Percent of Medicare Caps and Guarantees

How they can work for you

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Agenda

- About Milliman
- What is Percent of Medicare?
- Public Purchasing Guarantees
- Case Study: Indiana Department of Insurance
- Case Study: Colorado Option
- How Milliman Can Help You
- Q&A with Milliman Experts

These presentation slides are for discussion purposes only. They should not be relied upon without benefit of the discussion that accompanied them.

This presentation and Q&A is not intended to be an actuarial opinion or advice, nor is it intended to be legal advice.

Any statements made during the presentation and subsequent Q&A shall not be a representation of Milliman or its views or opinions, but only those of the presenter.

In preparing this presentation, we relied on data and information from the Centers for Medicare and Medicaid Services (CMS) and publicly available sources. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the information we present may likewise be inaccurate or incomplete.

About Milliman

4,800+ employees	$1.5 Billion (US) revenue in 2023	68 offices across the globe
75 years of experience	Our healthcare clients include over 80% of the health plans in the nation	We certify more than 40% Part C bids and more than 60% Part D bids

We are empowered by the diversity of our backgrounds, driven by a shared commitment to innovate, and inspired by a common mission:

To serve our clients to protect the health and financial well-being of people everywhere.

About Milliman

Industry Leader

Milliman is the largest and most respected actuarial firm, consulting to most of the health insurers in the nation, state Medicaid programs, providers, health tech solutions, and federal, state, and local government.

Deep Healthcare Expertise

We are broadly acknowledged to be the leading consulting firm to healthcare risk takers and providers.

We have consulted on health issues to clients in more than 30 countries on six continents and have more actuaries who focus specifically on health issues than any other firm in the world.

Rigorous

Deeply embedded in our culture is a rigorous internal peer-review process on all client projects to ensure we deliver the best in advisory services. A second qualified Milliman consultant will review all work products.

What is the Percent of Medicare?

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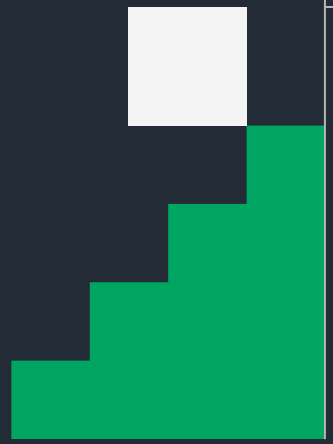
Percent of Medicare overview and considerations

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



1

Scope

The included scope. *What is the scope of services to be included?*

2

Actual payments

The numerator. What are the actual payments for the services?

3

Medicare payment

The denominator. *What is the Medicare payment for the services?*

4

Considerations

- How will the data be collected?
- How will the results be used?

