Cascade Care Medicare Pricing Methodology – DRAFT

December 12, 2019

Prepared for:
Washington State Health Care Authority

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At the request of Washington Health Care Authority (HCA), Milliman has prepared this DRAFT report detailing certain aspects of our recommended methodology for Cascade Care Medicare pricing. As discussed in further detail below, during the 2019 session, Washington's legislature established Cascade Care. HCA is currently developing a procurement for health carriers and insurers to satisfy several criteria. There are criteria relating to the reimbursement levels for facilities and providers relative to the amount Medicare would have reimbursed for the same or similar services. The intent of this report is to outline the draft methodology for determination of the Medicare reimbursement amounts specific to Cascade Care.

We understand that this document will undergo public comment for feedback. Once HCA considers these comments and solicits internal and workgroup feedback, the Medicare pricing methodology for Cascade Care may change. HCA and Milliman will finalize the Medicare pricing methodology and produce another report, later, to detail the procurement evaluation and validation process once these documents are ready for release. This document is an interim draft and subject to change at a future date.

I. BACKGROUND

On May 13, 2019, Governor Jay Inslee signed into law ESSB 5526[1], which requires HCA to conduct a procurement, in consultation with the Washington Health Benefit Exchange (HBE), for one or more public option health plans, known as Cascade Care. Private insurers or health carriers will offer standardized health insurance plans to individuals through the HBE for coverage effective January 1, 2021.

Among the requirements, the legislation requires the participating insurers to secure Cascade Care network(s) that satisfy, among other criteria, three medical cost requirements:

1. The average statewide reimbursement for medical services for the network(s), excluding pharmacy, may not exceed 160% of the total amount Medicare would have reimbursed providers and facilities for the same or similar services.
2. Rural hospitals, either sole community hospitals (SCH) or critical access hospitals (CAH), certified by the Centers for Medicare and Medicaid Services (CMS), must be paid at least 101% of their allowable costs. Allowable cost reimbursement is similar to the amount of reimbursement from Medicare, without consideration for sequestration, or final cost settlement adjustments.
3. Primary care services provided by a physician must be at least 135% of the amount Medicare would have reimbursed. HCA will be publishing the definition of Primary Care Services through their website.

[1] http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf

This report details our method to assign Medicare prices to commercial claims. It is important to understand that Medicare reimbursement is complicated, as it involves different reimbursement schedules and procedures for different categories of service as well as different types of providers. Further, Medicare does not always specify reimbursement for certain medical services, such as child immunization, which are more common in the individual health insurance market. With these complications and constraints in mind, our recommended Medicare pricing methodology is intended to be as transparent as possible to other insurers and be a good faith approximation of what Medicare would reimburse for each service or similar services.

This report should not be considered complete or exhaustive, as Milliman is in the process of collecting current individual health carrier data to ensure that the methods are applicable for all commercially reimbursed facilities and providers. We will specify further technical details in subsequent drafts, but intend to follow the general methodology outlined in this report.

II. MEDICARE PRICING METHODOLOGY OVERVIEW

Our methodology will evaluate whether the health carrier(s) actual reimbursement for medical claims is below the required 160% of the amount Medicare would have reimbursed providers. We begin with the insurer's allowed claims, where the allowed amount is the negotiated rate that the provider will receive from the insurer. This contracted amount is before any application of any member cost-sharing. Dividing the total Insurer Allowed Claim Amount by the amount Medicare would have allowed for these same services, as show in Figure 1 below, produces the percent of Medicare reimbursement. The rest of this report discusses how we determine this Medicare Allowed Amount for different providers and service types.

Figure 1: Required Allowed Reimbursement as a Percentage of Medicare Calculation

$$Required\ Allowed\ Reimbursement\ \%\ of\ Medicare = \frac{Insurer\ Allowed\ Claim\ Amount}{Medicare\ Allowed\ Amount} \leq 160\%$$

For a majority of medical services, our methodology follows the Medicare reimbursement methodology using standard Medicare reimbursement levels. We discuss this in more detail under section III.

There are certain types of services where Medicare does not have reimbursement levels that are appropriate for the non-elderly population in the individual market. It is therefore necessary to develop a comparable Medicare payment using alternative methodologies for these services. We discuss this in more detail under section IV.

