1300.71.31 Methodology for Determining Average Contracted Rate; Default Reimbursement Rate

(a)

The following definitions apply for the purpose of this section: (1) "Average contracted rate" and ACR mean 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. Beginning January 1, 2024, this rate is then adjusted to the date the service was rendered by using the inflation adjustment described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act. (2) "Default reimbursement rate" means the greater of the average contracted rate or 125 percent of the Medicare rate, payable to a noncontracting individual health professional pursuant to section 1371.31 of the Knox-Keene Act. (3) "Geographic region" 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. (4) "Medicare rate" means 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. (5) "Payor" means a health plan or its delegated entity that has the responsibility for payment of a claim for health care services subject to section 1371.9 of the Knox-Keene Act. The term Payor excludes health plans and entities described in subdivision (e) of section 1371.31 of the Knox-Keene Act. (6) "Services most frequently subject to section 1371.9" of the Knox-Keene Act means the 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 section 1371.9 in the applicable calendar year, as defined in subdivision (a)(1) of this section. (7) "Services subject to section 1371.9" of the Knox-Keene Act 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. (8) The definitions in subdivision (f) of section 1371.9 of the Knox-Keene Act apply for the purpose of this section.

(1)

"Average contracted rate" and ACR mean 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. Beginning January 1, 2024, this rate is then adjusted to the date the service was rendered by using the inflation adjustment described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act.

(2)

"Default reimbursement rate" means the greater of the average contracted rate or 125 percent of the Medicare rate, payable to a noncontracting individual health professional pursuant to section 1371.31 of the Knox-Keene Act.

(3)

"Geographic region" 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.

(4)

"Medicare rate" means 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.

(5)

"Payor" means a health plan or its delegated entity that has the responsibility for payment of a claim for health care services subject to section 1371.9 of the Knox-Keene Act. The term Payor excludes health plans and entities described in subdivision (e) of section 1371.31 of the Knox-Keene Act.

(6)

"Services most frequently subject to section 1371.9" of the Knox-Keene Act means the 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 section 1371.9 in the applicable calendar year, as defined in subdivision (a)(1) of this section.

(7)

"Services subject to section 1371.9" of the Knox-Keene Act 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.

(8)

The definitions in subdivision (f) of section 1371.9 of the Knox-Keene Act apply for the purpose of this section.

(b)

For all health care services subject to section 1371.9 of the Knox-Keene Act, payors shall comply with subdivision (e) and do the following: (1) For health care services most frequently subject to 1371.9, payors shall use the methodology described in this section to determine the average contracted rate; or (2) For health care services that do not fall under subdivision (b)(1), the payor may, but is not required to, use the methodology described in this section to determine the average contracted rate. If the payor uses a different methodology, that different 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.

(1)

For health care services most frequently subject to 1371.9, payors shall use the methodology described in this section to determine the average contracted rate; or

(2)

For health care services that do not fall under subdivision (b)(1), the payor may, but is not required to, use the methodology described in this section to determine the average contracted rate. If the payor uses a different methodology, that different 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.

(c)

Methodology for determining the average contracted rate.(1) 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: Rate = sum of [the allowed amount for the health service code under each contract x number of claims paid for each allowed amount]/Total number of claims paid for that code across all commercial contracts. Beginning January 1, 2024, this rate is then adjusted to the date the service was rendered by using the inflation adjustment described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act. Example: For hypothetical health care service code Z, and for a particular combination of the factors described in subdivision (c)(3), the payor's allowed amounts under its commercial contracts are: Contract A ($10), Contract B ($15), Contract C ($12). During the applicable calendar year, the payor paid, for code Z, 25 claims under Contract A, 30 claims under contract B, and 45 claims under contract C. The rate calculation pursuant to this subdivision (c)(1) is: ($10x25)+($15x30)+($12x45) / (total claims: 100) = a base ACR rate of $12.40 for health care service code Z. Beginning January 1, 2024, the rate, so calculated, is then adjusted for inflation by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics, as described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act. (2) The payor shall include the highest and lowest contracted rates when calculating the rate pursuant to subdivision (c)(1) by ensuring that the "number of claims paid at that allowed amount" multiplier for