Scope

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

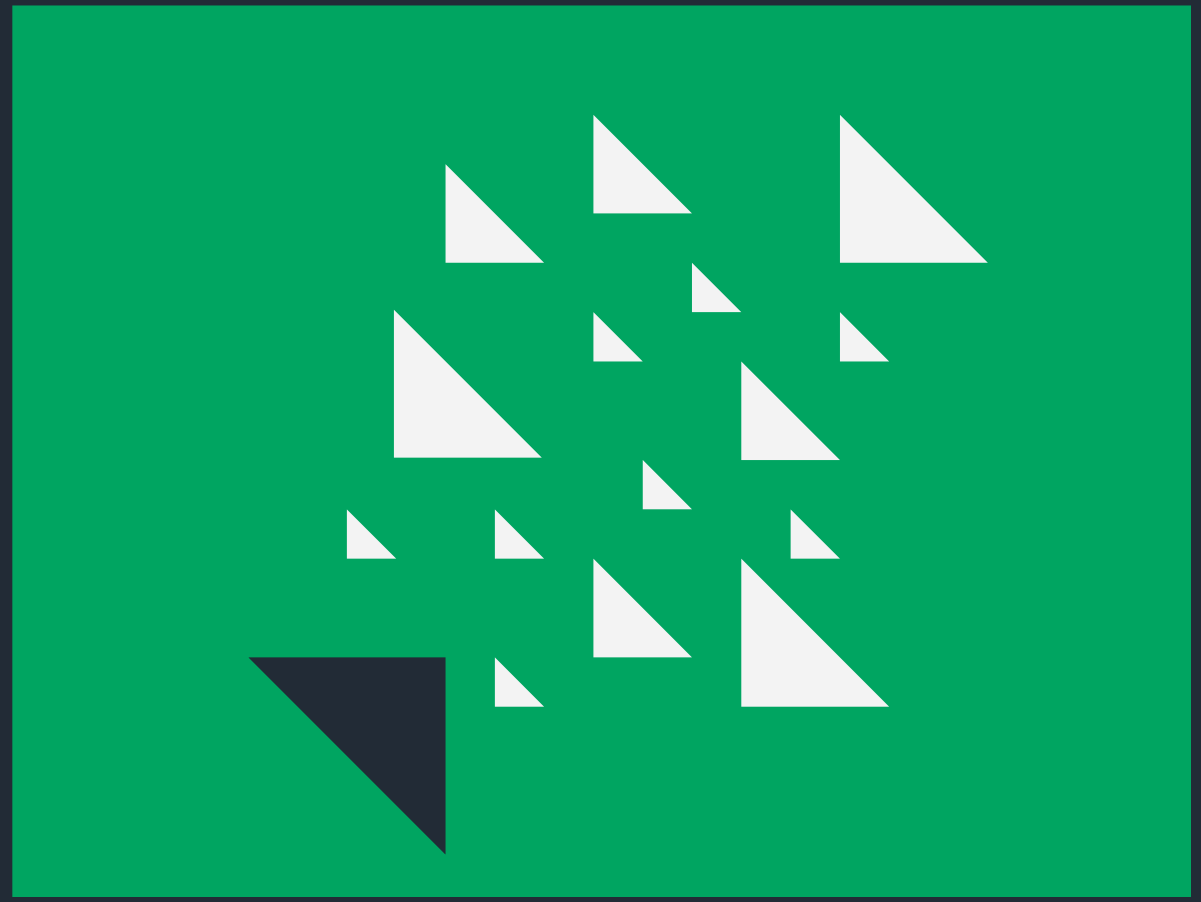
Depends on the purpose of the analysis.

Basic scope factors:

- Geographic area (e.g., rural areas in a state),
- Line of business (e.g., Medicaid),
- Performance period (e.g., CY2023).

Advanced scope factors:

- Non-Medicare services
- Claims runout period
- Denied claims
- Capitated services
- Claims with third-party payments



Services not covered by Medicare

Non-Medicare payers and some Medicare Advantage 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
- Non-emergency transportation services
- Custodial care nursing facility service
- Long-term home and community-based services

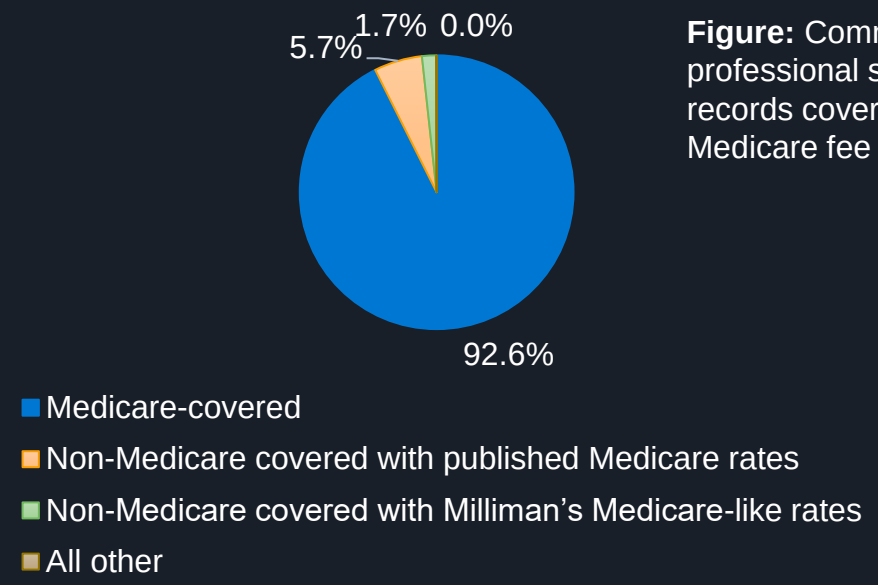


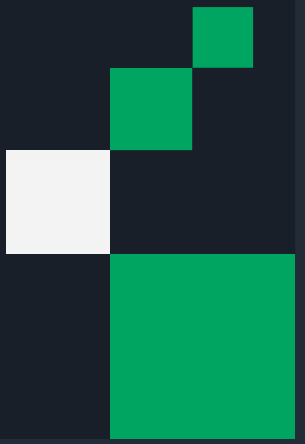
Figure: Commercial professional service line records covered by Medicare fee schedules

Actual payments

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.

