Cascade Care Medicare Pricing Methodology

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Prepared for:
Washington State Health Care Authority

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At the request of Washington Health Care Authority (HCA), Milliman has prepared this 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 has developed 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 methodology for determination of the Medicare reimbursement amounts specific to Cascade Care.

This report has been prepared for Washington State Health Care Authority and is subject to the terms and conditions of the contract with Milliman. It is our understanding that the information contained in this report will be utilized in a public document. This report should be distributed in its entirety. Any user of this information should possess a certain level of expertise in health care and Medicare reimbursement so as not to misinterpret the methodology 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 the Washington State 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.

I. BACKGROUND

On May 13, 2019, Washington State 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, for the commercial individual healthcare market. Private insurers or health carriers will offer standardized health insurance plans to individuals through the HBE for coverage effective January 1, 2021.

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

1. The total amount a health plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 160% of the total amount Medicare would have reimbursed providers and facilities for the same or similar services.
2. For services provided by rural hospitals certified by CMS as critical access hospitals or sole community hospitals, the rates may not be less than 101% of allowable costs as defined by CMS for purposes of Medicare cost reporting.
3. Reimbursement for primary care services, as defined by HCA, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than 135% of the amount that would have been reimbursed under the Medicare program for the same or similar services.

This report details our method to assign Medicare, or similar, prices to commercial claims for the purposes of estimating the listed reimbursement requirements.

Prices similar to Medicare allowed amounts are developed and assigned in cases where Medicare does not specify reimbursement for certain medical services, such as child immunization, which are more common in the individual health insurance market. Similar prices are also assigned when claims data are not sufficient to price using the Medicare methodology, such as in the case of bundled dialysis

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

payments. The process for developing similar prices and under what circumstances such prices are applied is described in greater detail in sections III and IV. With these complications and constraints in mind, the 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 exhaustive as it only provides an overview of the approach used to identify appropriate Medicare payments. Milliman also collected current individual health carrier data to evaluate the percentage of claims for which the described methods are applicable and the small percentage of claims for which we are unable to assign a Medicare or similar price. Based on this sample, we assessed the methodology to be a reasonably complete representation for the purpose of evaluating the statewide aggregate level of reimbursement and determined that excluding those claims without a Medicare or similar price would not have a significant impact on the reported results.[2]

II. MEDICARE PRICING METHODOLOGY OVERVIEW

Our methodology aims to evaluate whether a 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 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 remainder 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

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

For almost all 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.

Medicare also 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. Some of these payments are included and discussed in Section V. Certain other Medicare payments and adjustments are either not generally considered a standard part of Medicare paid amounts or conflict with other proposed HCA payment requirements relating to Cascade Care. These payments are excluded and discussed in Section VI.

While we try to have a methodology to assign all claims a Medicare or similar allowed amount, medical claims data inevitably have some data quality issues. Section VII discusses our approach to handling these data quality issues.

[2] This data was also used to evaluate the current reimbursement levels in the State of Washington for Health Benefit Exchange plans and validate the Medicare repricing methodology outlined in this document.

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 at an inpatient facility, at an outpatient facility, or was a 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. Fee schedules under for the CMS Prospective Payment Systems are published and described in further detail on the CMS website[3].

The pricing of Medicare allowed amounts uses the fee published by CMS as of the beginning of the federal fiscal year (FFY) for the Cascade Care calendar year being priced. CMS may update these values throughout the FFY. In order to reduce administrative burden, our Medicare allowed amounts do not reflect these interim updates. The initial Medicare schedules for the FFY is 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 classify claims as inpatient facility claims if they have a revenue code indicating the patient had a 'room and board' service. 'Room and board' revenue codes include the values within the range 0100 to 0219, and also 0022 and 0024.

b. The acute inpatient facility claims incurred during the entire admission are grouped together and assigned a Medicare Diagnosis Related Grouping (MS-DRG) hospital episode category. 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 facility's Medicare ID (also known as OSCAR ID or CMS Certification Number). 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 acute 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 assign 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 are not 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 Medicare ID code to identify the provider, we assign a Medicare reimbursement amount based on the Seattle-area average for that MS-DRG.

