Milliman
Medicare Repricer

Milliman's Medicare Repricer software provides the capability of repricing claims data to Medicare Allowable fees. Through a suite of reporting workbooks, users can validate, reconcile, and supply end users with inpatient, outpatient, Ambulatory Surgical Center (ASC), and professional claims repricing capabilities.

Additionally, Medicare Allowed amounts can be integrated into MedInsight's Cube Browser and Query Express. Fully documented output data-marts that facilitate drill-downs and ad hoc analytics promote the Medicare Repricer to function as a comprehensive repricing solution for all healthcare organizations.

Medicare Repricer Use Cases

Typical uses of the repricing output results include:

- Benchmarking reimbursement to Medicare payment levels
- Evaluating relative payment rates across carriers or providers
- Analyzing trends
- Converting payment contracts to Medicare-based fee schedules in a budget-neutral way
- Setting provider capitation rates
- Auditing Medicare Advantage provider payments

Medicare Repricer in Action

Provider Benchmarking

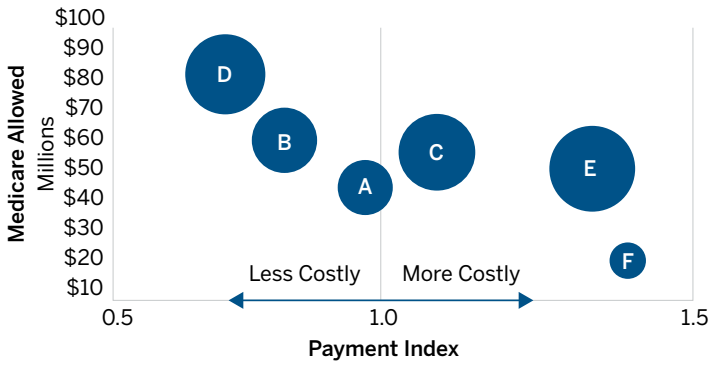
Medicare fees provide a baseline for benchmarking provider payment levels and measuring trends. Medicare pays a similar amount for the same services across providers, with variations based on regional wage and capital cost differences, medical education, uncompensated care and other factors. Medicare fees provide an easy-to-understand benchmark for making comparisons, and percentage of Medicare comparisons explicitly show the discrepancies between public and private reimbursement levels. The approach below is not limited to comparing hospitals, but can be used to compare provider groups, ASCs, and networks.

FIGURE 1: PROVIDER REIMBURSEMENT AS A PERCENTAGE OF MEDICARE

PROVIDER	ALLOWED CHARGES (A)	MEDICARE-ALLOWED (B)	ALLOWED AS A % OF MEDICARE (C = A/B)	PAYMENT INDEX (D = C/ AVERAGE)
Hospital A	$64,120,632	$47,385,190	135%	0.98
Hospital B	$75,132,182	$62,994,386	119%	0.86
Hospital C	$88,120,118	$58,928,234	150%	1.08
Hospital D	$91,132,921	$84,712,839	108%	0.78
Hospital E	$97,123,427	$53,882,882	180%	1.30
Hospital F	$43,132,283	$22,994,386	188%	1.35
Overall	**$458,761,563**	**$330,897,917**	**139%**	**1.00**

Using the information in Figure 1, Figure 2 visualizes the difference in provider cost based on the payment index benchmark. Each bubble represents one of the hospitals in Figure 1. In Figure 2, the 1.0 payment index vertical axis line represents the average reimbursement across all hospitals of 139% of Medicare. The larger the bubble, the greater the allowed charges for that hospital. Larger bubbles could mean a greater savings opportunity, depending on their position relative to the 1.0 payment index. From this chart, hospitals C and E have the most savings opportunity, since they are high volume and have a higher-than-average reimbursement as a percentage of Medicare.

FIGURE 2: COST RELATIVITY BASED ON PAYMENT INDEX



Convert Commercial Contracts to Medicare-Based Fee Schedules

Many payers see the value in using standardized fee schedules for all providers, which results in less administration, lower IT costs, consistent payment relationships between providers, and improved member and provider understanding of relative costs. Medicare provides a set of baseline fee schedules that providers are already paid on and understand. By using Medicare-based fee schedules, payers and providers can focus the negotiation on the multiple of Medicare used (e.g., 150% of Medicare fees), rather than the payment mechanics. To switch providers to Medicare-based fee schedules, the provider's current percentage of Medicare must be established. Based off of this information the rate increase and new percentage of Medicare are established. Figure 3 shows a sample calculation for a hospital from our above example:

FIGURE 3: HOSPITAL A – HOW TO CREATE A TARGET PERCENTAGE OF MEDICARE

Current Contractual Allowed	**$64,120,632**	(A)
Medicare Allowed	$47,385,190	(B)
Current Percentage of Medicare	135.32%	(C = A/B)
Negotiated Rate Increase	5%	(D)
Target Percentage of Medicare	**142.08%**	(E = C*(1+D))

Using the information from Figure 3, the hospital's reimbursement for a sample outpatient claim is developed in Figure 4. This claim is adjudicated using Medicare rules and paid at Hospital A's negotiated Target Percentage of Medicare of 142.08%. The target was calculated above using Medicare Repricer, historical claims, and the negotiated increase of five percent. Note that for maternity and newborn diagnostic related groupings (DRGs), we recommend using modified MS-DRG weights that reflect a commercial population, rather than a Medicare population.

FIGURE 4: HOSPITAL A – REIMBURSEMENT OF SAMPLE OUTPATIENT CLAIM

CPT	DESCRIPTION	APC	STATUS	FEE SCHEDULE	MEDICARE FEE	142.08% OF MEDICARE
36415	Routine venipuncture		A	Lab	$3.00	$4.26
45378	Diagnostic colonoscopy	0143	T	APC	$643.41	$914.16
71020	Chest X-ray	0260	X	APC	$45.04	$63.99
80048	Metabolic panel		A	Lab	$11.91	$16.92
81001	Urinalysis auto w/scope		A	Lab	$4.45	$6.32
Total					$707.81	**$1,005.66**

Configuration Options

Various Medicare Repricer options are available during the implementation process.

- Six years of Medicare Fee Schedules are maintained, allowing claims to be repriced to the claim date of service, or all data can be repriced to a single year of Medicare.
- Inpatient claims may include or exclude add-on amounts such as indirect medical education (IME), disproportionate care hospital (DSH), and uncompensated care pool (UCP).
- Outpatient options allow for approximating dialysis amounts.
- Professional options allow for geographic and specialty adjustments and limiting the repriced amounts based on billed charges.
- Option to apply maternity and newborn MS-DRG weights calibrated to a commercial population.

These options can be fine-tuned to fit the use cases of the client.

To learn more, contact milliman.medinsight@milliman.com or visit our website at medinsight.milliman.com.