Special case / adjustment considerations:

- Separate payment adjustments, e.g., collectability, late fees, or settlements
- Payments outside the claim system, e.g.:
  - prescription drug rebates and remunerations
  - Medicaid supplemental payments
  - Pay for performance arrangements
- Capitation payments



Medicare payments

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). It is important to clearly define how each Medicare payment component is considered in the process for assigning Medicare payments

Special case / adjustment considerations:

- IPPS payment components: IME, DSH, UCC, …
- Services not covered by Medicare
- Medicare relative weights reflect a Medicare population
- Medicare coding requirements
- Alternative methods to assign Medicare payments

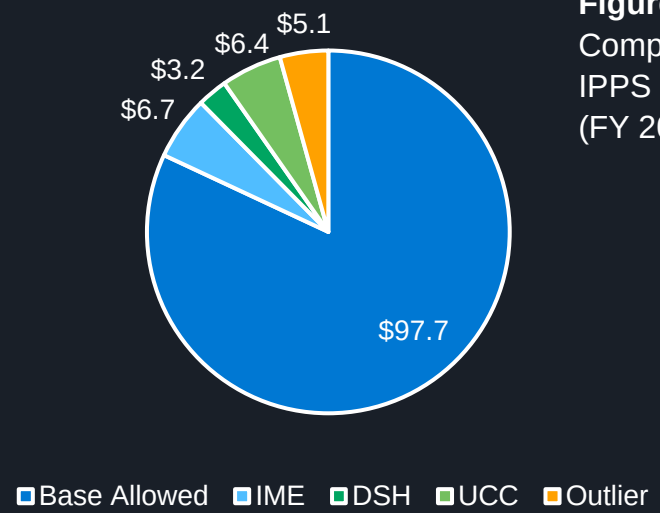


Figure: Components of IPPS payments (FY 2021, $B)

Additional considerations

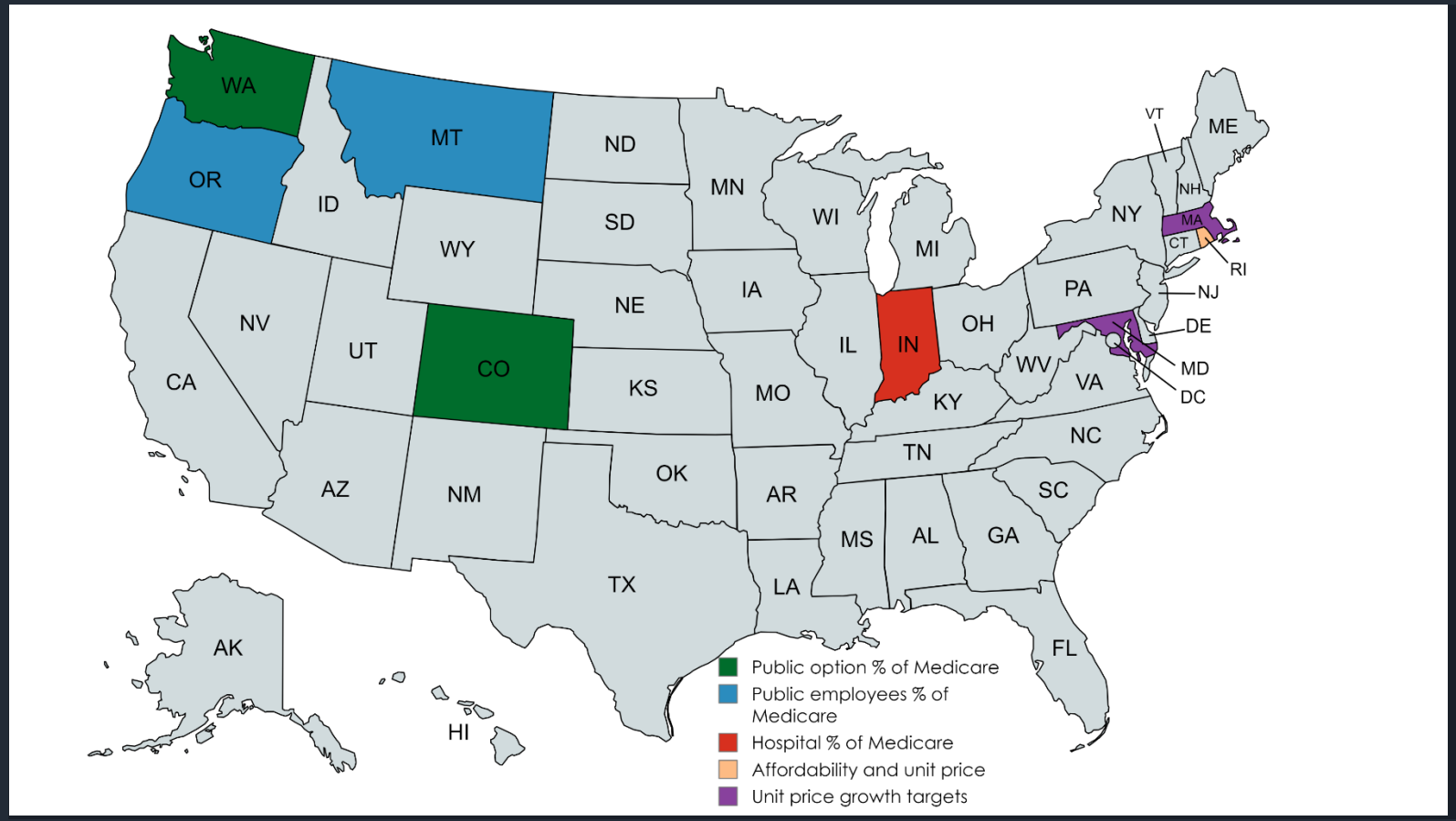
1. **Leveraging existing processes:** Existing processes may exist to collect detailed claims and encounter data, and to deliver reports to stakeholders. Understand how these process may align with the data elements and distribution methods needed to calculate and report percent of Medicare.

