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December 20, 2006

Richard Miles
Director Actuarial Division
Michigan Department of Community Health
Medical Services Administration
400 S. Pine Street
Lansing, MI 48909-7979

Re: OPPS Budget Neutral Analysis Review

Dear Dick:

Per your request, Milliman, Inc. (Milliman) has worked with Michigan Department of Community Health (MDCH) personnel to review and validate the OPPS budget neutral percent of Medicare. We understand that MDCH will use this analysis for internal and external communications.

This letter was prepared for internal use by MDCH and may not be released to others without prior written consent from Milliman, Inc. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDCH 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 letter must rely upon their own experts in drawing conclusions about Michigan's hospital outpatient prospective payment system. The estimates included in this letter cannot and do not consider every variation from the key assumptions and the effect of variations on the results.

Background

MDCH is implementing an OPPS, effective April 1, 2007. This OPPS will be based on the Medicare OPPS with a budget target adjustment, so that the amounts paid to providers in aggregate will initially be approximately equal to the current system of payment (pre-OPPS) for fee-for-service (FFS) and managed care payments combined.

MDCH used second quarter 2005 historical fee-for-service data as the baseline for the comparison of OPSS to pre-OPSS reimbursement levels. The OPSS to pre-OPSS impact by HCPCS was estimated using the FFS data and then managed care utilization by HCPCS was used to estimate the total MDCH impact.

The rest of this letter describes the overall results and provides an overview of our review methodology.

High Level Results

We estimate that paying 69.4% of 2006 Medicare would result in the same revenue to providers in total as the 2006 MDCH allowed amounts for FFS and managed care combined. The OPSS conversion would be revenue neutral in aggregate to the providers, but there will not be a neutral effect on every provider or on every payer. We estimate that 67.4% of 2007 Medicare OPSS will be revenue neutral to providers.

Methodology and Detailed Results

MDCH supplied Milliman with a second quarter 2005 claims file for all OPSS eligible facilities, with estimated MDCH second quarter 2006 allowed amounts and estimated OPSS allowed amounts at 60% of Medicare. Milliman then worked with MDCH to review and validate the current allowed (2Q 2006) and the OPSS estimates to estimate the impact on FFS and managed care payers.

A number of claims were excluded from the final comparison of OPSS to current MDCH. This includes dual eligible FFS claims, services that will not be affected by OPSS and services with inadequate information to re-price the claim under OPSS. This was generally due to obsolete (deleted) procedure codes and missing procedure codes. Exhibit 1 summarizes the claims submitted, the exclusions, and the totals included in the final comparison.

Exhibit 2 presents the impact by type of claim. We have aggregated bundled procedures with the relevant significant procedure so that we can compare OPSS to pre-OPSS by type of claim for emergency room and surgeries. The Radiology, Lab and Other sub-totals are procedure code based, not claim header based. The impact is not flat for every service but is 1.00 in total for the MDCH FFS and managed care data combined.

OPSS Assumptions for MDCH

We worked with MDCH to make payment assumptions in the analysis that are consistent with the way claims will be paid starting April 1, 2007.

A brief summary of the OPSS assumptions used:

1. All procedures with an APC allowed amount used the APC amount.
2. Non-APC procedures will be paid using lab or RBRVS fee schedules or paid percent of charges.
3. Procedures that are not covered by Medicare, but are covered by MDCH will continue to be paid using MDCH payment methodologies (not included in the budget neutral numbers).
4. Standard Medicare claim edits were used with the assumption that only 50% of the editing savings will be realized by MDCH (i.e., 50% will be re-billed and paid).

Impact of Exclusions

Over 93.4% of the fee-for-service claim lines that could be affected by the OPSS initiative were included in the analysis. For managed care claims, that figure is 95.4%. Based on our review of the excluded claims, we believe that if they were coded correctly and included in the analysis the budget adjustment factor would not materially change. If the excluded claims are biased toward claims that Medicare pays significantly higher or lower from the amount that MDCH pays, then that could bias the adjustment factor higher or lower.