Further, Medicare provides additional incentive payments and reimbursement adjustments to providers for a variety of different reasons, but with the common goal of incentivizing and improving the health care system. These payments are generally not possible to calculate within the pricing of claims data that we have available and therefore we have excluded these payments as part of our methodology. We discuss this in more detail under section V.

While we try to have a methodology to assign all claims a Medicare allowed amount, medical claims data will inevitably have some data quality issues. Section VI discusses our approach to handling these data quality issues, as well as consideration for what future changes to the methodology may be required as the data process evolves.

III. STANDARD MEDICARE REPRICING METHODOLOGY

A. PAYMENTS FOR PROSPECTIVE PAYMENT SYSTEM PROVIDERS

Medicare's Prospective Payment System (PPS) reimbursement methodologies vary based on whether the medical service was an inpatient facility, outpatient facility, or professional service. Medicare PPS payments to providers are set prospectively through a fee-for-service style fee schedule published by CMS. Our methodology does not make any adjustments for retrospective changes that Medicare may apply to these prospective payments.

Inpatient and outpatient facility claims rely on the fee schedules under the CMS Prospective Payment Systems, which are published and described in further detail on the CMS website[2].

The pricing of Medicare allowed amounts will use the fee published by CMS as of the beginning of the federal fiscal year (FFY) for the Cascade Care calendar year being priced. For example, we will use the CMS schedules as of October 1st, 2017 for FFY2018 to price any CY2018 claims data submitted by insurers interested in Cascade Care. CMS may update these values throughout the federal fiscal year. In order to reduce administrative burden, our Medicare allowed amounts will *not* reflect these interim updates. The initial Medicare schedules for the FFY will be used to price the corresponding Cascade Care calendar year claims data. For example, we will use the CMS schedules as of October 1st, 2020 for FFY 2021 to evaluate CY2021 reimbursement levels under Cascade Care.

We assign Inpatient facility claims a Medicare allowed amount using the following steps:

a. We will classify claims as inpatient facility claims if they have a revenue code indicating the patient had a 'room and board' service, using standard Milliman *Health Cost Guideline* (HCG) Grouper logic. 'Room and board' revenue codes include the values within the range 0100 to 0219, and also 0022 and 0024.

b. The inpatient facility claims incurred during the entire admission are grouped together and assigned a Medicare Diagnosis Related Grouping (MS-DRG) hospital episode category[3]. This MS-DRG is then mapped to an initial Medicare payment amount from Medicare under the Inpatient PPS (IPPS) reimbursement schedule. The IPPS payment is further adjusted based on the provider, using the National Provider Identification code (NPI). Additional outlier payment adjustments are made based on the estimated cost. For the outlier adjustment, cost is estimated based on a provider-specific cost-to-charge ratio multiplied by the billed dollars on the claim. A portion of cost, above a set threshold, is assigned as an additional outlier payment for each claim.

c. For inpatient facilities that are not paid based on the IPPS or at a percent of charge level (discussed below in the section "Payments for providers paid as a percent of cost"), we will assign a Medicare allowed amounts using the average IPPS base rate for the area they are located and the MS-DRG of the service being performed. Outlier payments will not be assigned to these providers, as we do not have a cost-to-charge ratio for these providers.

d. For claims where there is not a valid NPI code to identify the provider, we will assign a Medicare reimbursement amount based on the Seattle-area average for that MS-DRG.

[2] Inpatient PPS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index; Outpatient PPS: https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HospitalOPPS

[3] As stated in the Medicare Pricing Methodology Overview, we will provide further technical specifics in future documents for these categorization and mapping steps.