2. **Presentation context and intended use:** Understanding how the percent of Medicare statistics will be presented and used is critical for defining the decision points discussed in this presentation.

3. **Medicare Alternative Payment Models (APMs):** An increasing share of Medicare program payments run through Medicare Advantage and APMs. In 2023, the Medicare program did not have full financial risk for providing healthcare coverage to over two thirds of Medicare beneficiaries: most Medicare beneficiaries were enrolled in a Medicare Advantage plan, and of the 29.2M beneficiaries in traditional fee-for-service Medicare (i.e., not in Medicare Advantage), 13.2M beneficiaries, or approximately 45%, are assigned to an Accountable Care Organization (ACO).

https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/
https://www.cms.gov/newsroom/press-releases/cms-announces-increase-2023-organizations-and-beneficiaries-benefiting-coordinated-care-accountable
https://www.ahip.org/news/articles/new-hcp-lan-survey-results-show-increase-in-adoption-of-alternative-payment-models

State examples of unit price controls



WA: Cascade Care

CO: Public option

OR and MT: % of Medicare caps for public employee plans.

Indiana: Hospital % of Medicare limited to 285%

MA: Health care spending growth targets

MD: All payer model that sets growth targets and regulates hospital prices

RI: Affordability standards, including a cap on annual price increases for inpatient and outpatient services.

https://www.kff.org/health-costs/report/price-regulation-global-budgets-and-spending-targets-a-road-map-to-reduce-health-care-spending-and-improve-affordability/

https://www.ncsl.org/health/state-actions-to-control-commercial-health-care-costs

Oregon Health Care Authority

Oregon Educators Benefit Board
Public Employees Benefit Board

Service	% of Medicare Cap
In-network hospital	200%
Out of network hospital	185%

Senate Bill 1067 (2017 Regular Session) established a cap on PEBB/OEBB health benefit plan claims payments for inpatient and outpatient hospital services

- Effective: 2019
- Included: in and out of network fee for service (FFS) payments for hospital services
  - Non-FFS (e.g. capitation, VBP) must demonstrate actuarial compliance with these caps.
- For each hospital, carrier or TPA must refund payments above the % of Medicare cap
- Definition of Medicare: amount paid by Medicare for the claim

Excluded:

- Non-Medicare covered services
- Ambulatory surgical centers
- Specific rural hospitals
  - type A and B per ORS 442.470
  - Rural critical access hospitals
  - Hospitals located in counties with less than 70,000 residents and with 40% of annual patient revenue from Medicare (calculated annually using Oregon APCD)

