Washington State Health Care Authority
Carrier questions about public option/standardized plans

11-22-19, responses added 12/9/19

Agency	Carrier Question	Response
HCA	What is HCA's expectation for their involvement in the rate development piece of Public Option plans?	Assuming the question is referring to premium rate development, HCA is not involved.
HCA	Is it HCA's intention to allow any carrier who meets the minimum qualifications to offer public option plans in the first year?	HCA reserves the right to award one or more (all comers) Cascade Care public option plans. Cascade Care public option plans will be required to meet attestation requirements. For the first year (2021) a top priority of HCA, HBE and OIC is to achieve statewide participation with premium decreases.
HCA	Does the public option reimbursement cap apply to all providers contracted under the public option plan or just to providers governed by WA law? For example, if a provider based in Oregon is included in the network that supports the public option plan does the reimbursement cap apply to that Oregon based provider?	Cascade Care reimbursement requirements apply to all proposed network participants/OIC approved networks.
HCA	How will carriers demonstrate compliance with the reimbursement cap? Will it be based on a weighted average? And based on what metric(s) (claims? Contracted amounts? Volume? Membership distribution? Other?) Also, is the cap based on Medicare FFS or Medicare Advantage?	Carriers will demonstrate compliance with the reimbursement cap via dollar-weighted average. Cap is based on Medicare FFS reimbursement. Verification process is under development.
OIC/HBE	Carriers need to understand how the data call information will be used to determine criteria for a "Cascade Care compliant network". Network adequacy for Marketplace plans is determined by the OIC. How will this be reconciled with the OIC?	Carriers have been invited to submit data on current individual market plans to Milliman. Milliman will apply the proposed Medicare reimbursement methodology to the carrier submitted data, and share the results back with each carrier. This data exercise is voluntary; carriers are not required to share data with Milliman or HCA at this time. Individual plan data shared with Milliman will not be shared with HCA, and data are exempted from public disclosure laws, per the Cascade Care legislation. OIC's network adequacy is separate from this data exercise; data submitted for Milliman modeling exercise will not be used for network adequacy.

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OIC/HBE	In some situations, in order to meet OIC network adequacy requirements, carriers may be required to contract with certain provider types, no matter what the cost. As a result, carriers may need to pay rates above 160% of Medicare. How will OIC and HCA reconcile these nuances?	The 160% cap is in the aggregate, not as applied to each provider. OIC's network access standards are applied separately from the reimbursement caps
OIC/HBE	Carriers historical understanding is that a renewal product is required to stay in the market, is this requirement being reevaluated?	Renewal is a requirement of federal law; no state level re-evaluation is anticipated.
HBE	Will carriers have to offer public option plans to participate in the Exchange beginning in 2021?	No.
HBE	Is HBE considering designating a Bronze Standardized Plan and separately directing HCA to select the Public Option Bronze plan? (Not only is this inconsistent with how carriers understand the legislation, but this also reinforces the benefit of ultimately including only one standardized bronze plan in the portfolio of standard plans. By including only one standardized bronze plan, we can reduce consumer confusion and the challenging implementation scenarios that result from having multiple standardized bronze plans.)	The HBE Board recently approved one bronze standardized plan, which will be used in Cascade Care plans in 2021.
HBE	Is it accurate that HBE would consider a Public Option offering as having met the requirement to offer a Standardized Plan in a service Area?	Yes.
HBE	GENERAL REIMBURSEMENT 1. There are rate caps and floors stated in the legislation. Will the rate requirements be aggregated or applied at the individual provider level? If the rates are aggregated, will it be at the state or rating area level? 2. The rate caps are indicated to apply to hospitals, while the floors will apply to primary care physicians. Are any other provider types included in these requirements? For example, will specialist physicians or sub-acute facilities be included?	1) Aggregate reimbursement applies to all categories. A decision has not yet been made regarding whether rate requirements will be aggregated statewide or by service area. Enrollment may influence weighting. 2) Aggregate reimbursement applies to all categories. Floors apply to primary care physicians, as defined in the Cascade Care legislation.