each of the payor's highest and lowest contracted rates is at least 1 (one). (3) The payor shall calculate a rate described in subdivision (c)(1) taking into account each combination of these factors, at a minimum:(A) Health care service codes, including but not limited to Current Procedural Terminology (CPT) codes, (B) Geographic region, (C) Provider type and specialty, (D) Facility type, and, (E) Information from the independent dispute resolution process, if any, pursuant to section 1371.30 of the Knox-Keene Act. (4) For the purpose of subdivision (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 section, 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. (5) When the average contracted rate is the appropriate default reimbursement rate pursuant to subdivision (a)(1) of section 1371.31 of the Knox-Keene Act, the payor may adjust the rate determined under this subdivision (c) when it reimburses the noncontracting individual health professional, as appropriate. Appropriate reimbursement 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. (6) For anesthesia services subject to section 1371.9 of the Knox-Keene Act: (A) The payor shall use the anesthesia conversion factors set forth in the payor's provider contracts instead of an "allowed amount" to complete the calculation pursuant to subdivision (c)(1). (B) The factors that affect reimbursement pursuant to subdivision (c)(5) of this section shall include the sum of American Society of Anesthesiologists Relative

Value Guide (RVG) base units, time units, and physical status modifier. (7) The following claims shall be excluded from the average contracted rate calculation, except as specified:(A) Case rates, bundled payments, and global rates shall be excluded, except that the payor shall include the CPT code in which a global rate is embedded per the American Medical Association CPT code description. (B) Claims paid pursuant to capitation, risk sharing arrangements, and sub-capitation, except for fee-for-service payments made by a payor who receives capitation from another entity. (C) Denied claims. (D) Claims not in final disposition status, meaning claims for which a final reimbursement amount pursuant to claims settlement practices required by the Knox Keene Act has not been determined by the payor, including disputed claims. (E) Secondary payment rates pursuant to coordination of benefits clauses.

(1)

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: Rate = sum of [the allowed amount for the health service code under each contract x number of claims paid for each allowed amount]/Total number of claims paid for that code across all commercial contracts. Beginning January 1, 2024, this rate is then adjusted to the date the service was rendered by using the inflation adjustment described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act. Example: For hypothetical health care service code Z, and for a particular combination of the factors described in subdivision (c)(3), the payor's allowed amounts under its commercial contracts are: Contract A ($10), Contract B ($15), Contract C ($12). During the applicable calendar year, the payor paid, for code Z, 25 claims under Contract A, 30 claims under contract B, and 45 claims under contract C. The rate calculation pursuant to this subdivision (c)(1) is:

($10x25)+($15x30)+($12x45) / (total claims: 100) = a base ACR rate of $12.40 for health care service code Z. Beginning January 1, 2024, the rate, so calculated, is then adjusted for inflation by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics, as described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act.

(2)

The payor shall include the highest and lowest contracted rates when calculating the rate pursuant to subdivision (c)(1) by ensuring that the "number of claims paid at that allowed amount" multiplier for each of the payor's highest and lowest contracted rates is at least 1 (one).

(3)

The payor shall calculate a rate described in subdivision (c)(1) taking into account each combination of these factors, at a minimum:(A) Health care service codes, including but not limited to Current Procedural Terminology (CPT) codes, (B) Geographic region, (C) Provider type and specialty, (D) Facility type, and, (E) Information from the independent dispute resolution process, if any, pursuant to section 1371.30 of the Knox-Keene Act.

(A)

Health care service codes, including but not limited to Current Procedural Terminology (CPT) codes,

(B)

Geographic region,

(C)

Provider type and specialty,

(D)

Facility type, and,

(E)

Information from the independent dispute resolution process, if any, pursuant to section 1371.30 of the Knox-Keene Act.

(4)

For the purpose of subdivision (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 section, 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.

