Percent of Medicare comparisons: A primer on using Medicare payment rates as benchmark

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Comparing non-Medicare payment rates to estimated Medicare fee-for-service (FFS) payment rates[1] is used as a common benchmark when evaluating healthcare reimbursement levels. These Medicare payment rate benchmarks are used for activities such as unit price analysis, provider contract negotiations, and policy development. A key statistic calculated for such comparisons is the "percent of Medicare," defined as the actual payments divided by the estimated Medicare payments for the same service(s). However, the results of this calculation are influenced by decisions underlying the definitions for both actual claims payment amounts (the numerator) and the estimated Medicare payment amounts (the denominator). This paper outlines standard definitions and key considerations for scope and decision points when using percent of Medicare comparisons for analysis.

"Percent of Medicare" definition

The "percent of Medicare" statistic allows stakeholders to evaluate actual claims payment amounts compared to the standardized benchmark of Medicare fee-for-service (FFS) payment amounts. The percent of Medicare statistic is a ratio as follows:

$$Percent\ of\ Medicare = \frac{Actual\ Payments}{Medicare\ Payment}$$

In general, the actual payments reflect the sum of health insurer payments and patient cost sharing (i.e., the "allowed payment" or "allowable payment") and may also include other amounts like network access fees, value-based incentive payments, or third-party payments. The Medicare payment reflects what Medicare would pay for the same set of services and is determined by repricing claims data to the Medicare FFS allowable.

Scope considerations

To calculate the percent of Medicare, the first step is to determine what scope of services to include in the calculation. Typically, the scope of services depends on the purpose.

Basic scope factors include geographic area (e.g., rural areas within a state), line of business (e.g., Medicaid), and performance period (e.g., services performed in the most recent calendar year). More advanced scope factors include:

- **Non-Medicare services**: Traditional Medicare FFS does not cover some services that make up individuals' healthcare. See the Services Not Covered by Medicare sidebar for further discussion. Services that are not covered by Medicare or that are not widely used by Medicare patients may need to be excluded from the evaluated scope of services.
- **Claims runout period**: In addition to defining the service period (e.g., most recent calendar year), we also must define the period of time payments are collected past the service dates. We refer to this period as "runout." For example, we may include 2023 service dates paid or reported through March 2024 to provide three months' runout. The runout period can affect results if there is a difference in unit price between services that complete quickly versus services that take longer to complete (e.g., if outlier claims with a high percent of Medicare take longer than average to complete then a longer runout period would increase the overall percent of Medicare).

[1] Estimated Medicare payment rates are calculated by applying Medicare's groupers and fee schedules to claims experience data, such as with Milliman's Medicare Reference Pricer tool. See https://us.milliman.com/en/products/medicare-reference-pricer.

- **Denied claims**: How to identify and exclude denied claims.
- **Capitated services**: While the majority of claims payments are likely to be paid on a fee-for-service basis, an increasing volume of services are covered through capitated payments. When including capitated services (i.e., encounter data) in a percent of Medicare calculation, an approach is needed to allocate the capitation payments across the encounter data. See the Percent of Medicare for Capitation Arrangements sidebar for a simple example.
- **Claims with third-party payments**: For most analyses, it will be appropriate to exclude claims with third-party payments, where the service is covered under coordination of benefits arrangements between a primary and secondary payer. For example, if the goal is to measure Medicaid payments as a percent of Medicare payments, then the analysis should exclude claims with third-party coverage because Medicaid is the payer of last resort and those covered by non-Medicaid payers will have a different percent of Medicare result.
- **Other considerations**: The goal of the comparison may result in other considerations that will be determined on a case-by-case basis. Some examples may include:
  - Geographic region: Defining rural areas of a state, and whether geographic limitations will be applied to providers practicing in the defined area or patients who live in the defined area.
  - Limited service scope: If limiting to a set of services such as primary care services, a technical definition of services must be established. This may include limitations based on claims variables such as provider specialty or service code, e.g., Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS).
  - Provider limitation: Some providers, such as critical access hospitals (CAHs), rural health clinics (RHCs), or federally qualified healthcare centers (FQHCs), have unique payment structures that can influence overall results and should be considered for inclusion, exclusion, or stratification within the analysis.
  - Medicaid line of business: If a state has a managed Medicaid program, defining whether to include managed Medicaid carriers or use just state fee-for-service program data.

