Public Option Plan – Medicare Methodology Discussion (DRAFT)

Medicare Methodology for Cascade Care Public Option Plan

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Data Reliance and Limitations

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In performing our analysis of historical Uniform Medical Plan results, we relied on claim data supplied by HCA vendors: Regence and Moda Health, as well as the network data supplied by HCA. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. These historical

Background – Enabling Legislation

Cascade Care - Cost Criteria

- **A Ceiling on Provider Reimbursement**: Average Statewide reimbursement for medical services under the Cascade Care 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.
- **A Floor on Rural Hospitals**: Either sole community hospitals (SCH) or critical access hospitals (CAH) as certified by the Centers for Medicare and Medicaid Services (CMS), must be paid at least 101% of their allowable costs. Allowable costs reimbursement is similar to the amount of reimbursement from Medicare, without consideration for sequestration or final cost settlement adjustments.
- **A Floor on Primary Care Services:** Physician reimbursement must be at least 135% of the amount Medicare would have reimbursed.

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

The common thread through each of these cost criteria for the Cascade Care network is measurement of the actual reimbursement relative to Medicare.

Medicare Pricing Methodology Overview

Cascade Care – Medicare Percentage Calculation

- Starting with the data fields within the processed claims
- Assign every medical claim a Medicare Allowed Amount

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

- Assigning Medicare to every claim leads to considerations/issues such as:
  - Identification of National Provider Identification code and Medicare Certification Number
  - Determination of the applicable fee schedule year
  - Identification of Medicare covered fee schedule amount
  - Outlier adjustments
  - Procedures not covered by Medicare
  - Calculation of a Cost to Charge Ratio (CCR) for those facilities that are paid as a percent of cost

Medicare Pricing Methodology Overview

Selection of Fee Schedule Year

- Federal Fiscal Year (FFY) begins on October 1st each year.
- CMS inpatient hospital fee schedule goes in effect as of October 1st each year, and then receive interim updates throughout the FFY. The Cascade Care Medicare Pricing Methodology will not reflect these interim updates.
  - The published fee schedule in effect at the beginning of the FFY will be used to evaluate the following Calendar Year (CY).
  - For example the CMS schedule as of October 1, 2017 for FFY 2018 are used to price any CY 2018 inpatient claims data.
- For example we will use the CMS schedule as of October 1, 2020 for FFY 2021 is used to price any CY 2021 claims data.
- CMS outpatient hospital, and professional fee schedules go in effect as of January 1st each year.
- Cascade Care Networks are effective January 1, 2021.

Medicare Pricing Methodology – Prospective Payment

Inpatient Facility

Inpatient Prospective Payment System (IPPS)

- Room and board revenue codes are used within the Milliman Health Cost Guidelines (HCG) Grouper logic to identify inpatient claims.
- ICD diagnosis and procedure codes are used to assign the Medicare Severity Diagnosis Related Group (MS-DRG).
- An outlier payment adjustment is made based on the provider-specific cost to charge ratio.
- For claims without a valid National Provider Identification (NPI) code, we will assign a default Medicare reimbursement amount based on the Seattle-area average outlier-adjusted amount for the MS-DRG.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index

Medicare Pricing Methodology – Prospective Payment

Outpatient Facility or Ambulatory Surgical Center

Outpatient Prospective Payment System (OPPS)

- Revenue code and facility type is used to identify if the claim line falls under this fee schedule.
- Procedure code is used to assign the fee schedule, mostly Ambulatory Payment Classification (APC) amounts for hospitals or Ambulatory Surgical Center (ASC) Payment amounts for ASCs.
- NPI code is used to determine the area adjustment factor to the fee schedule. For providers without a valid NPI we will assume the provider is located in Seattle.
- Ancillary fee schedules are incorporated (e.g. clinical laboratory, RBRVS for physical therapy).
- For outpatient procedure codes that are not on the Medicare fee schedule, we will use the Medicare fee for services with a similar intensity.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HospitalOPPS

Medicare Pricing Methodology – Prospective Payment

Professional

Professional Fee Schedule Assignment

- Professional claims are identified as either no revenue code, or one of the following revenue codes: 0023, 0522, 0524, 0525, 0527, 0540-0549, 0570-0599, 0640-0649, 0651-0654, 0660-0669, 0960-0989
- Medicare amounts are assigned based on the Healthcare Common Procedure Coding System (HCPCS) code and the fee schedule year under evaluation.
- The main fee schedule is the Resource Based Relative Value System or RBRVS
- There are also fee schedules for the following service types: Ambulance, Anesthesia, Part B Drugs (ASP fee schedule), Durable Medical Equipment (DME), Clinical Laboratory (Lab), and Parenteral and Enteral Nutrition Items and Services (PEN)
- National Provider Identification (NPI) code is used to determine the area adjustment factor to the fee schedule. For services without a valid NPI we will assume the provider is located in Seattle.
- For professional procedure codes that are not in the Medicare fee schedule, we will use the Medicare fee for services with a similar intensity.

