Assembly Bill 72
Public Meeting

June 26, 2017

Agenda

1. Welcome and Introductions
2. Overview of AB 72
3. AB 72 Implementation Update
4. Standardized Average Contracted Rate Methodology
5. Independent Dispute Resolution Process
6. Next Steps

Overview of AB 72

Marta Green
Chief Deputy Director, Department of Managed Health Care

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.

Surprise Balance Billing

What is Surprise Balance Billing?

Occurs when an enrollee is balance billed the difference between the amount a noncontracting individual health professional charged and the amount the health plan paid, under specified circumstances.

“Services subject to HSC Section 1371.9”

When enrollees receive covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional.

Definitions

Individual Health Professionals

Physicians, surgeons, or other professionals who are licensed by the state of California to deliver or furnish health care services. Licensed dentists are excluded.

Contracting Health Facilities

Health facilities contracted with an enrollee's health care service plan to provide services under the enrollee's plan contract, including, but not limited to, the following providers:

- A licensed hospital
- An ambulatory surgery or other outpatient setting
- A laboratory
- A radiology or imaging center

Consumer Protections

For services rendered on or after July 1, 2017:

- Enrollees pay no more than the in-network cost sharing amount.
- Plans must notify enrollees and providers of the in-network cost sharing amount.
- Enrollees should not pay any bill until the plan notifies the enrollee of the cost sharing.
- Cost-sharing arising from services provided by noncontracting providers shall be counted towards any deductible and annual out-of-pocket maximums in the same manner as an in-network provider.

Preservation of Out-of-Network Benefits

Enrollees with out-of-network coverage (e.g. PPOs) may still access these benefits. However, noncontracting providers now have to obtain written consent from enrollees at least 24 hours in advance in order to bill the enrollee. The consent must meet the following requirements:

1. Obtained by the noncontracting provider (not the contracted facility).
2. Separate from other documents used to obtain consent for any other part of the care or procedure.
3. Informs the enrollee that they may elect to seek care from a contracted provider or may contact the plan in order to arrange to receive the service from a contracted provider for lower out-of-pocket costs.
4. Provides an estimate of the total out-of-pocket cost of care.
5. Provided in the enrollee's spoken language, if the language is a Medi-Cal threshold language.

Default Reimbursement Rate

Effective July 1, 2017:

For services rendered subject to HSC section 1371.9, unless otherwise agreed to by the noncontracting health professional and the plan, the plan 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

Average Contracted Rate

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 calendar year 2015.

Default Reimbursement Rate

Date of Service	Average Contracted Rate (ACR)
July 1, 2017 – December 31, 2017	ACR based on Calendar Year 2015 rates and Filed with the DMHC by July 1, 2017
January 1, 2018 – December 31, 2018	ACR adjusted by Consumer Price Index for Medical Services
January 1, 2019 - Ongoing	ACR based on the standard methodology defined in regulations

AB 72 Implementation Update

Mary Watanabe
Deputy Director, Health Policy and Stakeholder Relations

Average Contracted Rate Filing

By July 1, 2017, each health care service plan, and any entity to which it delegates responsibility for payment of claims, shall provide the following to the DMHC:

- Data listing its average contracted rates for the services most frequently subject to Section 1371.9 in each geographic region in which the services were rendered for the calendar year 2015;
- 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;
- The policies and procedures used to determine the average contracted rates.

July 1, 2017 Filing Documents

Average Contracted Rate Filing Documents:

- ACR Filing Overview
- Attachment 1: ACR Data Worksheet Instructions
- Attachment 2: ACR Data Worksheet
- Attachment 3: ACR Methodology Worksheet and Instructions
- Attachment 4: Policy and Procedure Instructions

Other Implementation Activities

- Annual Network Reporting
- Legislative Report
- Compliance Reviews

Standardized Average Contracted Rate Methodology

Mary Watanabe
Deputy Director, Health Policy and Stakeholder Relations

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.