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

a. We classify claim lines as outpatient if they have a valid revenue code and if the claim line is not classified as inpatient or professional.

[3] 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

b. We assign the procedure codes an initial Medicare allowed amount using Medicare's 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 Medicare ID. For claims where there is not a valid Medicare ID or other area identification provided by the plan, we assume the provider is located in Seattle.

c. We apply standard OPPS adjudication rules.

d. For outpatient procedure codes that are not on the current Medicare fee schedule, we assign a Medicare allowed amount based on one of two methodologies:

   i. We have developed crosswalk of historical HCPCS for services that are in use currently based on information from the AMA and CMS. For example, the Evaluation and Management (E&M) coding from prior years could be left in place for commercial reimbursement. We also map any deleted HCPCS/CPT codes to a current HCPCS/CPT code when a clear mapping is available. This first approach is our attempt to ensure consistency to historical Medicare payment levels even if the HCPCS/CPT code is no longer active for CMS.

   ii. For services without a clear mapping within the Medicare fee schedules, we select a service with similar resource usage as measured by the Milliman Global RVUs.[4] Attachment A-1 includes the published list of outpatient procedure codes that are not covered by Medicare and the corresponding similar resource intensity 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 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. For claims where there is not a valid provider location, we assume the provider is located in Seattle.

d. Similar to Section d of the outpatient methodology above, for professional procedure codes that are not on the current Medicare fee schedule, we assign a Medicare allowed amount based on one of two methodologies:

[4] Only codes with aggregate allowed amounts across all carriers of greater than $25,000 are remapped for the purposes of this process.

i. We have developed crosswalk of historical procedure codes for services that are in use currently based on information from the AMA and CMS. The example of E&M coding is still relevant. We also map deleted HCPCS/CPT codes to a current HCPCS/CPT code when a clear mapping is available. This first approach is our attempt to ensure consistency to historical Medicare payment levels even if the HCPCS/CPT code is no longer active for CMS.

ii. For procedure codes without a clear mapping within the Medicare fee schedules, we select a service with similar resource usage as measured by the Milliman Global RVUs.[5] Attachment A-2 includes the published list of professional procedure codes that are not covered by Medicare and the corresponding similar resource intensity service being used for Medicare assignment.

B. PAYMENTS FOR PROVIDERS PAID AS PERCENT OF COST

For cancer hospitals, children's hospitals, critical access hospitals (CAH), sole community hospitals (SCH), and rural health clinics (RHC), Medicare reimburses providers as a percentage of their reported cost:

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

Some of these facilities are identified by the third and fourth digits of their Medicare IDs. The third and fourth digit for children's hospitals is 33 and for CAHs it is 13. The one Washington designated cancer center is the Seattle Cancer Care Alliance (also known as Fred Hutchinson/University of Washington Cancer Consortium). Per the Cascade Care enabling legislation, SCHs must be paid at least 101% percent of cost. These facilities are identified based on the provider type reported in the CMS Provider Specific File[6]. RHCs are also defined by the third and fourth digits of their Medicare IDs that may be 34, 38, 39, or in the range 85 through 89.

The CMS published Medicare cost-to-charge ratio (CCR) is used to assign the Medicare allowed cost. For percent of cost-based payments, the Medicare cost is calculated as follows:

$$\text{Medicare Cost} = (\text{Billed Amount}) \times (\text{Provider's Inpatient or Outpatient CCR}).$$

The CCR published for 2018 relates to 2016 cost settlement activities. For Cascade Care we assume that the charge master increases reflect the subsequent cost settlement activity and have not applied any further changes in trend. Please see Attachment B for the list of these facilities and the corresponding CCR for 2018 services[7]. This Attachment requires annual updates to reflect the CCR to each year under evaluation.