Medicare Pricing Methodology – Cost Reimbursement

Cancer Hospitals, Children's Hospitals, SCH and CAH

Medicare Reimbursement as a percentage of the reported costs

- Cancer and Children's Hospitals are 100% of reported cost
- CAH are 101% of reported cost
- Cascade Care also mandates that SCH be paid at 101% of reported costs, which is different from how Medicare reimbursement would be assigned.
- For all cost reimbursement facilities the published cost-to-charge ratio is used to assign the Medicare Allowed cost.
- The CCR published in 2018 relates to 2016 cost settlement activities. For Cascade Care we will assume that the charge master increases will reflect the subsequent cost settlement activity of later years.
- For each evaluation year, in advance of the year beginning, we will publish the most current available CCR and list all of the facilities for which cost reimbursement applies

Medicare Pricing Methodology – Cost Reimbursement

Other Providers in Progress

Medicare Reimbursement as a percentage of the reported costs

- PPS and CCR for Cancer Hospitals, Children's Hospitals, SCHs, and CAHs include the most significant and material provider types. There are however additional providers that an Individual market network may need to include:
  - Psychiatric Hospitals
  - Rehabilitation Centers
  - Long Term Care Facilities
  - Hospice Facilities
  - Skilled Nursing Facilities
- From our commercial pricing experience with the Public Employee Benefit program, we do not anticipate these providers to be a material amount of claims for Cascade Care.
- We are still working to develop a Medicare pricing methodology for these providers but will likely rely on a combination of Medicare discount and CCR information, and the most currently available cost reports.

Medicare Pricing Methodology - Exclusions

Payments beyond the fee schedule based reimbursement

There are a number of additional payments that Medicare makes that reflect specific policy goals. Some of these payments can be recognized as a percentage increase (or decrease) to the base reimbursement rate, and other payments are lump sum amounts that are not available on a timely basis for consideration with claim based utilization. The primary adjustment are outlined below.

- Indirect Medical Education (IME) payments
- Disproportionate Share Hospital (DSH) and Uncompensated Care payments
- Provider settlements
- Sequestration
- Medicare Claim Edits
- Bundled payments and risk sharing
- Inpatient new technology payments
- Capital payments for new hospitals
- Physician Health Professional Shortage Areas
- Physician incentive payment adjustments (e.g. Merit-Based Incentive Payment System or MIPS)

Medicare Pricing Methodology - Exclusions

Data Quality Exclusions

In order to ensure that the data is high quality and representative of the Cascade Care population, we will review the claim data for the following quality considerations. If the quality considerations are not able to be resolved then we will make the following exclusions:

- Member based exclusion for members over age 65
- Claim based exclusion for All claims with Coordination of Benefits (COB) adjustments
- Facility claims with unrecognized Medicare provider identification number
- Facility claims with ungroupable MS-DRGs or professional claims with unrecognized procedure codes.
- Claims with unreasonable, inconsistent, or problematic financial values. For example:
  - Billed or Allowed Amounts less than $1.00
  - Allowed/Billed ratio is greater than 2.00 or less than 0.03

Services with Alternatives to Medicare Pricing

Maternity, Newborn, and Sole Community Hospital

- Maternity and Newborn
  - As the typical Medicare population is past the stage of pregnancy, the Medicare pricing for these MS-DRGs is not overly robust.
  - As an alternative approach, the Department of Veteran Affair's TRICARE payment relativity would be a reasonable substitute for the Medicare DRG weight.
- Sole Community Hospitals
  - As previously discussed, the Sole Community Hospitals are paid through a SCH adjustment factor within the PPS of reimbursement.
  - In order to be consistent with the enabling legislation we plan to assign Medicare amounts based on the CCR methodology.

Medicare Pricing Methodology – Illustrative
PEB Program Results: Tricare and Add-On Impact

	Full Medicare		Full Medicare, TRICARE weights for Maternity	
	With Add-On Payments (IME and DSH/UCP)	No Add-On Payments	With Add-On Payments (IME and DSH/UCP)	No Add-On Payments
Inpatient	**201%**	**240%**	**205%**	**245%**
Outpatient	217%	217%	217%	217%
Professional	134%	134%	134%	134%
Total	**165.5%**	**170.6%**	**166.2%**	**171.1%**

For illustrative and discussion purposes, Milliman used a sample of the Public Employee Benefit program data and assigned Medicare amounts to the claims under the four options above to show the impact of using TRICARE weights and inclusion of IME and DSH/UCP payments.

- CY2018 with 6 months of runout
- 2018 Medicare Fee Schedules
- Active employees, under age 65
- Excludes COB claims
- Based on Milliman's standard Medicare repricing methodology and is not necessarily consistent with the proposed Cascade Care methodology.
  - For claims that can't be assigned a Medicare amount or have poor data quality, we estimate the Medicare payments at the major service category (IP, OP, Prof) and member rating area as follows: (allowed) / (percent of Medicare average by major service category and rating area)

Medicare Pricing Methodology – Illustrative
PEBB Program Results: Materiality of Exclusions

	Billed		Allowed		MCR PMPM	Allow/MCR
Category	PMPM	% of Total	PMPM	% of Total		
Inpatient	$148.95	20%	$72.35	20%	$33.04	219%
Outpatient	$229.11	31%	$104.84	29%	$51.96	202%
Professional	$225.95	31%	$127.87	35%	$93.25	137%
Total - Assigned	$604.01	82%	$305.05	84%	$178.24	171%
Not Assigned	$131.71	18%	$59.72	16%		

For illustrative and discussion purposes, Milliman used a sample of the Public Employee Benefit program data and assigned Medicare pricing to the claims under the PPS and CCR methods for Inpatient and Outpatient, and the Professional Fee Schedule of only Medicare Covered Services.

- CY2018 with 6 months of runout
- 2018 Medicare Fee Schedules
- Active employees, under age 65
- Excludes COB claims
- Based on Milliman's standard Medicare repricing methodology and is not necessarily consistent with the proposed Cascade Care methodology.

Not Assigned claims in this illustration includes any claims that are for services in that:

- Do not have a Medicare covered HCPCS: Billed $83.13 PMPM 63% of Not Assigned; Allowed $48.15 PMPM 81% of Not Assigned
- Do not have a NPI and are assigned the default PPS: Billed $18.07 PMPM 14% of Not Assigned; Allowed $8.24 PMPM 14% of Not Assigned
- Data quality issues make up the remainder of the Not Assigned