Services not covered by Medicare

Non-Medicare payers and some Medicare Advantage (MA) plans may cover services that are not covered by traditional fee-for-service Medicare or not widely used by Medicare patients. Common examples include:

- Well-baby exams
- Newborn admissions
- Specific surgeries in an outpatient or office setting
- Routine eye exams (eye refractions)
- Dental services
- Sexual and reproductive health services
- Nonemergency transportation services
- Custodial care nursing facility services
- Long-term home and community-based services

Additionally, the Medicare program covers prescription drugs through Medicare Part D—however, Medicare does not publish a prescription drug fee schedule as each Part D carrier negotiates its own drug prices (though the Inflation Reduction Act enables federally negotiated prices for select drugs to go into effect starting in 2026).

Payment rates for services not covered by Medicare

Medicare publishes payment amounts for some services that Medicare does not cover. The main example of this is the Resource-Based Relative Value Scale (RBRVS) fee schedule used for professional payments. The RBRVS fee schedule includes payment rates for Medicare-covered and non-covered services. The underlying relative value units (RVUs) are developed by the Specialty Society Relative Value Scale Update Committee (RUC), which includes stakeholder representation beyond Medicare. They are therefore generally considered reliable for non-Medicare-covered services.

In cases where Medicare does not publish payment amounts for a service, Milliman develops Medicare-like payment relativities that can be used to enhance percent of Medicare calculations.[2]

For inpatient hospital admissions, Medicare publishes Medicare Severity Diagnosis-Related Group (MS-DRG) schedules that include relative weights for services typically covered for a commercially insured population. However, it should be noted that the Medicare MS-DRG relative weights may not be appropriate for commercial populations for the following key reasons:

- The maternity delivery MS-DRG weights reflect the Medicare-covered population of enrollees with disabilities, resulting in a higher intensity of care and lower credibility of data than diagnosis-related group (DRG) sets that are more commonly used for commercially covered maternity cases.
- The newborn birth MS-DRG weights were developed prior to 2005 and allocated into the MS-DRG structure, and therefore are based on information from more than 20 years ago.[3]
- There are other MS-DRGs with very low Medicare volume with less reliable relative weights. Examples include 010 (pancreas transplant) and 019 (simultaneous pancreas and kidney transplant with hemodialysis).
- The Medicare average length of stay (LOS) may be very different for a commercial or Medicaid population. Examples include 002 (heart transplant or implant of heart assist system without MCC), which has a significantly longer average LOS in commercial populations, and 885 (psychoses), which has a longer average LOS in the Medicare population.

For outpatient facility services, Medicare payment amounts are available for most services. However, Medicare does not publish rates for certain non-covered services and pays some based on cost. Medicare makes an effort to pay the same rate for the same service in different settings (e.g., injectable drugs, lab services, physical therapy), but there are also some differences that may be considered in any analysis. For example, ambulatory surgical centers are paid approximately 52% of what an acute hospital would get for the same surgery. In addition, office visits and some imaging services and cardiovascular services get paid significantly more in hospital settings versus ambulatory settings.

