**Policy and Procedures**
**Operating Manual**

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| **Policy Title**: | Non-Contracted Provider Reimbursement Policy | **Policy No.:** | *CL 19.2* |
| **Replaces Policy Title** *(if applicable)* | *N/A* | **Replaces Policy No.** *(if applicable)* | |
| **Department Owner** | Claims | **Policy Review Frequency:** | As needed |
| **Department Applicability** | Claims, Contract, Configuration | | |
| **Lines of Business** *(check all that apply)* | ☐ Commercial ☐ Medi-Cal ☐ Covered CA ☐ IFP | | |
| **Accreditations** *(check all that apply)* | ☐NCQA | ☐AAAHC | ☐_____ |

## I. POLICY

It is the policy of Valley Health Plan (VHP) to use the reasonable and customary (R&C) payment methodology to reimburse claims from non-contracted providers.

## II. PURPOSE

Describe the reimbursement methodology used by VHP to reimburse claims from non-contracted providers. The primary objectives of VHP's R&C policy are:

- To implement reimbursement approaches that comply with State requirements
- To maintain a policy that is transparent and administratively feasible for both providers and the plan

## III. DEFINITIONS

*N/A*

## IV. PROCEDURES

### 1. Medicare-Based Reimbursement and Use by Commercial Payers

Valley Health Plan's (VHP) reimbursement methodologies and rates for most non-contracted providers are based on the payment systems and rates used by the Medicare program. Using this approach, a percentage or multiple is applied to the current Medicare rate for the applicable service to arrive at the

VHP allowed amount or rate for the service. Services are generally identified by MS-DRG, CPT, or HCPCS codes.[1]

Medicare's reimbursement methodologies are commonly used by commercial payers, and Medicare rates are often used as the starting point for establishing commercial health plan fee schedules, rates, and allowed amounts. The Centers for Medicare and Medicaid Services (CMS) collects and evaluates provider costs in order to establish or change Medicare reimbursement rates through periodic (legislatively mandated) cost studies and Medicare Cost Reports filed by certain provider types such as hospitals.

## 2. VHP's Reasonable & Customary Policy

VHP's non-contracted R&C payment amounts are based on Medicare pricing sources. If Medicare does not price an item or service (typically because the service is not covered by Medicare), the allowed amount is established using Optum "gap fill" rates which are derived from the Resource Based Relative Value Scale (RBRVS) published by the CMS.[2] For items and services without a Medicare or Optum gap fill rate, a percentage of the provider's billed charges is paid.

Once the applicable Medicare pricing source has been identified for services billed, a percentage or multiple of the Medicare rate is applied. VHP has established separate percentages for non-contracted providers located in Northern California, Southern California, and outside the State of California.

VHP considered the following in order to establish its R&C policy:

- VHP's average contracted rates by provider type and service as a percentage of Medicare;
- Fair market value of services as indicated by commercial market median reimbursement rates calculated using data extracted from IBM Watson Health's MarketScan® database; and
- California Code of Regulations, Title 28, Section 1300.71, which includes the *Gould* Factors.[3]

VHP claims data for participating (in-network) providers were analyzed to calculate the average contract rates (by provider type) as a percentage of Medicare across the plan's network. For services subject to the requirements of A.B. 72, non-contracted rates were ultimately adjusted, if necessary, in order meet the requirements of the statute.

An analysis of commercial reimbursement benchmark data was completed using data extracted from IBM Watson Health's MarketScan® database. This database contains claims data for more than 250 million patients across the U.S. healthcare system. Data are contributed by large employers, managed care organizations, and other entities. MarketScan® data were used to calculate the market median allowed as a percentage of the Medicare rate by provider type for Northern California and Southern California, as well as the United States excluding California. Each of these geographic areas is considered a "market," and markets are defined based on Medicare's carrier and locality codes, as well as Metropolitan Statistical Area (MSA).

This analysis identified the market median allowed amount for each item or service, as identified by an appropriate billing code.[4] The median allowed amount[5] represents the prevailing amount that is paid for

[1] Inpatient hospital services are identified by Medicare Severity-Diagnosis Related Group (MS-DRG) while outpatient, professional, and other services are identified by Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS).
[2] The Essential RBRVS: A Comprehensive Listing of Values for CPT and HCPCS Codes. Optum 360. 2019.
[3] Gould v. WCAB (1992) 4 Cal.App.4th 1059.
[4] Such as MS-DRG, CPT, or HCPCS.
[5] The allowed amount is defined as the amount paid by the health plan plus coinsurance, copayments, and deductible amounts that are the member's responsibility. The median is used rather than the mean or average in order to avoid skewing due to unusually high or low allowed amounts (also called outliers).

the service by commercial payers in the market area. The market median allowed amounts were then divided by the Medicare rate for the same item or service in the same geographic area in order to calculate a "market percentage of Medicare" for each item or service. These amounts were then aggregated by provider type and service type (e.g., inpatient hospital, emergency outpatient hospital services, non-emergency outpatient hospital services, ambulance).

A geographical analysis found that Northern California market median allowed amounts aligned with the market medians in rating region 7 and region 9,[6] where most of VHP's contracted providers are located. It was determined that a Northern California rate for this analysis was appropriate because it aligned with regional medians in VHP's market as well as VHP's contract rates. Additional analyses identified substantial differences between market median rates paid in Southern California compared to Northern California; therefore, separate percentages of Medicare for Southern California were established. VHP's non-contracted rates are established to be within close range of the commercial market median allowed amounts for the appropriate provider location (e.g., Northern California, Southern California, U.S.).