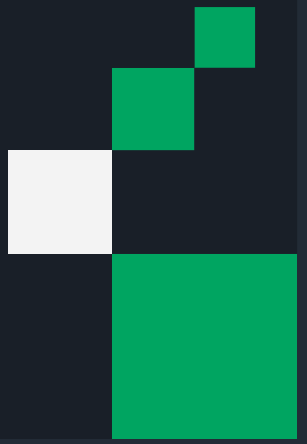
Sources: https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB1067

https://www.oregon.gov/oha/OPEBB/MeetingDocuments/IW-Attachment-3-OEBB-PEBB-Rules-Related-to-Hospital-Payments.pdf

Oregon Health Care Authority

Oregon Educators Benefit Board
Public Employees Benefit Board

- Note that 200% of Medicare limit for PEBB is based on actual Medicare payments for the same service so it would include Medical Education, Disproportionate Share, and Uncompensated Care payments
- There may be variations in how the payers interpreted the 200% limit and negotiated rates with each hospital.
- The add-on payments above may or may not have been included, but we generally expect add-ons would be included.
- Outlier payments may not match Medicare methodology and may result in higher commercial payments.
- Carve-outs for new technologies, high-cost implants and drugs may not match Medicare and may result in higher payments.



Public Purchasing Guarantees

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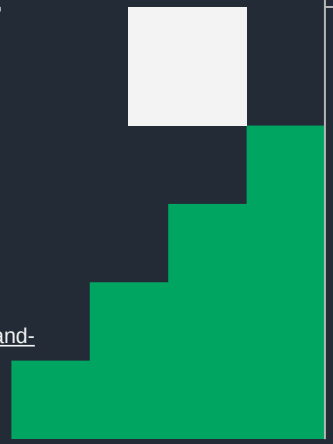
Cascade Care

Washington State Health Care Authority in conjunction with Washington State Health Benefit Exchange

Cascade Select is a legislated 'public option' program which works to guarantee the level of network unit cost for Washington plans on the individual market



Link to:
https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf?q=20220203164635

https://www.hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option

Enabling Legislation

(ESSB 5526 and SB 5377)

Cascade Care

- Standard Plan designs

Cascade Select

- Unit Cost Containment[1]

Unit Cost Containment

Medical Cost Percent of Medicare Limits:

- No more than 160% Statewide
- No less than 135% for Primary Care

Purchasing Goals

Increase availability of quality, affordable health care coverage in the individual market

Statewide Aim

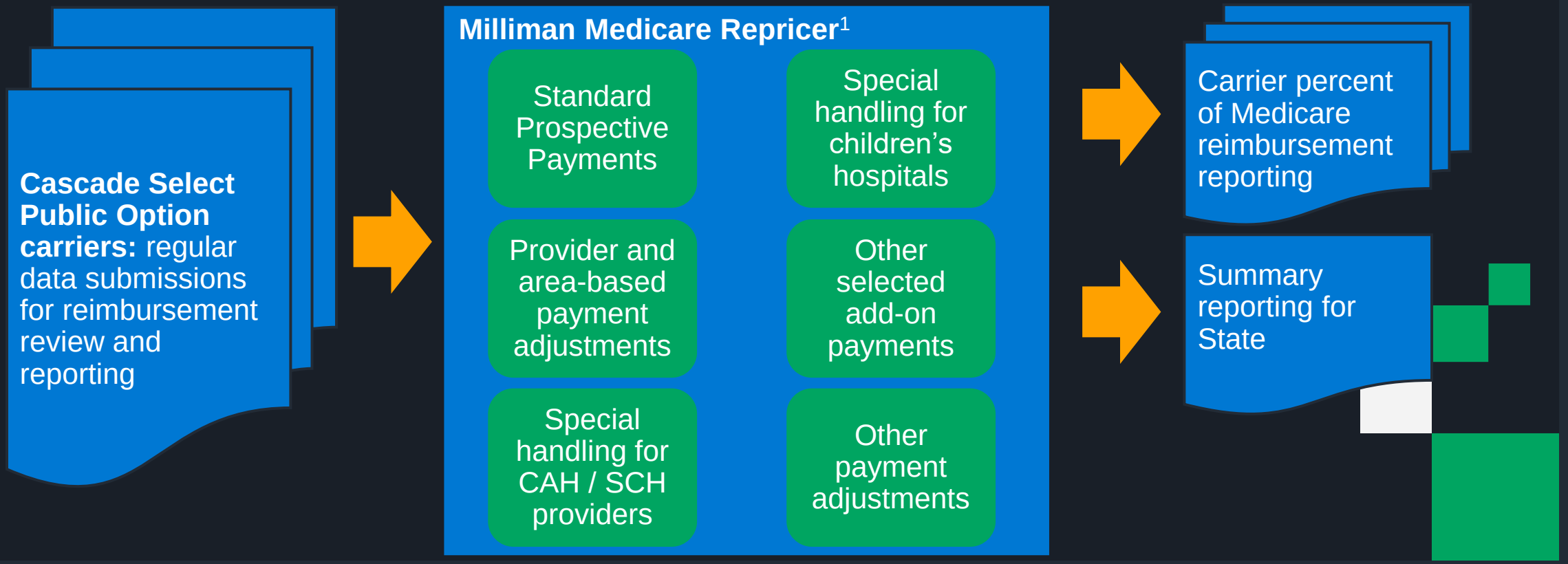
For 2024, 37 out of 39 Counties have a Cascade Select option