Estimated 2007 Budget Target Adjustment

In Exhibit 3 we estimate the 2007 budget target adjustment. In column (A) we show the OPSS allowed dollars from Exhibit 2 by payment methodology. Next (B), we show the estimated increase in 2007. Column (C) estimates the 2007 allowed charges at 69.4% of Medicare if no changes are made. At the bottom of Exhibit 3 we show that $69.4\% \times (A) / (C)$ is 67.4%. Assuming that the state of Michigan holds hospital outpatient allowed payments flat in 2007, then our estimate is that 67.4% of Medicare will be budget neutral.

Post Implementation Validation

We understand that MDCH will analyze the OPSS priced claims and compare to pre-OPSS allowed amounts (with some adjustment for edits) after six months and twelve months of claims experience is available. We agree that this review is warranted since provider coding may change with the OPSS implementation and only three months of experience was used for the impact analysis.

Data Reliance

For this analysis, we relied on data provided to us by Steve Ireland, Dick Miles and others at MDCH. We have not audited this data; however, we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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Variability of Results

Our projected estimates are not predictions of the future; they are only projections based on the assumptions. If the underlying data or assumptions are incorrect, then the estimates will be incorrect. The actual future OPPS costs will vary from our estimates and the emerging results should be carefully monitored with assumptions adjusted as appropriate.

Please call me at (206) 504-5569 or Rob Damler at (317) 524-3512 if you have any questions. Thank you for the opportunity to assist MDCH.

Sincerely,

Will Fox, FSA, MAAA
Principal & Consulting Actuary

/par
Enclosures

cc: Rob Damler

Exhibit 1
Michigan Department of Community Health
Data Reconciliation Summary

		<i>Claim Lines</i>	
		<u>FFS</u>	<u>Managed Care¹</u>
A	Source Data ²	1,520,974	843,048
B	Less Duplicate Claim Lines	-	2,769
C	Less Dual Eligibles	700,202	-
D	Less Not Affected by OPPS ³	7,307	6,207
E	Less Not Priceable Under OPPS	<u>53,719</u>	<u>38,416</u>
F	Used in OPPS Analysis	759,746	795,656
G	Used as percent of claims affected by OPPS (F ÷ (F+E))	93.4%	95.4%

(1) Managed care data was grossed-up to account for all managed care claims. The figures listed are prior to gross-up.

(2) The fee-for-service claims were incurred 2Q 2005 and the managed care claims were incurred 1Q 2006. Claims data from PHP Mid-Michigan, HP Michigan, and Great Lakes were used in our analysis.

(3) These services remain at current MDCH fee schedules or are excluded from the OPPS Initiative.

Exhibit 2
Michigan Department of Community Health
Estimated Impact by Milliman Case Category

Combined FFS and HMO

<u>Case Category</u>	<u>Units</u>	<u>Allowed Dollars @69.4%¹</u>		<u>OPPS Cost to Pre-OPPS Cost Ratio</u>
		<u>Pre-OPPS Method</u>	<u>OPPS Method</u>	
Total -- All Case Categories	4,263,275	\$139,177,763	\$139,125,704	1.000
Surgery	498,859	\$53,891,294	\$52,195,506	0.969
Radiology	333,186	19,337,415	25,636,455	1.326
Pathology / Lab	1,384,848	11,918,583	10,836,023	0.909
Emergency Room	838,675	32,651,144	30,775,864	0.943
Other	1,207,706	21,379,326	19,681,856	0.921

(1) HMO allowed dollars represents the HMO utilization but at the average FFS allowed per unit rates.

Exhibit 3
Michigan Department of Community Health
Estimated Budget Target Adjustment

	A	B	C
<i>Payment</i>	<i>2Q06 OPPS</i>	<i>Assumed</i>	<i>2Q07 OPPS</i>
<u>Methodology</u>	<u>Allowed @69.4%</u>	<u>2007</u>	<u>Allowed @69.4%</u>
	<u>(FFS & HMO)</u>	<u>Increase</u>	<u>(FFS & HMO)</u>
APC	\$124,034,107	3.4%	\$128,251,267
RBRVS	4,176,258	0.0%	4,176,258
Lab	10,719,315	0.0%	10,719,315
Cost to charge	<u>196,024</u>	<u>8.0%</u>	<u>211,706</u>
Total	\$139,125,704	3.0%	\$143,358,546

Estimated 2007 Budget Neutral Percent [69.4% x A / C]

67.4%