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	3. CMS makes yearly updates and adjustments to their fee for service reimbursement policies. Can we expect this legislation to accept these periodic updates by CMS? 4. Would this legislation follow the essential community provider (ECP) guidelines currently in place, or do we need to manually adjust our standard ECP offering? 5. To help expedite the contracting process needed to build a complete network, can we amend our current PPA when contracting with providers for this option, or will new full agreements need to be drafted? 6. For the current Exchange product, when building a network, we can evaluate potential providers based on fit and quality of care expected for our members. Will this legislation allow for this evaluation, or must carriers accept any provider willing to participate?	3) Our working understanding is that we will follow the yearly rates. Example: CMS rates released on 10/1/19 will be used for 2020 levels. 4) The federal (ACA) and state standards for Essential Community Providers apply to all health plans offered on the Exchange. No changes are expected for plan year 2021. 5) Whether an existing provider contract can be amended or a new provider contract must be filed will depend on the existing provider contract. Specific questions should be directed to OIC 6) There are no changes to the current requirements.
HBE	FACILITY REIMBURSEMENT 1. Add-on payments such as Disproportionate Share, Indirect Medical Education, Graduate Medical Education, and other pass-throughs can significantly increase the amount carriers reimburse providers. Will this legislation explicitly include or exclude these payments, or will it leave it to negotiation? If allowed to negotiate, how will these add-ons payments be accounted for in the rate measurement? 2. For facility types such as Children's hospitals that do not follow standard Medicare reimbursement methodologies, will there be additional guidelines on contracting and measuring reimbursement relative to Medicare and the legislation's rate requirements? We have traditionally tied these reimbursements to the facility-specific cost-to-charge	1) The inclusion of add-on payments in the Medicare rate reimbursement methodology is still under discussion. 2) We will provide additional guidelines for facility types that do not follow standard Medicare reimbursement methodologies. For Children's hospitals, our current methodology is tied to facility specific cost to charge ratio (please see the draft methodology report for details). 3) The Legislation as enacted does not offer direction as to the default methodology of carrier contracts. For the determination of the assigned Medicare amounts during validation the cost to charge ratio will be evaluated and published in advance of the performance year.

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	ratio with per diem maximums in order to avoid exposure to unnecessary charges. 3. To avoid exposure to excess charges, we use the facility's cost-to-charge ratio when setting the default rate of a contract. Will this legislation offer any direction on the defined default methodology? 4. For Exchange products, participating providers often request commercial-like structures and reimbursement terms. These arrangements can lead to disconnects between the carrier and provider when valuing the contract relative to Medicare. Additionally, these arrangements can lead to high costs for members due to exposure to percent of charge terms. If non-Medicare structures are allowed for this option, will there be further guidelines on how they are measured relative to Medicare?	4) The legislation as enacted does not put any constraints on how the provider contract structures are to be set by the carrier. The guideline for how Medicare amounts are assigned to each individual claim are covered within the Milliman report on Medicare methodology. We encourage you to review and provide comment on this methodology.
HBE	PHYSICIAN REIMBURSEMENT 1. To set reimbursement for covered services not valued by the CMS RBRVS, many commercial Payers will utilize a gap fee schedule from companies such as Optum (Ingenix). The intent of the gap fee schedule is to provide clearly defined reimbursement for essential covered services not currently valued by CMS. Will this legislation allow for the use of gap coding? If so, which pricing files would be approved? 2. When reimbursement for covered services is not valued by CMS or a gap fee source, providers are typically paid a discount off percent of charge, intended to reasonably cover their costs until the service is appropriately priced by either CMS or an approved gap code pricing file. For physician reimbursement in this legislation	1) We will publish a mapping of what the non-CMS covered codes would be for similar services. 2) We are not planning to provide approved gap code pricing files. Note: gaps should be ~5% of the total (small) and carriers should be working with a margin so as not to exceed the 160% limit.