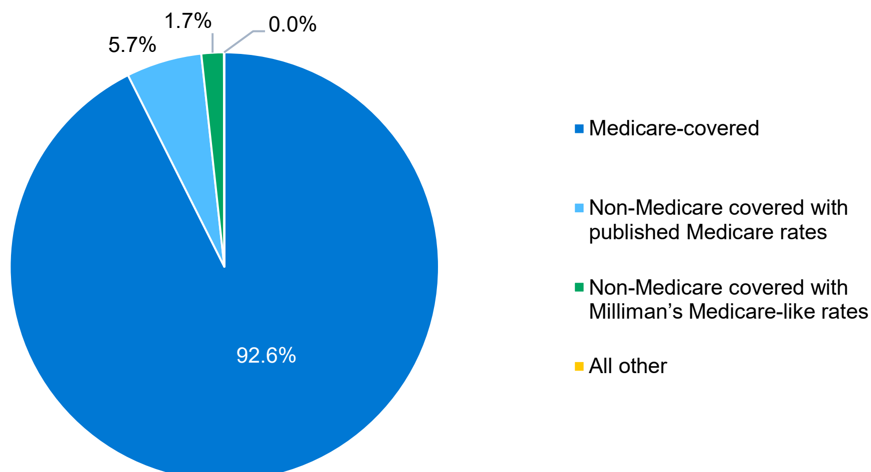
For professional services, Medicare payment amounts are based on the RBRVS, which includes RVUs for maternity, newborn services, and many services not covered by Medicare. However, Medicare payment rates are not available for some specific categories of service that are covered by non-Medicare payers such as nonemergency transportation, some types of durable medical equipment (e.g., breast pumps), and some types of home-based care.

Figure 1 shows an illustrative breakdown of professional services for a typical commercial plan between Medicare-covered, non-Medicare-covered with published Medicare rates, non-Medicare-covered with Milliman's Medicare-like rates, and all other. Figure 1 illustrates that Medicare fee schedules are applicable for approximately 98% of the service line records, and the remaining 2% would need an alternative solution.

[2] More information is available here: https://www.milliman.com/en/products/medicare-repricer.

[3] Based on a review of the FY 2005 through FY 2024 Hospital Inpatient Prospective Payment System rules published in the Federal Register.

FIGURE 1: COMMERCIAL PROFESSIONAL SERVICE LINE RECORDS COVERED BY MEDICARE FEE SCHEDULES



Actual payment calculation considerations

Once the scope is determined, calculating the actual payments component (i.e., the numerator of the percent of Medicare) is a relatively simple process of adding up actual payment amounts for the defined scope of services. However, some payment adjustments and components may not be reflected when the payments are recorded in the claims data, resulting in the need for additional information to adequately calculate payments. The following outlines special case considerations based on the authors' experience:

- Separate payment adjustments: It may be appropriate to recalculate the payment amount to reflect adjustments that occur after the initial calculation of the allowed payment amount. This could include adjustments for collectability, late fees, or settlements that occurred outside of the claims system.
- Payments outside the claims system:
  - Prescription drug rebates and remunerations: Drug manufacturers and pharmacies may offer rebates to payers based on specific criteria like sales volume. These rebates may not be reflected in the point-of-sale prices.
  - Medicaid supplemental payments: State Medicaid agencies may make lump sum payments outside of claims to providers directly or under state-directed payment arrangements (42 CFR 438.6) through Medicaid managed care organizations (MCOs). It is important to understand these additional payment mechanisms and their applicability to the goals of a defined analysis.
  - Pay for performance arrangements: Payers and providers may set up programs like quality bonus payments or risk-sharing arrangements, which can lead to additional payments outside of the claims system. If a risk-sharing arrangement has downside risk for the provider, then provider losses may also need to be considered.
- Capitation payments: Under capitation arrangements, providers receive an up-front payment that is not tied to actual utilization during the performance period.[4] Capitation payments are typically made on a per member per month (PMPM) basis, and the utilization associated with the capitation is typically recorded as encounters—which report the utilization and associated member cost sharing, but do not request a payment.[5]

[4] For discussion of capitation and healthcare provider prepayments, please see https://www.cms.gov/priorities/innovation/key-concepts/capitation-and-pre-payment.

[5] For discussion of claims and encounters, see https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/transactions/health-care-claim-equivalent-encounter-information.