C. OTHER NON-ACUTE PROVIDERS

Skilled nursing facilities (SNF) are paid based on Resource Utilization Groups (RUG) that identify both the services provided to patient and the patient's characteristics. SNF claims are identified as those claims with the presence of Revenue Code 0022 and are paid based on the standard Medicare SNF

[5] Only codes with aggregate allowed amounts across all carriers of greater than $25,000 are remapped for the purposes of this process.
[6] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_text
[7] Note that Attachment B does not include a list of all Sole Community Hospitals or their corresponding CCRs.

payment methodology.[8] Those SNF claims that lack either Revenue Code 0022 or a RUG assignment are not included in the repricing. In general, this exclusion is relatively small as SNF claims comprise only a small percentage of the total claim volume provided by the plans.

The plan data, collected for the purposes described in Section I, was analyzed to determine the presence of other provider types. A very small percentage of the data (approximately 0.2% of total allowed dollars) was attributable to psychiatric hospitals, rehabilitation, hospice, and LTC facilities. Due to the complexity of the payments for these services, the lack of available data (e.g. for rehabilitation payments, patient assessment information is required but is not available), and the immaterial impact exclusions have on the overall analysis, claims occurring at facilities of the types following are excluded:

1. Psychiatric Hospitals
2. Rehabilitation Centers
3. Hospice Facilities
4. Long Term Care (LTC) Facilities

IV. SERVICES WITH ALTERNATIVES TO MEDICARE PRICING

1. Outpatient Dialysis

Medicare payments for outpatient dialysis bundled payments are determined by the CMS ESRD PC Pricer. It accounts for each patient's characteristics and various comorbidities and applies an outlier logic. Data for patients' characteristics and their comorbidities are not easily available. We therefore approximate the dialysis bundled payment amounts assuming an average patient profile. We are not applying outlier payments.

Attachment C outlines the patient characteristics and how they are included in the development of the standardized base rate employed in this repricing. Each of these components are derived from publicly available reports including the 2008 ESRD PPS report to congress[9] for the composite comorbidity factor and the United States Renal Data System[10] for the composite age factor. The other adjustments factor is based on a comparison of expected to reported facility payments as in CMS-1674-F's facility impacts[11].

2. Sole Community Hospitals

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 employ cost-based rates for these providers as well.

3. Federally Qualified Health Clinics (FQHC)

Services performed at FQHCs are priced according to the PPS logic described above.

[8] SNF PPS payment information may be found at the following CMS site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index
[9] See (page 29): https://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDGeneralInformation/Downloads/ESRDReportToCongress.pdf
[10] See patient characteristics: http://www.usrds.org/reference.aspx
[11] See CMS's Final Rule for ESRD PPS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices-Items/CMS-1674-F

V. MEDICARE PAYMENTS INCLUDED IN METHODOLOGY

Certain additional payments that Medicare makes in order to fund and incentivize the healthcare system are included in our calculation of a Medicare allowed amount. Those included payments are itemized here.

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. These payments are included in our estimated Medicare payments.

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. These payments are included in our estimated Medicare payments.

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. These payments are included in our estimated Medicare payments.

VI. MEDICARE PAYMENTS EXCLUDED IN METHODOLOGY

In addition to the fee schedule based reimbursement that Medicare pays providers and the payments listed above, there are additional payments that Medicare makes in order to fund and incentivize the healthcare system. Some of these payments are 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. 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. Our methodology does not apply an adjustment for any provider risk-sharing programs.

2. 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 do not make any sequestration adjustment, and reflect the full fee schedule amount before any sequestration.

3. 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 performs similar review of their claims that Medicare currently performs.

4. 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 do not price services using a bundled payment methodology, but instead use a fee-for-service basis to assign the Medicare allowed amount.

5. 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%[12]). Our methodology does not include an adjustment for these additional payments.

6. Capital payments for new hospitals

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

7. 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

8. 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.