Enrollment for 2024 has continued to grow.

Cascade Care

Washington State Health Care Authority in conjunction with Washington State Health Benefit Exchange

Provider Reimbursement Requirement Evaluation Process



(1) Medicare Repricer reimbursement calculations are tailored to program-specific needs including selecting which Medicare add-on payments are included, handling of claims with data limitations, etc.

Cascade Care

Washington State Health Care Authority in conjunction with Washington State Health Benefit Exchange

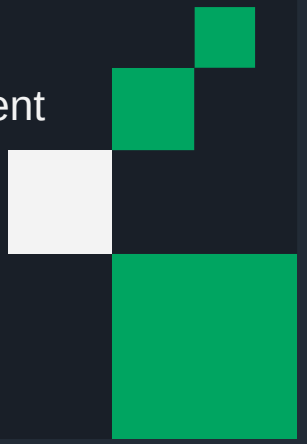
Carrier renewal and (re)procurement considerations

Procurement evaluation criteria (by rating area)

- Evaluation generally performed at a Rating Area-level
- Consumer access in all/expanding list of Washington counties
- Consumer affordability, evaluated by plan premium, relative to other plans available in the same areas
- Value based purchasing and other quality of care improvements
- Other considerations including county interdependencies (e.g., provider network requirements)

Carrier bidding/renewal considerations

- Provider contracting including the legislative requirement that hospitals contract with at least one Cascade Select carrier
- Competitive bidding based on carrier county coverage and premium rates
- Potential corrective action if reimbursement requirements are not met
- Impacts on commercial and other net-work reimbursement rates
- Administrative burden and margin



Uniform Medical Plan Classic: Four Component Trend Guarantee

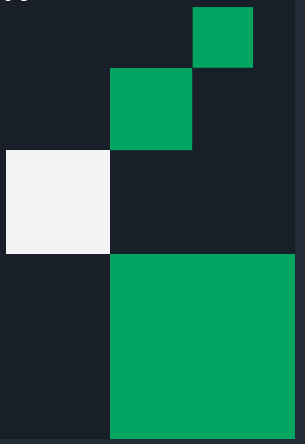
Washington State Health Care Authority self-funded health plan, medical trend-based performance guarantee

Performance Guarantee related year over year medical trend

Components bid during procurement

- Unit Cost Margin Guarantee
  - Represents the vendor's outlook on unit cost increases more than the Medicare Benchmark
- Utilization Margin Guarantee
  - Represents the vendor's outlook on utilization increases more than the Risk Score Benchmark

These two components were to capture vendor outlook into the future with alternatives for if the performance guarantee were missed to reset expectations for future years.