(5)

When the average contracted rate is the appropriate default reimbursement rate pursuant to subdivision (a)(1) of section 1371.31 of the Knox-Keene Act, the payor may adjust the rate determined under this subdivision (c) when it reimburses the noncontracting individual health professional, as appropriate. Appropriate reimbursement 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.

(6)

For anesthesia services subject to section 1371.9 of the Knox-Keene Act: (A) The payor shall use the anesthesia conversion factors set forth in the payor's provider contracts instead of an "allowed amount" to complete the calculation pursuant to subdivision (c)(1). (B) The factors that affect reimbursement pursuant to subdivision (c)(5) of this section shall include the sum of American Society of Anesthesiologists Relative Value Guide (RVG) base units, time units, and physical status modifier.

(A)

The payor shall use the anesthesia conversion factors set forth in the payor's provider contracts instead of an "allowed amount" to complete the calculation pursuant to subdivision (c)(1).

(B)

The factors that affect reimbursement pursuant to subdivision (c)(5) of this section shall include the sum of American Society of Anesthesiologists Relative Value Guide (RVG) base units, time units, and physical status modifier.

(7)

The following claims shall be excluded from the average contracted rate calculation, except as specified:(A) Case rates, bundled payments, and global rates shall be excluded, except that the payor shall include the CPT code in which a global rate is embedded per the American Medical Association CPT code description. (B) Claims paid pursuant to capitation, risk sharing arrangements, and sub-capitation, except for fee-for-service payments made by a payor who receives capitation from another entity. (C) Denied claims. (D) Claims not in final disposition status, meaning claims for which a final reimbursement amount pursuant to claims settlement practices required by the Knox Keene Act has not been determined by the payor, including disputed claims. (E) Secondary payment rates pursuant to coordination of benefits clauses.

(A)

Case rates, bundled payments, and global rates shall be excluded, except that the payor shall include the CPT code in which a global rate is embedded per the American Medical Association CPT code description.

(B)

Claims paid pursuant to capitation, risk sharing arrangements, and sub-capitation, except for fee-for-service payments made by a payor who receives capitation from another entity.

(C)

Denied claims.

(D)

Claims not in final disposition status, meaning claims for which a final reimbursement amount pursuant to claims settlement practices required by the Knox Keene Act has not been determined by the payor, including disputed claims.

(E)

Secondary payment rates pursuant to coordination of benefits clauses.

(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 section and section 1371.31 of the Knox-Keene Act. This subdivision (d) applies notwithstanding any other provision of this section.

(e)

Payment of default reimbursement rate.(1) Unless otherwise agreed by the payor and the noncontracting individual health professional, and except as provided in subdivision (b) of section 1371.31 of the Knox-Keene Act, the payor shall reimburse the noncontracting individual health professional, for all services subject to section 1371.9 of the Knox-Keene Act, the default reimbursement rate. (2) The payor shall indicate on claims payment documents the manner by which the payor satisfied this subdivision (e).

(1)

Unless otherwise agreed by the payor and the noncontracting individual health professional, and except as provided in subdivision (b) of section 1371.31 of the

Knox-Keene Act, the payor shall reimburse the noncontracting individual health professional, for all services subject to section 1371.9 of the Knox-Keene Act, the default reimbursement rate.

(2)

The payor shall indicate on claims payment documents the manner by which the payor satisfied this subdivision (e).

(f)

Filing requirements. (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. (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 section including the following information:(A) 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; (B) Information regarding which database is used for the determination of an ACR; (C) Certification that the database is statistically credible; and (D) Explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database. (3) For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.

(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.

(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 section including the following information:(A) 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; (B) Information regarding which database is used for the determination of an ACR; (C) Certification that the database is statistically credible; and (D) Explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database.

(A)

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;

(B)

Information regarding which database is used for the determination of an ACR;

(C)

Certification that the database is statistically credible; and

(D)

Explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database.

(3)

For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.

(g)

Enforcement. The Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act, including section 1394.