We assign Outpatient facility claims a Medicare allowed amount using the following steps:

a. We will classify claim lines as outpatient if they have a valid revenue code and if the claim line is not classified as inpatient or professional. This follows standard HCG Grouper assignment logic.

b. We assign the procedure codes an initial Medicare allowed amount using Medicare's Hospital Outpatient PPS (OPPS) fee schedule for hospital claims and the Ambulatory Surgical Center (ASC) Payment for ASCs. The OPPS payment is further adjusted based on the provider, using the National Provider Identification code (NPI). For claims where there is not a valid NPI code, we will assume the provider is located in Seattle.

c. We will apply standard OPPS adjudication rules.

d. For outpatient procedure codes that are not on the Medicare fee schedule, we will assign a Medicare allowed amount based on a service with similar resource usage. We will use the Milliman Global RVUs, which assigns a relative value or resource usage amount to a broader set of procedure codes than what Medicare prices. We will match the procedure code not listed on the Medicare fee schedule to a procedure code on the Medicare fee schedule based on both procedures having the same or similar Global RVU resource value. Appendix A-1 will include the published list of outpatient procedure codes that are not covered by Medicare and the corresponding similar service being used for Medicare assignment.

We assign Professional claims a Medicare allowed amount using the following steps:

a. Professional claims are identified as claims that either have no revenue codes or claims that have one of the following revenue codes:
0023, 0522, 0524, 0525, 0527, 0540-0549, 0570-0599, 0640-0649, 0651-0654, 0660-0669, 0960-0989

b. For the procedure code identification of each professional service, we will use the Healthcare Common Procedure Coding System (HCPCS) code for the fee schedule year under evaluation.

c. Professional and other non-inpatient, non-outpatient claims are assigned a Medicare allowed amount according to various Medicare fee schedules by service type. The main fee schedule is known as the Resource Based Relative Value System, or RBRVS. There are also separate fee schedules for the following services: Ambulance, Anesthesia, Part B Drugs (ASP fee schedule), Durable Medical Equipment (DME), Clinical Laboratory, and Parenteral and Enteral Nutrition Items and Services (PEN). The initial fee schedule payment is further adjusted based on the provider location, using the National Provider Identification code (NPI). For claims where there is not a valid NPI code, we will assume the provider is located in Seattle.

d. For procedure codes that are not mapped to the HCPCS code set or not included in a Medicare fee schedule, whether they are specific to a non-elderly population, obsolete or deleted, we will map these services to a valid Medicare procedure code with an equivalent meaning based on the HCPCS description. We also will review the Milliman GlobalRVU values to find a similar match between procedure codes that are included and excluded from the Medicare fee schedules. Appendix A-2 will include the

published list of professional procedure codes that are not included in a Medicare fee schedule and the corresponding similar service being used for Medicare assignment.

B. PAYMENTS FOR PROVIDERS PAID AS PERCENT OF COST

For cancer hospitals, children's hospitals, and critical access hospitals (CAH), Medicare reimburses providers as a percentage of their reported cost:

- 100% of cost for cancer and children's hospitals
- 101% of cost CAH

These facilities are identified by the second and third digits from the Medicare IDs. The third and fourth digit for children's hospitals is 33 and for CAH it is 13. We identify cancer facilities based on the hospital name and list them in Appendix B-1. For sole community hospitals (SCH) we identify those facilities that receive a PPS adjustment and as described below are working to develop a percent of cost reimbursement that is consistent with the Cascade Care enabling legislation.

The CMS published Medicare cost-to-charge ratio (CCR) is used to assign the Medicare allowed cost. This Medicare allowed is calculated as follows:

- Medicare Allowed Cost = (Billed Amount) x (Provider's CCR)

The CCR published for 2018 relates to 2016 cost settlement activities. For Cascade Care we assume that the charge master increases will reflect the subsequent cost settlement activity and have not applied any further changes in trend. Please see Appendix B-2 for the list of these facilities and the corresponding CCR for 2018 services. This appendix will require annual updates to reflect the CCR to each year under evaluation.

C. PAYMENTS FOR OTHER PROVIDERS – IN PROGRESS

While the PPS and CCR methodologies include the most significant and material provider types, there are additional providers that the Individual market network may include. As we collect line of business specific data from the carriers, we will add additional Appendices to summarize the methodology proposed for the assignment of Medicare allowed amounts. From our experience with the Public Employee Benefit program we do not anticipate these other providers to be a material amount of claims for Cascade Care. Here are the other providers we are working to develop a Medicare pricing methodology:

a. Psychiatric Hospitals
b. Rehabilitation Centers
c. Long Term Care (LTC) Facilities
d. Hospice Facilities
e. Skilled Nursing Facility (SNF)

IV. SERVICES WITH ALTERNATIVES TO MEDICARE PRICING

1. Maternity and Newborn

The typical over age sixty-five Medicare population is past the stage of pregnancy; hence, Medicare does not have a robust reimbursement schedule for maternity and newborn services. As an alternative approach to assign the Medicare allowed amounts for these services, we can rely

on the Department of Veteran Affair's TRICARE reimbursement relativities for hospital episodes[4]. The TRICARE schedule is developed for a population that is more similarly situated to the Cascade Care population and gives consideration to the Medicare relative weights for scaling these alternative factors.