VII. DATA QUALITY EXCLUSIONS

In order to ensure that the data is high quality and represents the Cascade Care population, we have applied exclusions as necessary for the assignment of Medicare allowed amounts. We have excluded claim and membership records for the following reasons:

Member-Based Exclusions:

1. Members who are over age 65 are excluded.

[12] See https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0

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

Date-Based Exclusions:

1. Membership records and claims outside of the calendar year are excluded.

   For example, when repricing 2018 claims, membership eligibility records must be from months in CY2018. Claims must have date of service in CY2018 and date of payment no later than June 30th 2019.

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 (Medicare ID) are excluded.

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

3. SNF claims lacking either Revenue Code 0022 or RUG assignment are excluded.

   SNF claims are identified using Revenue Code 0022 and RUG assignment is required to calculate their payments. See Section III-C for more detail.

4. Psychiatric Hospital, Rehabilitation Center, LTC Facility, Hospice Facility claims are excluded.

   These claims are excluded due to lack of accurate and reliable pricing and their immaterial volume. See Section III-C for more detail.

5. Facility inpatient claims with ungroupable MS-DRGs or facility outpatient and professional claims with invalid procedure codes are excluded.

   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.

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

   In order to ensure sufficient data quality in the comparison values of the insurers' 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 less than 0.03 or greater than 2.00
   - 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

VIII. 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 is 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 are 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, Peter Hallum, 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.

Appendix A-1
Cascade Care
Non-Medicare Priced HCPCS
Outpatient Services Remapping

Note: *HCPCS remapped based on RVU (a measure of service resource requirements) not based on service type.*

Original HCPCS	Remapped HCPCS
27130	20973
H0035	33263
S9480	11621
C9031	20973
J0604	92953
Q5103	15278
77059	11771
80050	29720
C9467	15842
59400	78647
27702	20973
23472	20973
S9131	92014
Q5006	62360
90993	28308
G0299	70260
63267	20973
99601	45317
G0151	96542
J7298	73202
58150	20973
58300	26010
99199	23107
15758	20973
S1090	69715
32663	20973
27486	20973
27244	20973
27535	20973
H0015	96405
H2013	57300
L8680	
S9123	G0249
27536	20973
50545	20972
71555	12055
21196	69970

Appendix A-2
Cascade Care
Non-Medicare Priced HCPCS
Professional Services Remapping

Note: *HCPCS remapped based on RVU (a measure of service resource requirements) not based on service type.*

Original HCPCS	Remapped HCPCS
99396	28510
99386	27570
99395	11042
S9123	20605
99385	11952
99199	27767
J7298	28312
77385	21014
H2014	76977
A9276	76977
99391	93463
77412	11644
99392	11100
Q5001	50686
Q5103	20979
0365T	94640
99393	45321
J7207	71110
99394	70450
90651	20611
99244	78700
92015	44500
80050	57150
97811	15272
J7307	28104
77386	33213
97810	G0288
H2019	44500
90750	38211
90868	45332
77523	20972
58300	59200
99383	58340
A4230	72125
99384	38200
90734	78140
H0032	17315
98943	70030
J7300	41017
99243	57420
0369T	11055
G0151	17004
99245	69005
A9277	37212
S9500	20551
J3490	36591
G0493	27767

Appendix A-2
Cascade Care
Non-Medicare Priced HCPCS
Professional Services Remapping

Note: *HCPCS remapped based on RVU (a measure of service resource requirements) not based on service type.*

Original HCPCS	Remapped HCPCS
99601	53025
97814	73560
99382	20931
H2017	94664
SH998	10022
55970	37244
A9274	92145
J3590	37237
90710	16025
97813	92561
99381	10040
G0299	19297
S9367	64425
90680	29425
J1744	28070
77387	51705
97014	51736
S9366	17111
90716	12001
E0603	90846
0364T	Q0035
90698	20527
H0020	93270
A4223	64405
J0714	70492
S2068	21127
E0486	23450
S9124	36425
99255	69433
92551	G0473
99602	70310
S9502	36440
99397	49400
99254	52000
S9379	20979
A9552	10080
G0152	54250
J7209	92953
S9342	G0445
A9278	19396
99442	36592
J7301	27768
J1726	G0444
0502F	92325
96040	51702
0368T	36620
J2182	G0444

