FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

CLAIMS	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2018	
		Policy # AHP ASO CL016	
	Payments to Non-Contracted Providers	**Review Date** 5/9/2023	**Applicable to:** ☐ Medicare Advantage ☐ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Elisabeth Fagan, Director of Health Plan Operations	

1.0 PURPOSE

1.1 To outline Aspire Health Plan's (AHP or Plan) policy and procedures to ensure compliance with requirements of Health and Safety Code (HSC) Sections 1371.31, 1371.9 as enacted in Assembly Bill (AB) 72 (AB 72) (Chapter 492, Statutes of 2016).

2.0 POLICY

2.1 The Plan will comply with all requirements of HSC Sections 1371.31, 1371.9 including regarding how the Plan's claims system identifies specified payments in accordance with AB 72 and dates used to determine provider network status.

3.0 DEFINITIONS

3.1 Refer to the AHP Definitions Manual.

4.0 PROCEDURE

4.1 Identifying payments to non-contracting providers for services rendered in a contracted facility and for services rendered at non-contracted facilities resulting from covered services received at an in-network facility:

4.1.1 The Plan will generate weekly reports to identify payments to non-contracted providers for services rendered in a contracted facility, as well as, for payments rendered at a non-contracted facility resulting from covered services received at an in-network facility as specified by DMHC.

4.1.2 The Plan will include in its quarterly and annual reports to DMHC all information and data pertaining to Section 1.a of this policy in accordance with AB 72 and Title 28, CCR Section 1300.71(q).

4.2 The Dates used to determine network status of a provider

4.2.1 When processing claims, the Plan uses the date of service to determine the network status of a provider.

4.3 Payment Methodology for Services that, when added together, comprise less than 80% **-** 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:

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

4.3.2 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.

4.4 Methodology for determining average contracted rate:

4.4.1 The methodology for determing the average contracted rate is in accordance with Title 28, CCR Section 1300.71.31.

4.5 Calculating the Claims Volume-Weighted Mean Rate- 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:

4.5.1 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.

4.5.2 **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.

4.6 Include the highest and lowest contracted rates - 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 one (1).

4.7 The payor shall calculate a rate described above, taking into account each combination of factors, at minimum:

4.7.1 Health care service codes, including but not limited to Current Procedural Terminology (CPT) codes,
4.7.2 Geographic region,
4.7.3 Provider type and specialty,
4.7.4 Facility type, and,
4.7.5 Information from the independent dispute resolution process, if any, pursuant to Section 1371.30 of the Knox-Keene Act.

4.8 Use unmodified and modified health care service codes - 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.

4.9 Adjust the rate determined appropriate - 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.

4.10 Use the Anesthesia conversion factors - For anesthesia services subject to Section 1371.9 of the Knox-Keene Act:

4.10.1 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).

4.10.2 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.

4.11 Determine what claims to exclude from the average contracted rate calculation - The following claims shall be excluded from the average contracted rate calculation, except as specified:

4.11.1 Case rates 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.

4.11.2 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.

4.11.3 Denied claims.

4.11.4 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.

4.11.5 Secondary payment rates pursuant to coordination of benefits clauses.

5.0 TRAINING

5.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

6.0 REVIEW PERIOD

6.1 Annually.

7.0 REGULATORY REQUIREMENTS AND REFERENCES

Health and Safety Code Sections 1371.30, 1371.31, and 1371.9
Title 28 CCR Rule 1300.71
DMHC APL 17-009

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.