- Plans and delegated entities 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.
- Plans and delegated entities are still required to pay the greater of 125% of Medicare or the Average Contracted Rate.

Standardized Methodology

- The methodology must take into account:
  - Information from IDRP
  - Specialty of the individual health professional
  - Geographic region in which services are rendered
- The methodology must include the highest and lowest contracted rate

ACR Calculation

Unweighted mean

$$\text{ACR} = \frac{\text{sum of all contract rates}}{\text{total number of contract rates}}$$

Example

For three contract rates of $10, $15, and $18:

$$\text{Unweighted ACR} = \frac{(10+15+18) = 43}{3} \quad \text{or} \quad \$14.33$$

ACR Calculation

Weighted mean

$$\text{ACR} = \frac{\text{sum (contract rate x \# of claims paid at rate)}}{\text{total number of claims}}$$

Example

For the same contract rates of $10, $15, and $18, and there are 5, 2, and 1 number of claims, respectively:

$$\text{Weighted ACR} = \frac{(10x5 + 15x2 + 18x1) = 98}{8} \quad \text{or} \quad \$12.25$$

Other Considerations

- Geographic Regions
  - Use Medicare regions or other regions
  - Geographic location based on address where service is provided
- Type of Provider or Provider Specialty
- Services with Payment Modifiers (i.e. -50 or -51 for bilateral or multiple procedures)

Other Considerations

- Services “Most Frequently Subject To”
- Claim Amount – before or after member cost sharing
- Medicare Rate
- Anesthesia Services

Other Considerations

- Which Claims to Include in Calculation
  - Claims adjustments
  - Denied claims
  - Disputed payments
  - Payments for providers with risk sharing arrangements
  - MOUs
  - Time period and claims run out
  - Sub-capitated providers
  - Case rates

Independent Dispute Resolution Process

Elizabeth Landsberg
Deputy Director, Help Center

Independent Dispute Resolution Process (IDRP)

- Begins September 1, 2017
- Ensures appropriate reimbursement while preserving access to other legal remedies
- Mechanism to dispute the default reimbursement rate
- Vendor to administer IDRP proceedings

Participating Parties

- Either party may initiate the IDRP, and when initiated, both parties must participate.
- Completion of one level of Provider Dispute Resolution (PDR) process required
- Health Plan is the default responding party if the Provider initiates IDRP
- Health Plan can delegate claim responsibility to a delegated entity

Fees

- Fees are split equally between the parties
- $315 for up to 10 “like” claims increasing up to $395 for 26-50 “like” claims
- Fees are paid directly to the vendor
- Nonrefundable
- If the responding party does not pay, there will be a default judgement entered for the amount the initiating party sought

Scope of IDRP Review

- Review of appropriateness of the default rate, not whether default rate was paid correctly
- Review organization will consider evidence and documentation submitted by both parties
- All relevant information

Arbitration Format

- True arbitration
- Review organization will consider all relevant information through the documentation submitted by both parties
- Reimbursement amount determined by the arbitrator
- Decision is binding

Timeframes

The full IDRP process is expected to take approximately 90 days:

- 30 days for DMHC process
- 30 days for responses from participating parties
- 30 days for the review organizations response

Next Steps

Mary Watanabe
Deputy Director, Health Policy and Stakeholder Relations

Implementation Timeline

Activity	Date
Stakeholder Meeting to Solicit Input on Standardized Average Contracted Rate Methodology and IDRP	June 26, 2017
Default Reimbursement Rate Filing Deadline and Effective Date	July 1, 2017
Independent Dispute Resolution Process (IDRP) Implemented	September 1, 2017
Formal Rulemaking Process	October 2017 – December 2018
Timely Access and Network Adequacy Report Filings	March 31, 2018
Regulations Effective	January 1, 2019
DMHC Report to the Legislature	January 1, 2019

Public Comment

Submit written comments by July 14, 2017 to:

stakeholder@dmhc.ca.gov