

Questions & Answers

2007-2009 Draft Per Capita Cost Report

The following questions have been asked by OHP Stakeholders regarding the 2007-2009 Draft Per Capita Cost Report. Department of Human Services' Actuarial Services Unit staff and/or PricewaterhouseCoopers (PwC) have provided the following answers. For additional information, contact Wendy Edwards at (503) 945-6512 or Wendy.Edwards@state.or.us.

Q1: On page 12 of the report, it states: Data on cost-to-charge ratios for hospital services in Oregon were obtained from ASU.

On page 20 of the report, it states: ASU staff worked with OMAP staff to quantify the amount of GME reported by the hospitals in order to develop adjusted cost-to-charge ratios for these hospitals.

Could you provide me the specific numbers and methodology used to arrive at OHSU's cost-to-charge ratio?

A1: Status Pending

Q2: With regard to the hospital cost-to-charge ratios that are used in the development of the per capita costs: are there 2 CCRs for each hospital (one for inpatient and one for outpatient)?

A2: Yes, there are two Cost to Charge Ratios (CCRs) for each hospital, one for outpatient (OP) and one for inpatient (IP).

Q3: Do you have, or is it possible to prepare a comparison of the 2008/09 per capita costs to the 2005/07 per capita costs by the summary level of service that appear in the plan's capitation rate worksheets (i.e. Total Physician, Total Outpatient, Total Prescription Drugs, Total Inpatient and Total Miscellaneous) for each eligibility category?

A3: Status Pending

Q4: Page viii- The draft report includes a new "Disclaimer" that indicates a possibility of material errors or omissions due to PwC's reliance on the State to provide accurate and complete data. Although plans confirm a limited data set (primarily total billed charges) with the state, certain other data critical to the PCC rate development is not confirmed (primarily utilization data). Further, the accumulation of individual plan data to the grand totals still remains a "black box" process for the plans. We understand that due to time constraints, a review of the accumulation process and controls in place to limit the possibility of material errors is not possible prior to issuing the final report. We believe such a

review would still be beneficial in helping insure the accuracy of the PCC calculations and the resulting capitation rates.

A4: Status Pending

Q5: Page 7- Please clarify the 5 different delivery systems, compared to the 3 noted in the same section of the prior report. I assume PCO is one of the changes, but what is the other?

A5: Status Pending

Q6: Page 10- Please consider clarifying that ASU staff only verified limited data elements with the managed care plans.

A6: Status Pending

Q7: Page 12- Is it possible to provide the list of Hospital CTC ratios and the date of the corresponding cost report year from which the data was derived? Could you please identify the numeric amount of the Medicare conversion factor used as the base rate in the PCC calculations?

A7: Status Pending

Q8: Page 19/20- (At your request, the following is “repeat” of my question from 08/10/06) Please see the attached summary of Medicare inpatient hospital reimbursement. It appears that the CTC ratios used for development of PCC are substantially different from Medicare payment rates. It appears that the current methodology for determining the hospital per capita costs has ignored the impact of Medicare PPS on Medicare hospital reimbursement (i.e. a “cost report” approach has been used instead of a “reimbursement” approach). Please compare/contrast this to the physician/professional component of the PCC that utilize Medicare “reimbursement”, particularly in light of the impact the federal DRA has had on the RBRVS conversion factor. If we are using Medicare reimbursement rates as a proxy for physician/professional, why is a different methodology being used for hospitals? It was “OK” to use the Medicare RBRVS system as a proxy for physician/professional when it was a cost-based system...is it still “OK” to use that system when a Federal budget component now lays on top of that system?

A8: Status Pending

Q9: Exhibit 9-A- As a follow-up/in support of item 6 above, the average cost per unit of service for a number of the physician/professional services show a decline in the draft 2008/09 PCC report as compared to the 2005/07 report, while there are significant increases in a number of the hospital based services.

A9: Status Pending

Q10: Page 23- Is it possible to provide plans with their “repriced” drug data (i.e. priced out at OMAP cost levels) for verification/analysis?

A10: Status Pending

Q11: Page 27 – It appears that there has been no cost increase applied to ENCC services...why? Also, should ENCC service costs be applied to other eligibility categories (for example, QIE requires that ENCC services also be provide to children with special needs)?

A11: Status Pending

Q12: Page 32- How/when will the change in the prioritized list related to the coverage of Morbid Obesity be factored in to the PCC’s?

A12: Status Pending

Q13: Page 39 – Can you provide a copy of the “new” prioritized list...it does not appear to be posted to the web.

A13: Status Pending

Q14: Page 82- For purposes of the data roll forward, why does it make sense to include PLMA with other TANF-related? In particular, maternity admits in PLMA will not decrease (as currently projected) as pregnancy is a primary driver of PLMA eligibility.

A14: Status Pending

Q15: Page 82- I recognize that there is an “art” to setting the trend factors, but it appears that the factors are on the “low” side. For example, the reference in the report to the CMS Medicare Economic Index details expected % changes in physician cost of above 2%, while an annual rate of 1.7% is used in the PCC draft report. Also, a PwC report (“The Factors Fueling Rising Healthcare Costs”) prepared in January 2006 for America’s Health Insurance Plans (AHIP) details cost and utilization increases at trend rates significantly higher than those used in the draft PCC calculations. Can you provide additional detail/insight into the selection of trend rates?

A15: Status Pending