Percent of Medicare for capitation arrangements

The following outlines an example of steps for calculating the percent of Medicare for services covered under a capitation arrangement:

1. Define the scope of services. The scope of services definition is used in steps 2 and 3 below to determine which capitation amounts and corresponding services are in scope.
2. Calculate the actual capitation amount for the services within scope. If only portions of the services covered under a capitation payment are within scope, then the capitation payment may need to be allocated between the services within scope and out of scope. One approach for this is to assume that the capitation as a percent of Medicare is the same for services in and out of scope—however, this requires analyzing both the services in scope and out of scope.
3. Develop a Medicare-equivalent payment amount for the encounters. Typically, the Medicare equivalent is calculated by repricing the encounter data to Medicare payment amounts. If detailed encounter data is not available, then alternative approaches may be necessary, such as estimating the Medicare payment amounts based on utilization summaries (e.g., visit counts).
4. Calculate the percent of Medicare:

$$Percent\ of\ Medicare = \frac{Actual\ Capitation}{Total\ amount\ would've\ paid\ under\ Medicare}$$

Figure 2 shows an illustrative example based on the following factors:

- Services covered under capitation are primary care evaluation and management (E&M) visits
- The total capitation payment is $1,225,000
- There are a total of 10,000 E&M visits during the performance period
- The average Medicare allowed payment per visit is $90.82

FIGURE 2: ILLUSTRATIVE EXAMPLE: MEDICARE % OF SERVICE CALCULATION

Metric	Amount
Utilization (covered visits)	10,000 visits
Medicare allowed per visit	$90.82
Medicare equivalent	$908,177
Capitation payment for covered visits	$1,225,000
Percent of Medicare	134.9%

Medicare payment calculation considerations

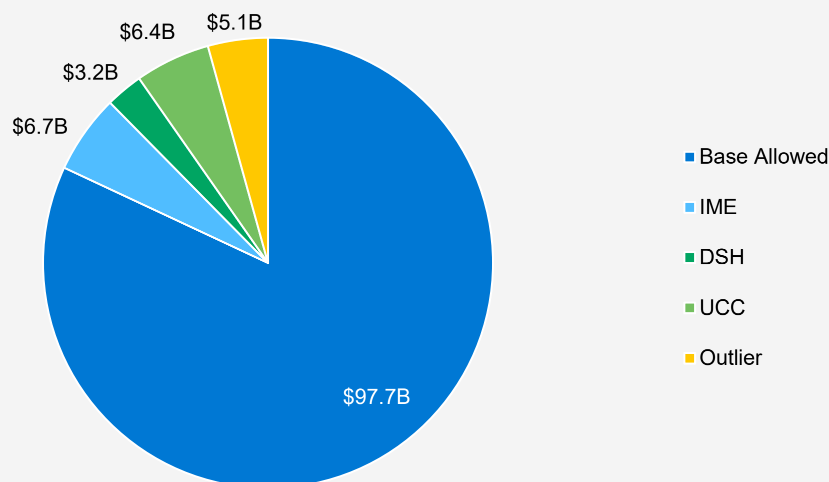
MEDICARE PAYMENT COMPONENTS

While stakeholders may assume that "Medicare" only has one definition in terms of provider payments, there are many components of Medicare payments (the denominator in the percent of Medicare). Developing a complete definition of Medicare requires defining how these components will be accounted for when estimating the Medicare payment amount. The appendix, Overview of Medicare Payment Adjustments and Components, lists many of the components and adjustments to consider when defining Medicare payments.

IPPS Add-on payments

The Inpatient Prospective Payment System (IPPS) add-on payments include indirect medical education (IME), disproportionate share hospital (DSH), uncompensated care (UCC), value-based purchasing (VBP), readmission, hospital-acquired condition (HAC), sole community hospital and Medicare-dependent hospital, new technology, low-volume hospital, and various pass-through adjustments. These adjustments increase the Medicare payment, with the exception of VBP, readmission, and HAC adjustments. The table in Figure 3 shows the major add-on payment components relative to the total IPPS payments for fiscal year (FY) 2021. IME, DSH, UCC, and outlier make up approximately 18% of the total IPPS payments.

