§ 1371.31. Reimbursement rate for noncontracting individual health professional; Reporting requirements; Exemptions

(a)(1) For services rendered subject to Section 1371.9, effective July 1, 2017, unless otherwise agreed to by the noncontracting individual health professional and the plan, 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. For the purposes of this section, "average contracted rate" means 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. This subdivision does not apply to subdivision (c) of Section 1371.9 or subdivision (b) of this section.

(2)(A) By July 1, 2017, each health care service plan and its delegated entities shall provide to the department all of the following:

(i) Data listing its average contracted rates 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.

(ii) Its methodology for determining the average contracted rate for the plan for services subject to Section 1371.9. The methodology to determine an average contracted rate shall ensure that the plan

includes the highest and lowest contracted rates for the calendar year 2015.

(iii) The policies and procedures used to determine the average contracted rates under this subdivision.

(B) For each calendar year after the plan's initial submission of the average contracted rate as specified in subparagraph (A) and until the standardized methodology under paragraph (3) is specified, a health care service plan and the plan's delegated entities shall adjust the rate initially established pursuant to this subdivision by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

(3)(A) By January 1, 2019, the department shall specify a methodology that plans and delegated entities shall use to determine the average contracted rates for services most frequently subject to Section 1371.9. This methodology shall take into account, at a minimum, information from the independent dispute resolution process, the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the plan includes the highest and lowest contracted rates.

(B) Health care service plans and delegated entities shall provide to the department the policies and procedures used to determine the average contracted rates in compliance with subparagraph (A).

(C) If, based on the health care service plan's model, a health care service plan does not pay a statistically significant number or dollar amount of claims for services covered under Section 1371.9, the health care service plan shall demonstrate to the department that it has access to a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region and shall use that database to determine an average contracted rate required pursuant to paragraph (1).

(D) The department shall review the information filed pursuant to this subdivision as part of its examination of fiscal and administrative affairs pursuant to Section 1382.

(E) The average contracted rate data submitted pursuant to this section shall be confidential and not subject to disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(F) In developing the standardized methodology under this subdivision, the department shall consult with interested parties throughout the process of developing the standards, including the Department of Insurance, representatives of health plans, insurers, health care providers, hospitals, consumer advocates, and other stakeholders it deems appropriate. The department shall hold the first stakeholder meeting no later than July 1, 2017.

(4) A health care service plan shall include in its reports submitted to the department pursuant to Section 1367.035 and regulations adopted pursuant to that section, in a manner specified by the department, the number of payments made to noncontracting individual health professionals for services at a contracting health facility and subject to Section 1371.9, as well as

other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities, as defined in subdivision (f) of Section 1371.9. The department shall include a summary of this information in its January 1, 2019, report required pursuant to subdivision (k) of Section 1371.30 and its findings regarding the impact of the act that added this section on health care service plan contracting and network adequacy.

(5) A health care service plan that provides services subject to Section 1371.9 shall meet the network adequacy requirements set forth in this chapter, including, but not limited to, subdivisions (d) and (e) of Section 1367 of this code and in Exhibits (H) and (I) of subdivision (d) of Section 1300.51 of, and Sections 1300.67.2 and 1300.67.2.1 of, Title 28 of the California Code of Regulations, including, but not limited to, inpatient hospital services and specialist physician services, and if necessary, the department may adopt additional regulations related to those services. This section shall not be construed to limit the director's authority under this chapter.

(6) For purposes of this section for Medicare fee-for-service reimbursement, 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.

(7) A health care service plan shall authorize and permit assignment of the enrollee's right, if any, to any reimbursement for health care services covered under the plan contract to a noncontracting individual health professional who furnishes the health care services rendered subject to Section 1371.9. Lack of assignment pursuant to this paragraph shall not be construed to limit the applicability of this section, Section 1371.30, or Section 1371.9.

(8) A noncontracting individual health professional, health care service plan, or health care service plan's delegated entity who disputes the claim reimbursement under this section shall utilize the independent dispute resolution process described in Section 1371.30.

(b) If nonemergency services are provided by a noncontracting individual health professional consistent with subdivision (c) of Section 1371.9 to an enrollee who has voluntarily chosen to use the enrollee's out-of-network benefit for services covered by a plan that includes coverage for out-of-network benefits, unless otherwise agreed to by the plan and the noncontracting individual health professional, the amount paid by the health care service plan shall be the amount set forth in the enrollee's evidence of coverage. This payment is not subject to the independent dispute resolution process described in Section 1371.30.

(c) If a health care service plan delegates the responsibility for payment of claims to a contracted entity, including, but not limited to, a medical group or independent practice association, then the entity to which that responsibility is delegated shall comply with the requirements of this section.

(d)(1) A payment made by the health care service plan to the noncontracting health care professional for nonemergency services as required by Section 1371.9 and this section, in addition to the applicable cost sharing owed by the enrollee, shall constitute payment in full for nonemergency services rendered unless either party uses the independent dispute resolution process or other lawful means pursuant to Section 1371.30.

(2) Notwithstanding any other law, the amounts paid by a plan for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual health professional.

(3) This subdivision shall not preclude the use of the independent dispute resolution process pursuant to Section 1371.30.

(e) This section shall not apply to a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) This section shall not apply to emergency services and care, as defined in Section 1317.1.

(g) The definitions in subdivision (f) of Section 1371.9 shall apply for purposes of this section.

(h) This section shall not be construed to alter a health care service plan's obligations pursuant to Sections 1371 and 1371.4.

HISTORY:

Added Stats 2016 ch 492 § 2 (AB 72), effective January 1, 2017. Amended Stats 2021 ch 615 § 225 (AB 474), effective January 1, 2022, operative January 1, 2023.