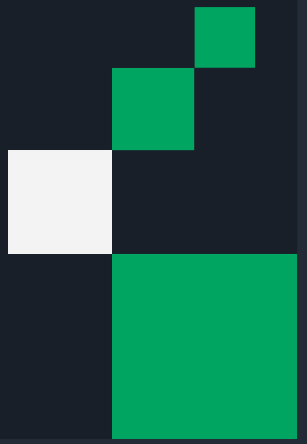
Uniform Medical Plan Classic: Four Component Trend Guarantee

Washington State Health Care Authority self-funded health plan, medical trend-based performance guarantee

Performance Guarantee related year over year medical trend

Calculated Components during Reconciliation

- Unit Cost Benchmark Trend
  - Medicare Repricing of both the base and the performance year to measure change in the Medicare Fee Schedule from the base to the performance year.
  - Maximum of the two measured outcomes.
- Utilization Benchmark Trend
  - Milliman Advanced Risk Adjusters are used for a concurrent evaluation of both the base and performance year populations
  - Percentage change in the risk score is the benchmark of utilization



Uniform Medical Plan Classic: Four Component Trend Guarantee

Washington State Health Care Authority self-funded health plan, medical trend-based performance guarantee

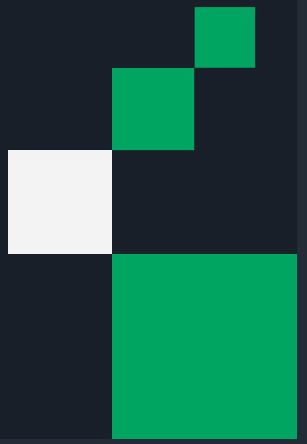
Performance Guarantee related year over year medical trend

Guarantee Level of Performance Year Medical Allowed Cost:

Base Year Allowed Cost
x Unit Cost Benchmark Trend
x Unit Cost Margin Guarantee
x Utilization Benchmark Trend
x Utilization Margin Guarantee

Performance Year Allowed Cost Target

Actual Allowed Cost below Performance Target satisfies Performance Guarantee



Indiana Department of Insurance Benchmarking

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Indiana House Bill (HB) 1004

Oversight of Health Care Costs (key components)

- Department (of insurance) to calculate the commercial prices as a percent of Medicare for hospital inpatient, hospital outpatient, and practitioner services for Indiana non-profit hospitals.
- Data submission process is to be defined by the department.
- Show total difference with 285% of Medicare allowed.
- Calculations completed before November 1, 2024 (and annually thereafter) - report due December 1.

Note that the legislation only specified that the analysis is performed, NOT how the results will be used.

Medicare Definition

- Legislation was not specific regarding what components of the Medicare amount to include.
- These can be very impactful:
  - **IPPS Components as a % of Total IPPS Payment**

Component	Nationwide	Indiana
Outlier	4.2%	3.3%
DSH + UCP	11.2%	9.2%
IME	6.4%	6.7%

- *DSH: Disproportionate Share Hospital payments*
- *UCP: Uncompensated Care payments*
- *IME: Indirect Medical Education payments*

Milliman recommendation was to provide two versions:

1) A "full" Medicare with all adjustments (used as the key statistic), and
2) A more comparable version with multiple hospital-specific adjustments removed.

Other Medicare Differences Impacting Analysis

Geographic Variation Example

2022 Medicare PPS Area Relativity

Service	PPS	Nationwide	Indiana
Inpatient	IPPS	1.000	0.917
Outpatient	OPPS	1.000	0.967
Professional	PFS	1.000	0.955
Total	Combined	1.000	0.947

- *Medicare PPS Area Relativity: Relativity of fully loaded Medicare payments for a specific area to the national average.*
- *Includes Sole Community Hospital and Medicare Dependent Hospital adjustments.*
- *Does not include CAHs or HPSA adjustments.*

All values are approximate estimates and will vary based on service and provider mix.

Sources: Milliman *Medicare Repricer* and *Commercial Reimbursement Benchmarking Model*

Other Medicare Differences Impacting Analysis

Payer unit price trend expectations

Unit price and mix trends from Small Group ACA filings

		2021 Rate Filing		2022 Rate Filing		2023 Rate Filing	
Area	ServiceType	2019 to 2020	2020 to 2021	2020 to 2021	2021 to 2022	2021 to 2022	2022 to 2023
Indiana	Inpatient	3.1%	3.1%	3.7%	2.8%	3.4%	3.7%
	Outpatient	3.0%	3.0%	2.8%	2.9%	4.1%	4.0%
National	Inpatient	3.3%	3.3%	3.7%	3.2%	4.0%	4.0%
	Outpatient	3.3%	3.5%	3.4%	3.1%	3.4%	3.4%

Sources: URRT Public Use File (PUF) data. Represents payer best estimates as of spring 2022. Includes the impact of service mix.