The first step in the alternative is to group hospital episode claims to a MS-DRG, which includes the following codes: 765-770, 774-798, 805-807, 817-819, and 831-833.

These MS-DRG codes reflect the severity of the childbirth, as a premature newborn will cost more than a healthy baby delivered at term. These MS-DRGs can then be mapped to the TRICARE DRGs, which have an alternative Medicare allowed reimbursement that is more applicable to a under age 65 population.

2. Sole Community Hospitals

At this time, we are finalizing the 101% of cost benchmark for sole community hospitals (SCHs). Medicare IPPS and OPPS reimbursement includes a payment adjustment for SCHs. Since the legislation specifies that sole community hospital rates may not be less than 101% of allowable costs, we plan to develop cost based rates for these providers as well.

V. MEDICARE PAYMENTS EXCLUDED IN METHODOLOGY

In addition to the fee schedule based reimbursement that Medicare pays providers, there are a number of additional payments that Medicare makes in order to fund and incentivize the healthcare system. Some of these payments are generally recognized as a percentage increase to the base rate reimbursement level and are provider specific. Other payments are lump sum amounts that are not available on a timely basis for consideration.

1. Indirect Medical Education (IME) payments

Under Medicare, teaching hospitals that train physicians receive an additional payment from Medicare to pay for these education programs.

2. Disproportionate Share Hospital (DSH) payments

Under Medicare, hospitals providing a high share of care to Medicaid-enrolled and low-income patients are expected to receive an additional DSH payment from Medicare.

3. Uncompensated Care Payments (UCP)

Under Medicare, hospitals receiving DSH payments receive additional uncompensated care payments for the care provided to Medicaid-enrolled and low-income patients.

4. Provider Settlements

Many providers participate in risk-sharing programs with either insurance companies or CMS, where the provider group's total cost of care is compared to a benchmark and gains or losses are shared between payer and provider. Additionally, many PPS payment streams are settled to a

[4] FY2018 weights are available at: https://www.health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/Diagnosis-Related-Group-Rates/TRICARE-CHAMPUS-ASA-and-DRG-Weights-Summary/Fiscal-Year-2018

target amount. The proposed methodology is based solely on the prospective Medicare allowed amounts. Our methodology does not apply an adjustment for any provider risk-sharing programs.

5. Sequestration

Under current law, Congress sequesters a portion of Medicare reimbursement to providers, where a portion of the payment is withheld and paid at some indefinite time in the future. Under our methodology, we will not make any sequestration adjustment, and will reflect the full fee schedule amount before any sequestration.

6. Medicare Claim Edits

In certain cases, Medicare employs claim edits to deny payment for claims that may be miscoded or fraudulent. The Government Accountability Office (GAO) provides an example: an edit may deny payment for quantities of service that exceed those provided under normal medical practice or that are anatomically impossible, such as more than one appendectomy on the same beneficiary. Our methodology does not deny payment based on claim edits, as we expect the insurer will perform similar review of their claims that Medicare currently performs.

7. Bundled Payments

Under Medicare's Bundled Payment for Care Improvement (BPCI), certain services, such as hip replacement or bariatric surgery, are paid at a comprehensive fee, rather than on a fee-for-service basis. Commercial insurers may also have these arrangements with provider groups. Under our methodology, we will not price services using a bundled payment methodology, but will instead use a fee-for-service basis to assign the Medicare allowed amount.

8. Inpatient new technology payments

Medicare pays an additional new technology payment for new medical devices that have been approved by the Food and Drug Administration (FDA) and are not substantially similar to existing technology. The impact of these payments vary from year to year, but is generally very small (i.e. less than 1%). Our methodology does not include an adjustment for these additional payments.

