic Region
The regions specified for physician reimbursement for Medicare fee-for-service by the US Department of Health and Human Services.

Default Reimbursement Rate
The greater of the Average Contracted Rate or 125 percent of the Medicare rate.
Definitions

Medicare Rate

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.

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ACR Calculation

\[
\text{Rate} = \frac{\text{sum of (allowed amount for the health service code under a contract } x \text{ number of claims paid at that allowed amount)}}{\text{Total number of claims paid for that code across all commercial contracts}}
\]
### ACR Calculation Example

<table>
<thead>
<tr>
<th>Contract</th>
<th>Contract Rate</th>
<th>Total Number of Claims Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$10</td>
<td>25</td>
</tr>
<tr>
<td>B</td>
<td>$15</td>
<td>30</td>
</tr>
<tr>
<td>C</td>
<td>$12</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

\[
\text{ACR} = \frac{($10 \times 25) + ($15 \times 30) + ($12 \times 45)}{100 \text{ (total claims)}} = \$12.40
\]
Average Contracted Rate

- Include the highest and lowest contracted rates when calculating the ACR. The number of claims paid at the allowed amount for the highest and lowest contracted rate must be at least one (1).

- Use unmodified health care service codes to calculate the Average Contracted Rate, except for CPT codes with payment modifiers “26” and “TC”.

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Distinct ACRs

Consider each combination of factors, including at a minimum:

- Health care service code, including but not limited to CPT codes
- Geographic region
- Provider type and specialty
- Facility type
Average Contracted Rate

When the Average Contracted Rate is the appropriate reimbursement rate, the payor shall adjust the rate determined when it reimburses the noncontracting individual health professional to account for relevant payment modifiers or claim-specific factors that affect the amount of reimbursement.
Anesthesia Services

- Use the anesthesia conversion factors in the provider contracts instead of the allowed amount to calculate the Average Contracted Rate.
- The factors that affect the reimbursement include the sum of base units, time units, and physical status modifier.
Exclusions

The following shall be excluded from the Average Contracted Rate calculation:

• Case rates and global rates, except for CPT codes in which a global rate is embedded.
• Claims paid pursuant to capitation, risk sharing arrangements and sub-capitation.
• Denied claims.
• Claims not in final disposition status.
Integrated Health Systems

Payors that did not pay a statistically significant number or dollar amount of claims subject to Health and Safety Code Section 1371.9 as a result of their health care service plan model shall:

- Demonstrate access to and use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region as the source of rate data for the purpose of payment of the default reimbursement rate.
Public Comment

Submit written comments by September 22, 2017 to:

stakeholder@dmhc.ca.gov

Consumer Participation Program

- Submit a “Petition to Participate in a Proceeding”.
- Issue: “AB 72 Standardized Methodology for Average Contracted Rate”.
- [California Department of Managed Health Care > About the DMHC > Opportunities to Participate](#)
Questions

Mary Watanabe
Deputy Director
Health Policy and Stakeholder Relations
Mary.Watanabe@dmhc.ca.gov
(916) 324-2560

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