FIGURE 3: COMPONENTS OF IPPS PAYMENTS (FY 2021)



Source: FY 2021 MedPAR experience for facilities paid under IPPS. https://resdac.org/cms-data/files/medpar.

The add-on adjustments may be policy-related and are not necessarily calibrated to expected cost differences such as the additional costs of being a teaching hospital. Add-ons complicate adjudication to Medicare-allowed, and the add-on adjustments can change throughout the year.

Stakeholders may define Medicare payments as "what the Medicare program would have allowed." In this case, it is still important to clearly define how each Medicare payment component is considered in the process for assigning Medicare payments.

Medicare-specific claim coding

Medicare payment systems require specific claim coding to assign the Medicare payment amount.[6] For non-Medicare claims, providers most often do not complete all the claims coding elements required to precisely assign Medicare payment. The table in Figure 4 provides common examples. Note that we reference the standard paper claims forms, but the same applies to electronic claims form equivalents: the 837i for the UB-04/CMS-1450[7] and the 837p for the CMS-1500.[8]

FIGURE 4: COMMON EXAMPLES OF CLAIMS CODING ELEMENTS

Medicare claim coding element	Claim form location	Payment systems affected
Health Insurance Prospective Payment System (HIPPS)[9]/Home Health Resource Group (HHRG)	HCPCS element in the UB claims form.	Home Health (HH) Prospective Payment System (PPS)
HIPPS / Resource Utilization Group (RUG) and Patient-Driven Payment Model (PDPM) codes	HCPCS element in the UB claims form.	Skilled Nursing Facility (SNF) PPS
Case Mix Group (CMG)	HCPCS element in the UB claims form.	Inpatient Rehabilitation Facility (Rehab) PPS
Value and occurrence codes	Value and occurrence code elements in the UB claims form.	IPPS, Outpatient Prospective Payment System (OPPS), End-Stage Renal Disease (ESRD) PPS
National Drug Code (NDC)	HCPCS description element in the UB claims form.	IPPS New Technology and COVID-19 Payments
Dates	Dates of service, admission, and discharge elements.	HH PPS (pays in 30-day episodes)

If the claims code elements required to assign accurate Medicare payment amount are not available or not applicable for the comparison population, then the following options may exist for these services:

1. Exclude services that cannot be assigned an accurate Medicare payment amount from the comparison.
2. Use an alternative method to assign Medicare payments, e.g.:
   A. Simplified adjudication logic like using a per diem for skilled nursing facility services that is adjusted for wage index, but not all the Patient-Driven Payment Model (PDPM) adjustments.
   B. Using a discount from billed charges, i.e., apply a provider-specific discount based on each provider's Medicare fee-for-service payment data and the billed charges in the comparison data.

For some services, different payers require a different set of codes to be used to describe a given service. For example, commercial dialysis claims often use codes different from those required by Medicare. In some such instances, a straightforward mapping of codes can be used to assign codes that can be repriced to a Medicare fee schedule.

ADDITIONAL CONSIDERATIONS FOR CALCULATING AND PRESENTING PERCENT OF MEDICARE

Leveraging existing processes: Existing processes may exist to collect detailed claims and encounter data, and to deliver reports to stakeholders. While adding new data elements to these processes may enhance the percent of Medicare calculation, it may not be feasible in practice. Therefore, considering existing data collection and reporting processes is an important part of making the decisions outlined in this paper.

[6] See the Medicare Claims Processing Manual published by CMS for more information: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.

[7] See https://www.cms.gov/files/document/837i-form-cms-1450-mln006926.pdf.

[8] See https://www.cms.gov/files/document/837p-cms-1500pdf.