9. Capital payments for new hospitals

Medicare may also make payments to hospitals for certain capital investments to build or expand a hospital. Our methodology does not include an adjustment for this.

10. Physician Health Professional Shortage Areas

Medicare makes additional payments for professionals in certain areas where there are few physicians available to practice. Our methodology does not include an adjustment for this additional payment beyond the Cascade Care requirement that primary care physicians are paid a minimum of 135% of Medicare

11. Physician incentive payment adjustments

Medicare has several incentive programs that reward or penalize physicians based on different quality and performance metrics. These programs include Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), the Maintenance of Certification Program (MOC), the Primary Care Incentive Payments (PCIP) program, or the Merit-based Incentive Payment System (MIPS). Our methodology does not include an adjustment for these payment adjustments.

VI. DATA QUALITY EXCLUSIONS

In order to ensure that the data is high quality and represents the Cascade Care population, we review the data and may also need to apply exclusions as necessary for the assignment of Medicare allowed amounts. We have added the following exclusion considerations below. Upon review of the actual carrier data that we receive, we may make additional adjustments as needed, as we cannot foresee all possible issues that may be present within the data. We are not anticipating that any of these exclusions would represent a material volume of claims.

Member-Based Exclusions:

1. Members who are over age 65 are excluded.

   Members over age 65 are eligible for Medicare and therefore not likely to participate in Cascade Care. We will exclude these members and their claims.

Claim-Based Exclusions:

1. All claims with Coordination of Benefits (COB) adjustments are excluded.

   When claims are paid by multiple parties – either two health insurance companies or a different type of insurance, such as auto or workers compensation, the portion paid by the participating Cascade Care health insurer may not be representative of a typical payment through the network. Therefore, we would generally exclude these claims from the percentage of Medicare reimbursement calculation.

2. Facility claims with unrecognized Medicare provider identification (ID) are excluded.

   It is essential for facility claims to have a valid six digit Medicare provider identification, as the reimbursement will vary based on the facility. If the facility provider ID is not valid, we will exclude the claims.

3. Facility Inpatient claims with ungroupable MS-DRGs or with professional claims with invalid procedure codes are excluded.

   Similarly, it is essential for the claims to have standard coding so that we can map claims to the corresponding Medicare values. If claims have invalid codes, they may be excluded.

4. Claims with unreasonable, inconsistent, or problematic financial values are excluded.

   In order to insure sufficient data quality in the comparison values of the insurer's allowed amounts, we use the following criteria for identifying claims for financial exclusions. These adjustments are based on standard practice within Milliman's Medicare pricing processes.

   - The billed or allowed amount for a claim is less than $1.00.
   - The allowed/billed ratio is greater than 2.00 or less than 0.03
   - The billed/Medicare allowed ratio is less than 10% or greater than 6000%
   - The allowed/Medicare allowed ratio is less than 5% or greater than 1500%
   - The (paid + patient pay + COB) amount is more than 10% different from the allowed amount

VII. LIMITATIONS AND QUALIFICATION STATEMENT

This report is subject to the terms and conditions of the contract between Washington Health Care Authority and Milliman dated December 15, 2017. The information contained in this report has been prepared for HCA in support of its communications with healthcare industry stakeholders. The material is intended to explain the methodology that will be used to price Cascade Care insurer claims on a Medicare basis. The information presented in this report may not be appropriate for any other purpose, including evaluating the other conditions that carriers must satisfy under Cascade Care.

It is our understanding that the information contained in this report will be released publicly. Any distribution of the information should be in its entirety. Any user of this report must possess a certain level of expertise in actuarial science, healthcare modeling and payments so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for Health Care Authority by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about premium rates, levels of network reimbursement, trend rates, and other assumptions.

The methodology listed in this report is a *summary* of the technical steps that will be followed to reprice claims under Medicare. As pricing schedules, coding practices, and provider practices change, the methodology should be updated to be a good faith approximation of Medicare's reimbursement rules. Emerging experience should be monitored and appropriate adjustments should be made as necessary.

Ben Diederich, Cheryle Wong, Nathan Nystrom, and Mike Hamachek collectively authored this report. Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses described in this report.