Relevant California legal authority were also considered (28 CCR § 1300.71) in establishing VHP's non-contracted rates. This regulation requires that, "the payment of the reasonable and customary value for the health care services rendered [be] based upon statistically credible information that is updated at least annually…" and is met through the use of the MarketScan® and other market analysis described previously. In addition, the regulation includes the *Gould* Factors, which were considered, by identifying and evaluating the charges, allowed amounts, VHP contract rates, market medians, and Medicare rates for items and services according to their specific codes or code sets. These code sets such as DRG, CPT, and HCPCS identify specific types and levels of services and are structured to identify the type and severity of services. In addition, Medicare DRG rates paid to hospitals include adjustments for certain hospital characteristics such as teaching status and number of low-income patients served. Professional rates are derived from the Resource-Based Relative Value Scale (RBRVS), which was developed by researchers at Harvard in the 1980's and includes factors for practice expenses and costs of liability insurance. Physician specialty is also an indicator of physician training and payment varies for some services based on the level of the practitioner's training.

Other considerations in the context of the *Gould* Factors include provider billed charges, allowed amounts, and allowed-to-charge ratios, which are taken together to evaluate the percentage of billed charges that is actually paid by health plans. Unusual circumstances, as stated in the *Gould* Factors, may include the evaluation of outliers and provisions for payment for extraordinarily high cost cases.

For certain provider types for which commercial reimbursement benchmark data is not available, the R&C policy is established using other approaches. Specifically, for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities (IRF), the R&C policy is to reimburse these facilities based on a percentage of the Medicare rate. However, instead of aligning the reimbursement rates with commercial market median ranges (which are not available), the rates are established to ensure a reasonable rate above actual costs. This is measured by the Medicare and all-payer margins, which are published periodically by the Medicare Payment Advisory Commission (MedPAC).

### 3. Other Payment Provisions for Non-Contracted Providers

In addition to the above reasonable and customary policies, VHP's payments to non-contracted providers for medically necessary covered services are made in accordance with VHP's authorization procedures. Payment for non-contracted post-stabilization services may be denied if a provider fails to seek prior authorization, as specified by Health and Safety Code section 1262.8(b). In the case where a provider fails to seek prior authorization for post-stabilization services, the unauthorized services should not be billed to

[6] Rating regions were established by the Affordable Care Act. There are 19 rating regions in California.

VHP, nor should the member be balance-billed. If VHP receives a claim which improperly contains unauthorized post-stabilization services commingled with emergency and any authorized post-stabilization services, VHP may issue an interim payment consisting of a per diem rate for the emergency services and VHP's understanding of which services represent authorized post-stabilization services. Per diem rates for each MS-DRG are calculated by dividing the total allowed amount per this R&C policy by the geometric mean length of stay (GMLOS) for the MS-DRG. GMLOS is calculated using the IBM Watson MarketScan® database as the primary data source and published Medicare data as a secondary data source for each geographic area described previously. Total per diem payments to a non-contracted provider cannot exceed the established MS-DRG allowed amount. Once VHP receives further information from the provider establishing which services represent emergency and authorized post-stabilization services, VHP will reprocess the claim and if the reprocessed payment amount is greater or less than the interim payment, VHP may make a further payment, or seek the return of an overpayment, respectively.

VHP's Provider Dispute form may be accessed here:
https://valleyhealthplan.sccgov1.acsitefactory.com/sites/g/files/exjcpb771/files/Provider-Dispute-Form-Final.pdf

VHP's claims settlement practices and dispute resolution mechanism are discussed here:
https://www.valleyhealthplan.org/providers/forms-and-resources/claims-settlement-practices-dispute-resolution-mechanism

In cases where VHP is timely notified that a member's emergent medical condition has been stabilized, and a member is transferred, VHP applies its existing transfer reimbursement approach where the allowed amount is based on the MS-DRG as billed by the hospital with the appropriate patient discharge status code. If the receiving hospital is a contracted provider, VHP pays the provider according to the contract provisions. If the receiving hospital is a non-contracted provider, VHP pays the provider based on the provisions of this R&C policy.

Covered services are reimbursed by VHP in accordance with CMS billing and reimbursement guidelines, including, but not limited to any applicable reductions and/or discounts (e.g., Hospital Acquired Conditions (HAC), Other Provider-Preventable Conditions (OPPCs), and multiple procedures), which may be amended by CMS from time to time. Reimbursement rates to non-contracted providers are established as described above and final amounts are calculated using industry standard code auditing software, which incorporates CMS, American Medical Association (AMA), and other standard coding guidelines.

VHP pays non-contracted providers for covered services at the lesser of the non-contracted provider's billed charges or at the reasonable and customary rates discussed in this policy, less applicable co-payment, co-insurance, and deductible amounts (collectively referred to as co-payments) as specified in the VHP's member's benefit plan. VHP is not liable for co-payments or non-covered services rendered or payment for health care services rendered that are limited or excluded by the member's benefit plan, and under such circumstances, a provider may seek payment for such services from VHP members. Non-contracted providers are prohibited from balance billing members for covered services.

## V. APPROVED/REVISION HISTORY

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| **Effective Date:** | 3/1/22 | **Last Reviewed or Revised Date:** | 8/12/24<br>9/23/21<br>9/26/20<br>2/1/22 |
| **Approved By Manager:** | | **Title:** | Claims Manager |

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|---|---|---|---|
| **Manager Signature:** | | **Date:** | |
| **Approved By Department Executive:** | | **Title:** | COO |
| **Department Executive Signature:** | | **Date:** | |
| | | | |
| **Committee Reviewed By (if applicable):** | ☐ UM<br>☐ P&T<br>☐ QIC<br>☐Compliance<br>☐ _____ | **Approved Date:** | |
| **Committee Chair Name (if applicable):** | | | |
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