Appendix A-2
Cascade Care
Non-Medicare Priced HCPCS
Professional Services Remapping

Note: *HCPCS remapped based on RVU (a measure of service resource requirements) not based on service type.*

Original HCPCS	Remapped HCPCS
J7296	19328
90707	G0279
90723	29581
90736	55870
A4351	92953
A4352	96160
94799	64405
90633	90849
J7297	33264
A6549	19284
K0108	G0120
V2520	65222
G0399	15157
0297T	11044
01996	G0442
99441	G0278
81479	52283
T2042	50390
77525	20972
S9501	15852
Q5002	72125
S9126	41105
99253	11310
17380	51700
S9374	70110
G0155	11983
99242	90834
E0604	G0421
B4161	58263
90696	G0117
0295T	36476
95941	11302
77062	11055
99387	19030
77522	42892
92310	72240
V2702	73030
G0153	42831
S9325	20979
G0157	15152
97799	15775
0372T	G0422
90620	29505
77399	29035
A9502	38211
S9338	92562
A4232	89230

Appendix A-2
Cascade Care
Non-Medicare Priced HCPCS
Professional Services Remapping

Note: *HCPCS remapped based on RVU (a measure of service resource requirements) not based on service type.*

Original HCPCS	Remapped HCPCS
Q0508	G0101
S5180	92561
A9500	11730
G0463	43205
49999	37228
E0118	G0513
S9351	70150
V2599	64492
98967	36592
B4157	67420
55980	37229
H0031	11922
E0445	54800
G0300	54250
90700	70140
90636	73525
S9999	G0404
E2617	36252
99024	70355
0037U	37223
S9061	77790
0500F	15274
0359T	46500
A4927	94760
E2609	54352
99429	51784
S0620	G0245
27216	27105
A9541	11042
90378	77615
S9359	70200
A9572	32998
77061	71110
A6251	16000
99443	51605
S0073	29365
44799	95810
90867	26170
90647	G0296
G0156	59025
96110	G0329
99401	70310
A9562	12020
0346T	20931
Q5005	21451
49329	58770

Appendix B
Cascade Care
Percent of Charge Facilities (CCR Payment Basis)

Note: Facilities without CCR information will have Medicare Allowed calculated using PPS.