[9] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/hippsuses.pdf.

Presentation context and intended use: Understanding how the percent of Medicare statistics will be presented and used is critical for defining the decision points outlined in this paper. For example:

- If the percent of Medicare is presented as part of a provider reimbursement negotiation, then it may be important to include all payment streams from the payers to the provider, including capitation payments.
- If the percent of Medicare is presented as a comparison to the provider's funding under the Medicare program, then it may be important to include all Medicare payment components.
- If the percent of Medicare is used to measure unit price trends, then typically a single Medicare year is recommended and specific Medicare payment components may be excluded to help maintain a consistent denominator over time.

Medicare Alternative Payment Models (APMs): Percent of Medicare comparisons are based on comparisons to Medicare FFS payment amounts. However, increasing shares of Medicare program payments run through Medicare Advantage and APMs. Medicare adopted APMs to incentivize quality and efficiency of care delivery and the "outside of the claims system" payment adjustments associated with these programs are generally not reflected in the Medicare fee schedule. In 2023, the Medicare program did not have full financial risk for providing healthcare coverage to over two-thirds of Medicare beneficiaries. Specifically, more than half of Medicare beneficiaries were enrolled in a Medicare Advantage plan,[10] and of the 29.2 million beneficiaries in traditional fee-for-service Medicare (i.e., not in Medicare Advantage), 13.2 million beneficiaries, or approximately 45%, are assigned to an accountable care organization (ACO).[11] Additionally, the majority of Medicare Advantage provider payments flow through APMs.[12] Therefore, while percent of Medicare is a well understood unit price metric, stakeholders should consider its relevance to their goals as the Medicare system itself moves toward paying for value rather than per unit of care delivered.

Conclusion

While unit price is one of many measures of healthcare performance, the percent of Medicare metric is well understood and will continue to be used by stakeholders. When developing and reporting percent of Medicare results, it is important that the scope, actual payment amounts, and Medicare payment amounts are clearly defined and appropriate for the comparison goals.

[10] Ochieng, N. et al. (August 9, 2023). Medicare Advantage in 2023: Enrollment Update and Key Trends. KFF. Retrieved April 14, 2024, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

[11] CMS (January 17, 2023). CMS Announces Increase in 2023 in Organizations and Beneficiaries Benefiting from Coordinated Care in Accountable Care Relationship. Press release. Retrieved April 14, 2024, from https://www.cms.gov/newsroom/press-releases/cms-announces-increase-2023-organizations-and-beneficiaries-benefiting-coordinated-care-accountable.

[12] AHIP (December 15, 2021). New HCP-LAN Survey Results Show Increase in Adoption of Alternative Payment Models. Retrieved April 14, 2024, from https://www.ahip.org/news/articles/new-hcp-lan-survey-results-show-increase-in-adoption-of-alternative-payment-models.

Appendix: Overview of Medicare payment adjustments and components

Medicare payments often start from a base financial amount and then go through a series of adjustments and adjudication steps to calculate the final payment amount. The table below outlines some of the key payment adjustments and components.