Other Medicare Differences Impacting Analysis

Medicare Reimbursement Trends and CPI

Index	Service Type	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
Medicare Unit Price (Indiana)	**IPPS**	2.0%	2.7%	1.8%	3.1%
	OPPS	1.0%	2.9%	1.1%	2.6%
Medicare Unit Price (Nationwide)	**IPPS**	3.0%	2.7%	1.8%	1.1%
	OPPS	1.3%	2.4%	1.6%	4.7%
CPI	**Inpatient**	4.2%	1.7%	4.1%	3.3%
	Outpatient	3.1%	2.0%	2.4%	3.9%

IPPS and OPPS trend estimates are based on the Milliman IPPS/OPPS Trend Model. Trends reflect the Indiana state average and include wage index and other provider-specific adjustments (DSH, IME, UCP).

Actual IPPS and OPPS unit price trends for individual hospitals may vary significantly from what is shown above.

CPI reflects January to January trends from the inpatient hospital services and outpatient hospital services series from the BLS. Series IDs: CUSR0000SS5702; CUSR0000SS5703

Case Study: Colorado Option

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Colorado Option – ACA Individual and Small Group

Starting in 2024, the Colorado Division of Insurance is required to enforce premium rate reductions for Colorado Option subsidized plans. If the commissioner determines that the cost of providing care by certain hospitals and/or health care providers was a cause for a carrier missing the premium requirements, the commissioner can set the hospital/providers reimbursement rates so the carrier can meet the premium.

Two New Rate Templates

Purpose to collect information

Detailed Inputs include

- % of Medicare
  - By Provider NPI
  - By Care Setting

Medicare Repricer

Process client data

Line level detail

- Summarize data to populate templates
  - Attestation Required

Rate Filing Submitted

Regulatory requirements met

Ongoing reporting and contracting support

- Hospital Specific Reimbursement Floors

Source: BY24 CO Option Cost of Care Data Template and BY24 CO Option Negotiated Rate Template

How Milliman Can Help You

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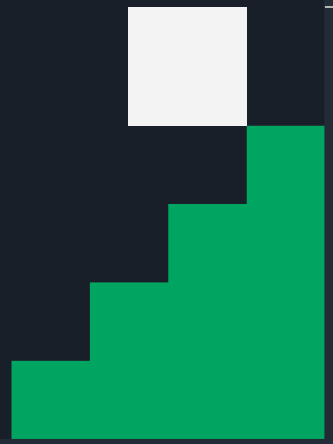
Medicare fee schedules

Milliman has a complete software solution for pricing claims to Medicare allowable fees and can price the claims that fail to adjudicate under the Medicare fee schedules.



- Inpatient Prospective Payment System (IPPS)
- Skilled Nursing Facility (SNF) PPS
- Inpatient Psychiatric Facility PPS
- Inpatient Rehabilitation Facility (Rehab PPS)
- Long-Term Care Hospitals (LTCH)

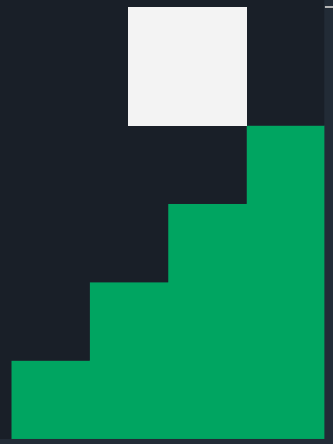
- Outpatient Prospective Payment System (OPPS)
- Critical Access Hospital (CAH) interim payments
- Ambulatory Surgery Center (ASC)
- Dialysis Facility (ESRD) PPS

- Physician RBRVS
- Ambulance
- Clinical Lab
- Parenteral and Enteral (PEN)
- Durable Medical Equipment & Prosthetics (DME-POS)
- Anesthesia

- Average Sales Price (ASP) drug fee schedule
- Home Health
- Maryland Waiver Hospitals

Medicare fee schedules

- Batch Processing
- Individual Claim Pricing



1. **Standalone .NET**

2. **MedInsight**

3. **Cloud**

4. **Web Portal**

Q&A

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Q&A

We are happy to answer your questions now with the Q&A chat within Zoom, but if you would rather follow up with send us an email, please feel free to contact any of us below.

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Thank you

Any additional questions can be sent to:
medicarepricersupport@milliman.com