Medicare ID	Facility Name	Facility Type	Cost to Charge Ratio Inpatient	Cost to Charge Ratio Outpatient	Cost Coverage
381317	ADVENTIST HEALTH TILLAMOOK	Critical Access Hospital	0.636	0.620	101%
501319	ARBOR HEALTH MORTON HOSPITAL	Critical Access Hospital	1.000	0.528	101%
521300	ASCENSION EAGLE RIVER HOSPITAL	Critical Access Hospital	0.627	0.353	101%
061324	ASPEN VALLEY HOSPITAL	Critical Access Hospital	0.834	0.675	101%
501330	ASTRIA SUNNYSIDE HOSPITAL	Critical Access Hospital	0.332	0.293	101%
031301	BENSON HOSPITAL	Critical Access Hospital	0.879	0.404	101%
131301	BOUNDARY COMMUNITY HOSPITAL	Critical Access Hospital	1.000	0.719	101%
511300	BROADDUS HOSPITAL ASSOCIATION, INC	Critical Access Hospital	1.000	0.617	101%
271320	CABINET PEAKS MEDICAL CENTER	Critical Access Hospital	0.842	0.514	101%
501313	CASCADE MEDICAL CENTER	Critical Access Hospital	0.981	0.829	101%
500016	CENTRAL WASHINGTON HOSPITAL	Sole Community Hospital	0.382	0.340	101%
381320	COLUMBIA MEMORIAL HOSPITAL	Critical Access Hospital	0.494	0.379	101%
501308	COULEE MEDICAL CENTER	Critical Access Hospital	0.890	0.646	101%
501311	EAST ADAMS RURAL HOSPITAL	Critical Access Hospital	1.000	0.675	101%
051316	FAIRCHILD MEDICAL CENTER	Critical Access Hospital	0.353	0.414	101%
501322	FERRY COUNTY MEMORIAL HOSPITAL	Critical Access Hospital	1.000	0.561	101%
501301	GARFIELD COUNTY MEMORIAL HOSPITAL	Critical Access Hospital	1.000	1.000	101%
500031	GRAYS HARBOR COMMUNITY HOSPITAL	Sole Community Hospital	0.318	0.166	101%
131327	GRITMAN MEDICAL CENTER	Critical Access Hospital	0.570	0.387	101%
501323	JEFFERSON HEALTHCARE	Critical Access Hospital	0.537	0.440	101%
021309	KANAKANAK HOSPITAL	Critical Access Hospital	1.000	1.000	101%
123300	KAPIOLANI MEDICAL CENTER FOR WOMEN & CHILDR	Children's Hospital	0.368	0.305	100%
500110	KITTITAS VALLEY COMMUNITY HOSPITAL	Sole Community Hospital	0.663	-	101%
501333	KITTITAS VALLEY COMMUNITY HOSPITAL	Critical Access Hospital	0.682	0.467	101%
501316	KLICKITAT VALLEY HOSPITAL	Critical Access Hospital	1.000	0.556	101%
501334	LAKE CHELAN COMMUNITY HOSPITAL	Critical Access Hospital	0.738	0.553	101%
501305	LINCOLN HOSPITAL	Critical Access Hospital	1.000	0.646	101%
501337	LOURDES MEDICAL CENTER	Critical Access Hospital	0.322	0.324	101%
271329	MADISON VALLEY MEDICAL CENTER	Critical Access Hospital	1.000	0.909	101%
503301	MARY BRIDGE CHILDREN'S HOSPITAL	Children's Hospital	0.283	0.283	100%
501336	MASON GENERAL HOSPITAL & FAMILY OF CLINICS	Critical Access Hospital	0.508	0.382	101%
501328	MID VALLEY HOSPITAL	Critical Access Hospital	0.642	0.476	101%
501310	NEWPORT COMMUNITY HOSPITAL	Critical Access Hospital	0.912	0.548	101%
271336	NORTH VALLEY HOSPITAL	Critical Access Hospital	0.629	0.601	101%
501321	NORTH VALLEY HOSPITAL	Critical Access Hospital	0.983	0.539	101%
501314	OCEAN BEACH HOSPITAL	Critical Access Hospital	0.921	0.483	101%
501307	ODESSA MEMORIAL HEALTHCARE CENTER	Critical Access Hospital	1.000	1.000	101%
500072	OLYMPIC MEDICAL CENTER	Sole Community Hospital	0.526	0.413	101%
031304	PAGE HOSPITAL	Critical Access Hospital	0.760	0.348	101%
381316	PEACE HARBOR MEDICAL CENTER	Critical Access Hospital	0.741	0.688	101%