FIGURE 5: KEY PAYMENT ADJUSTMENTS AND COMPONENTS

Category	Component	How it affects comparisons	Discussion
Payment adjustments	Area adjustments	Increase or decreases the Medicare payment	Inpatient, outpatient, professional, and other payments under Medicare are paid with geographic adjusted rates, which vary from the national average rates.
	Inpatient Prospective Payment System (IPPS) add-ons	Typically increases the Medicare payment	IPPS add-ons reflect federal policy goals and may or may not be appropriate in other contexts. Geographically close hospitals may have significantly different payment levels due to add-ons.
	Outlier payments	Typically increases the Medicare payment	Facility claims with estimated cost above a specified threshold can be eligible for outlier payments beyond the fee schedule payment rate. Outlier payments are calculated to be below a hospital's cost, and smaller hospitals may not want the risk associated with outliers.
	Organ acquisition cost	Increases the Medicare payment for transplant services	Fee-for-service Medicare pays a small pass-through payment per diem on both transplant and non-transplant admits, with a reconciliation calculation at the end of the year. Because transplant rates differ across populations, the pass-through payment may not be calibrated to other populations. Medicare Advantage plans often do not pay the pass-through payment, and instead pay an acquisition cost with each transplant.[13]
	Physician specialty adjustments	Decreases the Medicare payment	Services rendered by specific specialty types are reimbursed at a discounted rate. These specialty types include: nurse practitioner, licensed clinical social worker, certified clinical nurse specialist, and physician assistants.
	Quality and value-based purchasing adjustments	Increases or decreases the Medicare payment	Adjustments for specific quality and value measures. Examples include the Hospital Value-Based Purchasing Program and the Merit-Based Incentive Program (MIPS) adjustments to professional payments.[14]
	Health Professional Shortage Area (HPSA)	Increases the Medicare payment	Primary care and mental health services provided in areas with identified shortages of physicians are eligible for a 10% bonus payment.
Edits	MS-DRG Hospital-Acquired Condition (HAC) adjustment	Typically decreases the Medicare payment	CMS does not allow certain hospital-acquired conditions to adjust the DRG. This is separate and in addition to the 1% reduction applied to providers who have a relatively high rate of HAC.[15]
	Outpatient Prospective Payment System (OPPS) edits	Typically decreases the Medicare payment	OPPS claims are edited for incorrect or inappropriate coding, which can deny claim payment and decrease reimbursement.
	Professional edits	Typically decreases the Medicare payment	Professional claims are edited for incorrect or inappropriate coding, which can deny claim payment and decrease reimbursement.

[13] CMS pays the organ acquisition cost on behalf of Medicare Advantage plans for certain organs such as kidneys.

[14] For more information, please see:

- https://www.cms.gov/medicare/quality/value-based-programs/hospital-purchasing
- https://qpp.cms.gov/mips/overview

Note that MIPS adjustments are typically not applied to the patient cost-sharing amount.

[15] For information on how IPPS payments are adjusted for a hospital's overall HAC rate, see https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-acquired-condition-reduction-program-hacrp.

Category	Component	How it affects comparisons	Discussion
Non-PPS hospital providers	Critical access hospitals (CAHs)	Typically increases the Medicare payment	Most services provided at a CAH are reimbursed at 101% of estimated cost, which is often higher than the standard Medicare reimbursement rate.
	Cancer hospitals	Typically increases the Medicare payment	Services are paid using an approach that considers each hospital's historical cost levels.
	Children's hospitals	Typically increases the Medicare payment	Services are paid based on cost.
	Maryland (MD) Waiver hospitals	Typically increases the Medicare payment	The prospective Medicare payment to MD Waiver hospitals is 92.3% of billed charges, which is often higher than the standard Medicare reimbursement rate.[16]
Non-covered or ancillary services	Services not covered by Medicare	Increases the services repriced to Medicare payments	When services not covered by Medicare are repriced to the Medicare fee schedule, it increases the repriced payment amount relative to what Medicare would pay. An example is repricing more than one annual wellness visit per member annually, where Medicare would only pay for a single visit annually.
	Ancillary fee schedules and payment systems	Increases or decreases the Medicare payment	Services performed in certain facility types are reimbursed under a different prospective payment system.
Adjustments outside of the prospective payment system	Retrospective payment settlements	Increases or decreases the Medicare payment	Under Medicare's prospective payment systems certain payment streams are paid through a settlement process outside of the claim system, e.g., the financial reconciliation associated with the Hospital Cost Report filings.
	Sequestration	Decreases the Medicare payment	Typically sequestration is applied to the Medicare payment net of any beneficiary cost sharing, so it may not be considered part of the Medicare-allowable.

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[16] See https://hscrc.maryland.gov/Pages/payers.aspx.