501340	PEACEHEALTH PEACE ISLAND MEDICAL CENTER	Critical Access Hospital	0.958	0.724	101%
500041	PEACEHEALTH ST JOHN MEDICAL CENTER	Sole Community Hospital	0.308	0.290	101%
501329	PEACEHEALTH UNITED GENERAL MEDICAL CENTER	Critical Access Hospital	0.566	0.337	101%
501312	PROSSER MEMORIAL HOSPITAL	Critical Access Hospital	0.506	0.377	101%
500019	PROVIDENCE CENTRALIA HOSPITAL	Sole Community Hospital	0.250	0.174	101%
381318	PROVIDENCE HOOD RIVER MEMORIAL HOSPITAL	Critical Access Hospital	0.713	0.462	101%
021306	PROVIDENCE KODIAK ISLAND MEDICAL CTR	Critical Access Hospital	0.702	0.421	101%
501326	PROVIDENCE MOUNT CARMEL HOSPITAL	Critical Access Hospital	0.700	0.337	101%
381303	PROVIDENCE SEASIDE HOSPITAL	Critical Access Hospital	0.660	0.415	101%
501309	PROVIDENCE ST JOSEPH HOSPITAL	Critical Access Hospital	0.782	0.357	101%
500002	PROVIDENCE ST MARY MEDICAL CENTER	Sole Community Hospital	0.351	0.234	101%
021301	PROVIDENCE VALDEZ MEDICAL CENTER	Critical Access Hospital	0.973	0.799	101%
501331	PULLMAN REGIONAL HOSPITAL	Critical Access Hospital	0.696	0.430	101%
501320	QUINCY VALLEY HOSPITAL	Critical Access Hospital	1.000	1.000	101%
500033	SAMARITAN HOSPITAL	Sole Community Hospital	0.364	0.296	101%
381323	SAMARITAN LEBANON COMMUNITY HOSPITAL	Critical Access Hospital	0.541	0.443	101%
381314	SAMARITAN PACIFIC COMMUNITY HOSPITAL	Critical Access Hospital	0.583	0.484	101%
431329	SANFORD CHAMBERLAIN MEDICAL CENTER	Critical Access Hospital	1.000	0.419	101%
500138	SEATTLE CANCER CARE ALLIANCE	Designated Cancer Center	0.503	0.433	100%
503300	SEATTLE CHILDREN'S HOSPITAL	Children's Hospital	0.344	0.397	100%
131314	SHOSHONE MEDICAL CENTER	Critical Access Hospital	1.000	0.479	101%
503302	SHRINERS HOSPITAL FOR CHILDREN	Children's Hospital	0.642	0.642	100%
501315	SKYLINE HOSPITAL	Critical Access Hospital	1.000	0.614	101%
501338	SNOQUALMIE VALLEY HOSPITAL	Critical Access Hospital	0.761	0.834	101%
501335	ST ELIZABETH HOSPITAL	Critical Access Hospital	0.299	0.185	101%
500030	ST JOSEPH HOSPITAL	Sole Community Hospital	0.287	0.311	101%
131312	ST LUKE'S MCCALL	Critical Access Hospital	0.554	0.516	101%
131323	ST LUKE'S WOOD RIVER MEDICAL CENTER	Critical Access Hospital	0.535	0.587	101%
501304	SUMMIT PACIFIC MEDICAL CENTER-SWING BED UNIT	Critical Access Hospital	0.696	0.422	101%
051328	TAHOE FOREST HOSPITAL	Critical Access Hospital	0.589	0.480	101%
501324	THREE RIVERS HOSPITAL	Critical Access Hospital	0.791	0.543	101%
501332	TRI-STATE MEMORIAL HOSPITAL	Critical Access Hospital	0.523	0.443	101%
393302	UPMC CHILDREN'S HOSPITAL OF PITTSBURGH	Children's Hospital	0.203	0.166	100%
501339	WHIDBEYHEALTH MEDICAL CENTER	Critical Access Hospital	0.576	0.334	101%
501327	WHITMAN HOSPITAL AND MEDICAL CENTER	Critical Access Hospital	0.989	0.542	101%

Appendix C
Cascade Care
Dialysis Base Rate Development

Note: *Labor portion of base rate is adjusted by facility or area wage index.*

RVU Calculation - Based on RBRVS CF	
2018 RBRVS Conversion Factor	35.9996
2018 Dialysis Base Rate	232.37
Composite Age Factor	1.090
Composite Comorbidity Factor	1.007
BSA Factor	1.000
BMI Factor	1.000
Other Adjustments (Implied)	1.017
Aggregate Adjustment	1.117
Adjusted Base Rate	259.48